

# Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

## Version 11

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## Introduction

1. This document sets out the terms and conditions of service (TCS) for doctors and dentists (hereafter referred to as doctors) in approved postgraduate training programmes under the auspices of Health Education England (HEE). It supersedes the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002<sup>1</sup> and the provisions currently contained in Schedules to the directions to HEE with regard to GP specialty trainees (GP registrars) when employed in practice settings. These TCS will also apply to a doctor employed in a relevant training post during a period of grace approved by the postgraduate dean.
2. These terms and conditions are not intended to apply to any doctor or dentist not in training on a General Medical Council (GMC)/HEE approved training programme, or to a dentist training on a dental foundation training programme.
3. These TCS do not apply to any doctor undertaking a period of shadowing immediately prior to commencing work as a foundation doctor. Separate arrangements should be used for this shadowing period.
4. Sections of the *NHS Terms and Conditions of Service Handbook*<sup>2</sup> which apply to doctors employed under these TCS are listed in Schedule 14.
5. This TCS document, the principal statement of terms and conditions (contract of employment), and any local employer-level agreements (including employment policies), contain the entire terms and conditions of employment, such that all previous agreements, practices and understandings between the employer and the employee (if any) are superseded and of no effect. Where any external document is incorporated by reference, such incorporation is only to the extent so stated and not further or otherwise.
6. The TCS set out in this handbook shall incorporate, and be read subject to, any amendments which are from time to time the subject of negotiation by the appropriate negotiating bodies and are approved by the Secretary of State after considering the results of such negotiations. A record of amendments to these terms and conditions of service will be available in the relevant section of the [NHS Employers website](#).
7. The standards of training and education for doctors are agreed between the employer and HEE, and are subject to an annual agreement (the Learning and Delivery Agreement) between the parties.
8. As specified within the ‘*Code of Practice: Provision of Information for Postgraduate Medical Training*’ (“the Code”) in Annex C, Employers are required to provide doctors with timely, accurate and detailed information regarding their training posts and

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<sup>1</sup> Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002, [https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Terms\\_and\\_Conditions\\_of\\_Service\\_NHS\\_Medical\\_and\\_Dental\\_Staff\\_300813\\_bt.pdf](https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Terms_and_Conditions_of_Service_NHS_Medical_and_Dental_Staff_300813_bt.pdf)

<sup>2</sup> NHS terms and conditions of service handbook, <https://www.nhsemployers.org/tchandbook>

relevant arrangements in advance of starting work in order to enable them to plan ahead in an acceptable and meaningful manner. Doctors equally have a responsibility to provide full information, where requested, to inform recruiting organisations, and upcoming and current employers of their intentions, and ensure they maintain up to date contact details for communications. For the purposes of this provision a doctor is someone who has applied for and been offered postgraduate medical training posts/programmes as referred to in the Code, or who has commenced a training programme and is due to change employer as part of the training programme.

- a. Should Health Education England fail to provide all of the information required by the Code to the employer, or delay in sending the information so that the employer is not in receipt of it 12 weeks prior to the commencement of a doctor's post, or notify the employer of changes to the required information at any point within the 12 weeks prior to the commencement, the employer will take reasonable steps to provide the required information relating to the generic work schedule and the duty roster within the timeframes specified within schedule 4 of this TCS and the Code. Where this is not reasonably practicable, the employer will take reasonable steps to provide the doctor with the relevant information as soon as possible.
- b. Where an employer is receiving doctors on an approved postgraduate training programme and has entered into a lead employer arrangement with another organisation ("the host organisation"), some duties as specified in this schedule may be devolved to the host organisation. It remains the lead employer's contractual responsibility to ensure fulfilment of the requirements relating to the generic work schedule and the duty roster as specified within the Code. Host organisations should themselves comply with the provisions of this paragraph 8 and the Code on behalf of the lead employer, or provide sufficient information to lead employers to enable them to do so. Where a host organisation has failed to comply with the provisions of this paragraph 8 and the Code itself or provide the lead employer with all the necessary information to fulfil the requirements relating to the generic work schedule and the duty roster within the specified timeframes, the lead employer will take reasonable steps to provide the doctor with the relevant information as soon as possible.
- c. A work schedule may be subject to review from time to time. If an employer makes changes to the doctor's post, generic work schedule and/or duty roster owing to service and/or commissioning requirements, the employer will still take reasonable steps to provide an amended generic work schedule and duty roster to the doctor within the timeframes specified within schedule 4 of this TCS and the Code . Every effort should be made to anticipate such changes in the work schedule and reach agreement on such changes. Where that is not reasonably practicable, the employer will take reasonable steps to provide the doctor with the relevant information as soon as possible.
- d. In the event that a doctor fails to provide the information required by the employer, as specified within the Code, and/or notifies the employer of information which materially impacts upon the post, the generic work schedule or the duty roster, the employer will still take reasonable steps to provide an amended generic work schedule and / or duty roster to the doctor within the timeframes specified within schedule 4 of this TCS and the Code. Where that is not reasonably practicable, the employer will take reasonable steps to

provide the doctor with the relevant information as soon as possible.

- e. Doctors should be able to request leave in advance of the production of the duty roster. Where an employer has met the requirements of the 8 week timeframe for a doctor's post, as specified within the Code, this should allow for individual annual leave requests to be submitted, acknowledged and potentially agreed, ahead of the duty roster being issued. Following this, if a doctor requests changes to the duty roster, after it being issued 6 weeks prior to commencing a post, such requests will only be accommodated in exceptional circumstances, other than routinely requested annual leave and mutually agreed swaps. Where such requests are granted, the employer will take reasonable steps to inform other affected doctors of any changes to the duty roster as soon as reasonably practicable.
9. NHS Improvement and HEE will be asking all employers to establish regional streamlining processes for recruitment and induction by April 2017.
  10. HEE will be leading a review of the processes which allow transfer 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.
  11. In order to mitigate against any disadvantage that could be suffered by any doctor who takes time out of training due to illness, caring responsibilities or any other legitimate reason, employers must facilitate as necessary the provisions that will be made by HEE for 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 to be in place by August 2017.

## Abbreviations

F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
StR	Specialty Registrar
SpR	Specialist Registrar
ACAS	Advisory, Conciliation and Arbitration Service
CCT	Certificate of Completion of Training
COGPED	Committee of General Practice Education Directors
CQC	Care Quality Commission
DME	Director of Medical Education
FPP	Flexible pay premium / premia
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
HEE	Health Education England
JLNC	Joint Local Negotiating Committee
LTFT	Less than Full Time
NHSI	NHS Improvement
NIHR	National Institute for Health Research
OOP	Out Of Programme
OOPC	Out Of Programme (Career Break)
OOPE	Out Of Programme (Experience)
OOPR	Out Of Programme (Research)
OOPT	Out Of Programme (Training)
PIDA	Public Interest Disclosure Act 1998
SID	Senior independent director
TCS	Terms and Conditions of Service
WTR	The Working Time Regulations 1998 (as amended)

## Definitions

Acting down	Acting down is where a doctor is requested by their employer to cover the duties of a more junior colleague within their contracted working hours, although it may extend to covering the duties of a more junior colleague during unplanned additional hours. This definition does not apply, however, where the doctor undertakes duties as part of their normal workload which a more junior doctor might be competent to undertake; nor does it apply where a doctor agrees to undertake locum work at a more junior level.
Allocated leave	Allocated leave is residual leave which is allocated to an individual doctor after requests for leave have been accommodated as best as possible.
Caring responsibilities	Significant responsibilities to care for another person, whether solely or as part of a group (for example of family members). This may include but is not limited to acting as a carer for a child or an ill or disabled family member.
Director of Medical Education (DME)	<p>The DME is a member of consultant medical staff and an employee of the employer / host organisation who leads on the delivery of postgraduate medical and dental education in the Local Education Provider (LEP), ensuring that doctors receive a high-quality educational experience and that GMC/GDC standards are met, together with the strategic direction of the organisation and Health Education England (HEE). The DME is responsible for delivering the educational contract between the LEP/ lead provider (LP) and HEE local team.</p> <p>For the purposes of these terms and conditions, where reference is made to the DME, the responsibilities described may be discharged by a nominated deputy to the DME.</p>
Doctor	Wherever 'doctor' is used in these terms and conditions, it is intended to mean a doctor or dentist in an approved postgraduate training programme under the auspices of HEE.
Doctor or dentist in training	A doctor or dentist in postgraduate medical or dental education undertaking a post of employment or a series of posts of employment in hospital, general practice and/or other settings.
Duty roster	The prospective working pattern and range of duties expected for each individual doctor on a rota for that rotation.
Educational review	An educational review is a formative process which enables doctors to receive feedback on their performance and to reflect on issues that they have encountered. Doctors will be able to raise concerns relating to curriculum delivery and patient safety. This will include regular discussions about the work schedule.
Educational supervisor	A named individual who is selected and appropriately trained to be responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time. The educational supervisor may be in a different department, and occasionally in a different organisation, to the trainee. Every trainee should have a named educational supervisor and the trainee should be informed of

	the name of the educational supervisor in writing. This definition also covers approved clinical supervisors in GP practice placements.
Employer	The organisation by which the employee is employed and which holds the contract of employment.
Episodes of work	Periods of continuous work within an on-call period separated by periods of rest.
Fixed leave	Fixed leave is leave built into the construction of the rota with days or weeks blocked out for each doctor in advance.
Form B	Form B is a GMC document which approves a training post at a specific point in time. It provides an outline of the educational and service activities and the expected learning outcomes from the post.
Guardian of safe working hours	A senior appointment made jointly by the employer / host organisation and junior doctors, who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.
Host organisation	An organisation where a doctor is deployed to work in a post for a fixed period of time under a lead employer arrangement. The employer can also be, but is usually not, the host organisation.
Integrated clinical academic pathway	Integrated clinical academic pathway combines both clinical and academic components within one training programme (for example, those defined under the auspices of the National Institute for Health Research (NIHR)).
Lead employer	An organisation that issues and holds the contract of employment throughout a doctor's training programme, during which the doctor may be deployed into one or more host organisations.
Long shift	For the purposes of these TCS, a long shift is any shift that exceeds 10 hours in duration.
On-call	A doctor is on-call when they are required by the employer to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period. A doctor carrying an 'on-call' bleep whilst already present at their place of work as part of their scheduled duties does not meet the definition of on-call working.
On-call period	An on-call period is the time that the doctor is required to be on-call (as defined above) by their employer.
Period of grace	6 months of continued employment after a doctor has successfully completed their specialist training. Periods of grace are not applicable to GP trainees.
Placement	For the purposes of these TCS, a placement is a setting into which a doctor is placed to work for a fixed period of time in a post or posts in order to acquire the skills and competencies relevant to the training curriculum, as described in the work schedule.



Post	For the purposes of these TCS, a post has approval by the GMC/HEE for the purposes of postgraduate medical and dental education. Each approved post is located within an employer or host organisation.
Professional leave	Professional leave is leave in relation to professional work.
Professional work	Professional work is work done outside of the requirements of the curriculum and/or the employer/host organisation for professional bodies such as Royal Colleges, Faculties or the GMC/GDC. Non-trade union activities undertaken by for a recognised trade union, for example work on an Ethics Committee would count as professional work, however trade union duties and activities are covered through recognition agreements.
Public holiday	Holidays recognised by the NHS in England. Currently, these are: New Year's Day; Easter Friday (otherwise also known as Good Friday); Easter Monday; the two May bank holidays; the August bank holiday; Christmas Day and Boxing Day.
The regulator	General Medical Council or (for dental programmes) other relevant body.
Resident on-call	A doctor who is resident on-call is required to be present on site and available to work for the whole on-call period, but will not be expected to be working during that time unless called upon to do so.
Rota	The working pattern of an individual doctor or group of doctors.
Rota cycle	The number of weeks' activity set out in a rota, from which the average hours of a doctor's work and the distribution of those hours are calculated.
Rotation	A rotation is a series of placements made by the HEE local office into posts with one or more employers or host organisations. These can be at one or more locations.
Senior independent director	Non-executive director appointed by the board of directors to whom concerns regarding the performance of the guardian of safe working hours can be escalated where they are not properly resolved through the usual channels.
Shift	The period which the employer schedules the doctor to be at the work place performing their duties, excluding any on-call duty periods.
Special leave	Special leave for any circumstances will be defined by the employer's local policy.
Study leave	Study leave is leave that allows time, inside or outside of the workplace, for formal learning that meets the requirements of the curriculum and personalised training objectives. This will include regional educational events where the time is protected.
Training programme	Training programmes and training posts are approved by the GMC or (for dental programmes) HEE. Learning environments and posts used for training are recommended for approval by HEE for the purpose of postgraduate medical/dental education. Time spent in

Work schedule	those posts/environments allows the doctor to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificate of Completion of Training (CCT).
Work schedule review	<p>A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.</p> <p>A work schedule review is a formal process by which changes to the work schedule may be suggested and/or agreed.</p> <p>A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.</p> <p>A work schedule review should consider safe working, working hours, educational concerns and/or issues relating to service delivery.</p>
WTR reference period	Reference period as defined in the Working Time Regulations 1998 (as amended), currently 26 weeks.

## References

The *Gold Guide* as referenced in these TCS, refers to the document entitled *A reference guide for postgraduate specialty training in the UK*<sup>3</sup> as amended from time to time. A separate *Gold Guide* for dental training entitled *A Reference Guide for Postgraduate Dental Specialty Training in the UK* (or any successor document) should be referred to with regard to dental training programmes.

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<sup>3</sup> A Reference Guide for Postgraduate Specialty Training in the UK, also known as the Gold Guide, Eighth Edition, is accessible via the [COPMeD website](https://www.copmed.org.uk/images/docs/gold_guide_8th_edition/Gold_Guide_8th_Edition_March_2020.pdf) - [https://www.copmed.org.uk/images/docs/gold\\_guide\\_8th\\_edition/Gold\\_Guide\\_8th\\_Edition\\_March\\_2020.pdf](https://www.copmed.org.uk/images/docs/gold_guide_8th_edition/Gold_Guide_8th_Edition_March_2020.pdf)

# SCHEDULE 01

## GENERAL DUTIES AND RESPONSIBILITIES

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1. Doctors have clinical and professional responsibility for their patients (for doctors in public health medicine, this is for their population) as set out in the General Medical Council (GMC) guidance *Good Medical Practice*<sup>4</sup> or any successor documents, as amended or substituted from time to time. It is the duty of a doctor:
  - a. to maintain professional standards and obligations as set out by the GMC and the General Dental Council (GDC), as appropriate
  - b. to keep patients (and/or their carers, if appropriate) informed about their condition
  - c. to involve patients (and/or their carers, if appropriate) in decision-making about their treatment
  - d. to maintain the required level of skills and knowledge, and
  - e. to protect patients and colleagues from any risk posed by their own health or fitness to work.
2. A doctor is responsible for carrying out any work related to, or reasonably incidental to, the duties set out in their work schedule, such as:
  - a. the keeping of records and the provision of reports
  - b. the proper delegation of tasks, and
  - c. other related duties.
3. Doctors will be expected to be flexible and to cooperate with reasonable requests to cover for their colleagues' absences where the doctor is competent to do so, and where it is safe and practicable for the doctor to do so. Where doctors carry out work in accordance with this paragraph and such work takes place outside of their contracted hours, they will receive either an equivalent off-duty period in lieu or appropriate remuneration at the rates described in Schedule 2.
4. A doctor will be prepared to perform duties in occasional emergencies and unforeseen circumstances (for example short-term sickness cover), if they are able and safe to do so, where the employer has had less than 48 hours' notice, and the duty is for less than 48 hours' duration of cover. Commitments arising in such circumstances are, however, exceptional and the doctor should not be required or expected to undertake work of this kind for prolonged periods or on a regular basis.
5. A doctor is expected to engage fully with the training programme.
6. A doctor is expected to engage constructively with the employer in the design of services and of safe working patterns to support that service delivery.
7. A doctor will make all reasonable efforts to achieve agreed training and service delivery objectives.
8. A doctor employed under these TCS must continue to hold a place in an approved postgraduate training programme.

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<sup>4</sup> Good medical practice, [https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-1215\\_pdf-51527435.pdf](https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-1215_pdf-51527435.pdf)

9. A doctor must sit such examinations as are required for the completion of training. These must be completed in accordance with the curriculum, including the timetable approved by the regulator (the GMC or other body, as appropriate).
  
10. Doctors in general practice (GP trainees, including foundation doctors) working in supernumerary training settings are additional, not intrinsic, to the workforce. Doctors in these settings contribute to service provision, however the effective running of the service should not be dependent on their attendance and they will not be used as a substitute for a locum.

# SCHEDULE 02

## ARRANGEMENTS FOR PAY

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### Pay and other allowances

1. Doctors shall be paid a basic salary at a nodal pay point linked to the grade and the level of responsibility required in the post to which they have been appointed, at the rates set out in Annex A, as reviewed from time to time.
2. The basic salary for a doctor employed full time is calculated on an average of 40 hours' work per week.
3. The value of basic salary for doctors training less than full time shall be pro rata to the levels in Annex A, based on the proportion of full-time work that has been agreed.

### Additional hours

4. Additional hours of work set out in a doctor's work schedule shall be remunerated at the basic pay rate, 1/40<sup>th</sup> of weekly whole-time equivalent for each additional hour worked, subject to the provisions of paragraph 20 below.

### Weekend allowance

5. A doctor rostered to work at the weekend (defined as one or more shifts/duty periods beginning on a Saturday or a Sunday) at a minimum frequency of 1 in 8 across the length of the rota cycle will be paid an allowance. These will be set as a percentage of full-time basic salary in accordance with the rates set out in the table below:

Frequency	Percentage
1 weekend in 2	15%
Less frequently than 1 weekend in 2 and greater than or equal to 1 weekend in 3	10%
Less frequently than 1 weekend in 3 and greater than or equal to 1 weekend in 4	7.5%
Less frequently than 1 weekend in 4 and greater than or equal to 1 weekend in 5	6%
Less frequently than 1 weekend in 5 and greater than or equal to 1 weekend in 6	5%
Less frequently than 1 weekend in 6 and greater than or equal to 1 weekend in 7	4%
Less frequently than 1 weekend in 7 and greater than or equal to 1 weekend in 8	3%
Less frequently than 1 weekend in 8	No allowance

6. A doctor working less than full time will also be entitled to be paid this allowance when working on a rota where the doctors working full time on that same rota are in receipt of such an allowance. The allowance paid to the doctor working less than full time will be paid pro rata, based on the proportion of the full-time commitment to the weekend rota that has been agreed in the doctor's work schedule. For example, a doctor

making a 50 per cent contribution to the rota would be paid 50 per cent of the value of the availability allowance paid to a doctor making a full contribution to the rota.

## **LTFT allowance**

7. A doctor who is training less than full time and is in receipt of the 2016 pay provisions, will be paid an annual allowance of £1,000 for as long as they continue to train less than full time basis This is a fixed amount which will apply to all LTFT doctor and will be paid in addition to any other sums, as set out in this schedule. The allowance will be spread out over the year and paid in monthly instalments. This allowance will come into effect from December 2019.
8. Doctors who are already in receipt of the £1,500 transitional LTFT allowance will continue to receive this as per schedule 15 paragraph 20, but will not be entitled to the £1,000 permanent allowance on top of this. When a doctor's entitlement to the transitional LTFT allowance ends, they will then be entitled to receive the £1,000 permanent allowance.

## **On-call availability allowance**

9. A doctor on an on-call rota who is required by the employer to be available to return to work or to give advice by telephone, but who is not normally expected to be working on site for the whole period, shall be paid an on-call availability allowance.
10. The value of the allowance described in paragraph 9 is set out in Annex A and is based on 8% of a full-time basic salary for the relevant grade.
11. This allowance will take the form of a cash sum set out in Annex A, as amended from time to time.
12. For doctors employed on a less-than-full-time basis, in any grade, the value of the on-call availability allowance shall be paid pro rata, based on the proportion of full-time commitment to the rota that has been agreed in the doctor's work schedule. For example, a doctor making a 50 per cent contribution to the rota would be paid 50 per cent of the value of the availability allowance paid to a doctor making a full contribution to the rota.
13. This allowance will not be payable where a doctor's working pattern does not include any periods of work that meet the description in paragraph 9 above.

## **Payment for work undertaken whilst on-call**

14. Doctors shall be paid for their average hours of work (as defined in schedule 3 paragraph 35) undertaken while on-call, either in the workplace or remotely, at the rates of pay described in this Schedule. The hours paid will be calculated prospectively across the rota cycle and the estimated average hours at each rate of pay will be set out in the work schedule. For the purposes of pay, these total estimates shall be converted into equal weekly amounts by dividing the total number of prospective hours at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure and the doctor shall be paid 1/12<sup>th</sup> of the annual figure for each complete month, or a proportion thereof for any

partial months worked (as per paragraphs 83-85 on annual salaries).

15. If, across the rota cycle, the doctor works a greater number of hours than the prospective average estimate, the individual doctor will be appropriately compensated for these hours using the process set out in paragraphs 73-82 below.

## **Hours that attract a pay enhancement**

16. An enhancement of 37 per cent of the hourly basic pay rate shall be paid on any hours worked between 21.00 and 07.00, on any day of the week.
17. Where a shift is worked which begins no earlier than 20.00 and no later than 23.59, and is at least 8 hours in duration, an enhancement of 37 per cent of the hourly basic rate shall also be payable on all hours worked up to 10:00 on any day of the week. Where such a shift begins before 20:00, rostering guidance must be adhered to as defined in schedule 3 paragraph 6.
18. Where a shift ends after 00:00 and before 04:01, the entirety of the shift will attract an enhancement of 37 per cent of the hourly basic rate.
19. The number of hours in the rota for which an enhancement is paid will be assessed across the length of the rota cycle (as set out in the work schedule), as described in paragraph 14 of Schedule 4 of these TCS and converted into equal weekly amounts by dividing the total number of hours to be paid at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure and the doctor will be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked, as per paragraph 81-83 on annual salaries.

## **Counting of hours**

20. Average total hours, and average hours that attract an enhancement, will be assessed in quarter hours, rounded up to the nearest quarter hour.

## **Flexible pay premia**

21. Flexible pay premia, as set out in Annex A, may be payable under the circumstances described in paragraphs 22-47.
22. A doctor must have a national training number to be eligible for flexible pay premia.
23. A doctor can receive more than one flexible pay premium where the eligibility criteria for more than one premium has been met. A doctor cannot be eligible for the same flexible pay premium twice.
24. 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 28 to 47 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.
25. Flexible pay premia are additional to basic pay, and are not included for the purpose of calculating any other allowances or enhancements.

26. Where flexible pay premia are payable, these will be paid to less-than-full-time trainees pro rata to their agreed proportion of full-time work.
27. The values and application of flexible pay premia will be reviewed from time to time and details will be updated in Annex A.

**a) General practice**

28. A flexible pay premium shall be paid to doctors employed on general practice training programmes.
29. The value of such a premium for each doctor shall be fixed at the rate applicable to the general practice training programme at the point in time when that doctor first entered that programme.
30. Such a premium is only payable to a doctor on such a programme whilst the doctor is working in a general practice placement. It is not payable when the doctor is working in a hospital or any other setting.
31. Such a premium will not be payable to doctors on a different training programme (for example, on a Foundation training programme) when they are working in a general practice placement.

**b) Hard-to-fill training programmes**

32. Flexible pay premia may be payable for doctors working and training on defined hard-to-fill training programmes. Where this is the case, the identity of the defined programmes, the grades on those programmes for which the premium is payable and the value of the premia applying each programme will be set out in Annex A.
33. Where a trainee on a defined hard-to-fill training programme is working towards dual accreditation with another programme, the value of the premium payable each year shall be pro rata to the progress the trainee is making towards CCT.
34. The value of each such premium shall be fixed for each doctor at the amount set out in Annex A as applying to that programme at the point in time when that doctor first entered that programme.
35. Payment of such a premium to that doctor shall continue while the doctor remains employed under these TCS, until such time as the doctor exits the particular training programme to which that premium applies.



## **c) Clinical academics**

### **i) Integrated clinical academic pathway**

36. A flexible pay premium shall be payable to a doctor on an integrated clinical academic pathway (e.g. an NIHR pathway), at the point at which the doctor has both successfully completed the higher degree specified by the academic pathway and returned to the same training programme.

37. The value of such a premium will be fixed for each doctor at the amount set out in Annex A for this purpose at the point in time when that doctor, having completed the higher degree, returns to the same training programme.

38. Payment of such a premium to that doctor shall continue while the doctor remains employed under these TCS, until such time as the doctor exits that training programme.

### **ii) Other academic career pathways**

39. A flexible pay premium shall be payable to a doctor who:

a. has been appointed to and has taken up employment on a core, higher or run through training programme; and

b. has subsequently undertaken research as part of an out of programme research experience (OOPR) approved by the post graduate dean or has undertaken research on a less than full-time basis whilst continuing to undertake training also on a less than full-time basis and

c. has returned to, or continued as a less than full time doctor in, employment on a training programme under these terms and conditions, unless the research qualification is deemed not of relevance to that programme by the post graduate dean

40. The value of such a premium will be fixed for each doctor at the amount set out in Annex A for this purpose, at the point in time when that doctor returns to employment under these terms and conditions of service.

41. Payment of such a premium to that doctor will continue while the doctor remains employed under these TCS, until such time as the doctor exits the particular training programme to which that premium applies.

## **d) Oral and maxillo-facial surgery (OMFS)**

42. A flexible pay premium will be payable to doctors undertaking higher training in OMFS to recognise the requirement for such doctors to complete undergraduate degrees in both medicine and dentistry. The premium will be payable at the point in time when the doctor commences employment in a post on a higher training programme in OMFS.

43. The value of such a premium shall be fixed for each doctor at the amount applicable to the OMFS higher training programme, as set out in Annex A, at the point in time when that doctor first entered that programme.

44. Payment of such a premium to that doctor shall continue while the doctor remains employed under these TCS, until such time as the doctor exits the particular training programme to which that premium applies.

#### **e) Exceptional flexible pay premia**

45. There will be occasions when doctors take time out of training to undertake recognised activities that are deemed to be of benefit to the wider NHS. These include but are not limited to public health emergencies. Where such occasions occur, these are set out in Annex A. A doctor who has undertaken such an activity may be eligible to receive a flexible pay premium upon return to training. Eligibility criteria for such a premium is set out in Annex A.

46. The value of any such premium will be fixed for each doctor at the time that the recognised activity takes place, as set out in Annex A, at the point in time when the doctor first undertook the activity.

47. Payment of such a premium to that doctor will begin at the point where the doctor returns to training in the same training programme on which the doctor was training prior to undertaking the recognised activity and will continue while the doctor remains employed under these TCS, until such time as the doctor exits that training programme.

### **Pay protection on changing training path**

48. Where a doctor chooses to switch directly from one training programme (other than a Foundation programme) into an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose) and the doctor's basic pay (as defined in paragraphs 1 to 3 above) in the new appointment is lower than that paid in the immediately previous appointment on the previous training programme, the doctor may be eligible for pay protection. To be eligible for protection, the doctor must take up the first appointment on the new training programme no later than 12 months after leaving the original training programme, and such period of time could as a reasonable adjustment be extended in the event that a doctor is disabled (for the purposes of the Equality Act 2010), and/or could be extended to account for sickness absence or parental leave.

49. Where a doctor opts to switch into a hard-to-fill specialty having achieved an Outcome 1, Outcome 2, Outcome 6, or Outcome 7, in their most recent ARCP, and would have otherwise progressed to the next grade had they not switched specialty, their pay protected amount will be based on the basic salary for the grade they would otherwise be at had they not switched.

50. Where a doctor opts to switch into a hard-to-fill speciality part-way into a training year without having achieved an Outcome 1, Outcome 2, Outcome 6, or Outcome 7 in their most recent ARCP, or where a doctor opts to switch into a hard-to-fill speciality before their ARCP, their pay protected amount will be based on the basic salary for the grade they were at prior to switching speciality.

51. The amount of pay protection due to a doctor described in paragraph 48 above will

depend on their ARCP outcome as set out in paragraphs 49-50 and the doctor will continue to progress up the pay scale whenever they successfully progress onto the next grade as if they had not switched specialties. For example, if a doctor switches into GPST1 and is pay protected at the ST2 pay point, and successfully progresses to GPST2, their pay protected amount will increase accordingly and be based on the ST3 nodal point. Pay for additional hours, hours at enhanced rates, or any other amounts will be based on this higher salary amount. The doctor will receive the relevant flexible pay premium in addition to this.

52. Where a doctor is pay protected and does not subsequently progress onto the next grade, their salary will not automatically increase to the value of the next grade's pay point. For example, where a doctor switches into GPST1 and is pay protected at the ST2 pay point and remains at GPST1 the following year, their pay protection will continue to be based on the ST2 pay point for as long as they remain at GPST1. The doctor will need to progress to GPST2 in order for their pay protection to increase to the ST3 salary. Pay for additional hours, hours at enhanced rates, or any other amounts will be based on this basic salary amount. The doctor will receive any relevant flexible pay premium on top of this.
53. Where a doctor, for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010<sup>5</sup>), or to caring responsibilities, switches directly from one training programme (other than a Foundation programme) into another training programme, whether or not that programme is an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose), and the doctor's basic pay is reduced as a result of the switch, then the provisions of paragraphs 49 and 50 will also apply to that doctor.
54. In addition to the hard-to-fill training programmes identified in Annex A, for doctors changing specialties only, the JNC(J) will determine and maintain a list of additional specialties to which pay protections applies ("Difficult to Recruit Specialities"). A list of these difficult to recruit specialties appears at [www.nhsemployers.org](http://www.nhsemployers.org). Those choosing to switch directly from one training programme (other than a Foundation Programme) to a difficult to recruit speciality shall have their pay protection assessed and calculated in accordance with paragraphs 49 to 52.
55. Where a specialty has been defined as difficult to recruit, the JNC(J) will review this classification every three years in order to determine whether or not the specialty should continue to be defined as a difficult to recruit specialty.
56. Pay protection for agreed difficult to recruit specialties shall continue while the doctor remains employed under these TCS, or until the doctor exits the particular training programme.
57. Where a specialty is no longer defined as difficult to recruit, a doctor already receiving pay protection according to paragraph 54 will continue to do so until they exit the particular training programme.

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<sup>5</sup> Equality Act 2010, <http://www.legislation.gov.uk/ukpga/2010/15/contents>

## Pay protection on re-entering training from a career grade

58. Where a doctor already employed in the NHS in a nationally recognised career grade (defined for the purposes of this schedule as being an NHS medical practitioner appointed on national terms and conditions of service other than those for doctors and dentists in training), chooses to return to training in an agreed hard-to-fill training programme and as a result of the decision to return to training, the doctor's basic pay (as defined in paragraphs 1-3 above) would be lower than that received in the previous career-grade job (exclusive of any pay for additional hours / sessions, excellence awards or similar payments, on-call or other allowances, pay premia or any other supplementary payments paid or received) the doctor will be eligible for pay protection.
59. To be eligible for this pay protection the doctor must:
- a. have at least 13 months' continuous service in the same nationally recognised career grade at the point immediately prior to re-entering training, and
  - b. move immediately from their nationally recognised career grade to the hard to fill training programme.
60. The amount of any pay protection due to a doctor described in paragraphs 58 and 59 above will be calculated by comparing the basic salary paid to the doctor whilst employed in the previous career grade (as described in paragraph 58 above), with the sum total of the following:
- a. the nodal point applicable to the doctor's entry level into the hard-to-fill training programme, plus
  - b. any additional payments due in that post, including;
    - i. pay for additional rostered hours
    - ii. any enhanced rates paid for hours worked that attract such enhancements
    - iii. any on-call availability allowance
    - iv. any weekend allowance
    - v. any appropriate flexible pay premium.

Where the basic salary paid to the doctor whilst employed in the previous career grade exceeds the sum total described above, the doctor will be eligible to have his / her basic salary protected on a mark-time basis and so will receive an additional amount sufficient to increase the total salary so that it equals the higher level of basic salary previously paid. This sum will not be taken into consideration when calculating pay for additional hours, hours at enhanced rates or any other amounts, which will be based on the actual basic salary for the post in which the doctor is employed.

61. Where a doctor already employed in the NHS in a nationally recognised career grade (as defined in paragraph 58 above) re-enters training for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010<sup>6</sup>), in any training programme, whether or not that programme is an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose), and the doctor's basic pay is reduced as a result of the switch, then

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<sup>6</sup> Equality Act 2010, <http://www.legislation.gov.uk/ukpga/2010/15/contents>

the provisions of paragraphs 58-60 will also apply to that doctor.

## Leave and pay for new parents

62. The provisions governing paid occupational maternity, adoption, and shared parental leave are set out in Schedule 14.
63. Additionally, to the above provisions, if a doctor returns from an approved period of time out of programme and:
  - a. the continuity of service provisions mean the doctor is eligible for paid occupational maternity, adoption, and shared parental leave, but
  - b. the reference period for calculating paid occupational maternity, adoption, and shared parental leave means that the value of the occupational parental pay would otherwise be nil,then the pay reference period is defined as being the doctor's last period of paid employment in the previous training placement immediately prior to commencing the period of time spent out of programme.

## London weighting

64. London weighting for doctors will be paid as set out in Annex A.
65. London weighting is a fixed sum, paid pro rata to doctors working less than full time, and is not taken into account in the calculation of any other allowances or enhancements.

## Pension arrangements

66. Doctors will be eligible for membership of the NHS Pension Scheme, the provisions of which are set out in the NHS Pension Scheme Regulations 2015<sup>7</sup> (as amended).
67. The following will be pensionable in the NHS Pension Scheme:
  - a. All hours worked up to 40 hours per week on average and paid at the basic pay rate.
  - b. London weighting.
  - c. Pay protection amounts as described in paragraphs 48-61.
68. The following will not be pensionable in the NHS Pension Scheme:
  - a. Payments for additional rostered hours above 40 per week.
  - b. Enhancements paid under the provisions of paragraph 16-17.
  - c. Weekend, on-call availability and Less Than Full Time allowances.
  - d. Flexible pay premia
  - e. Travelling, subsistence and other expenses paid as a consequence of the doctor's work for the employing organisation or the wider NHS.

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<sup>7</sup> The National Health Service Pension Scheme Regulations 2015, [http://www.legislation.gov.uk/ukxi/2015/94/pdfs/uksi\\_20150094\\_en.pdf](http://www.legislation.gov.uk/ukxi/2015/94/pdfs/uksi_20150094_en.pdf)

## **Changes to the work schedule affecting pay**

69. Where pay is increased as a result of changes to the work schedule, pay will be altered from the date that the change is implemented. Other than in exceptional circumstances, such changes to pay will usually be prospective.
70. Where changes to the work schedule are required by the employer and total pay would be decreased as a result, the doctor's total pay will be protected and so remain unchanged until the end of the particular placement covered by that work schedule. This protection will not extend to any subsequent placement, including a placement where the doctor returns at a later date to the same post.
71. Where changes to the work schedule are requested by the doctor and agreed by the employer, and total pay would be decreased as a result, the doctor's total pay will be reduced in line with the change in the work schedule, from the date that the change is implemented.

## **Pay in exceptional circumstances to secure patient safety**

72. Because of unplanned circumstances, a doctor, in their professional judgement, may consider that there is a duty to work beyond the hours described in the work schedule, in order to secure patient safety. In such circumstances, employers will appropriately compensate the individual doctor for such hours, if the work is authorised by their clinical manager. This authorisation would be given before or during the period of extended working, or afterwards if this is not possible. When possible and practicable, doctors will use reasonable endeavours to seek approval from their clinical manager before or during the event. However, it is recognised that a doctor may not be able to gain prior authorisation due to circumstances at the time and this should not prevent the doctor from submitting an exception report as per schedule 5. Once an exception report has been submitted by the doctor, it must be validated and an outcome agreed within 7 days to allow for payment for the additional hours worked.
73. Such compensation should be by additional payment (at the basic pay rate as described in paragraph 4 above, uplifted by any enhancement that may apply at the time that the unscheduled work takes place, as described in paragraphs 16-17 above), or by time off in lieu, or by a combination of the two. Where safe working hours are threatened by such an extension of working hours, time off in lieu will be the preferred option. If the additional hours of work have caused a breach of rest requirements, the time off in lieu must be taken within 24 hours unless the doctor self declares as fit for work and the manager agrees, in which case it can be accrued. Time off in lieu arising from breaches of hours but not rest can be accrued.
74. Where time off in lieu is agreed by the doctor and the report's actioner as the outcome of an exception report, there will be a four week window from the outcome being agreed for the doctor and rota manager to discuss and allocate time off in lieu to a future shift in their working pattern, before the end of that rotation. Where this does not occur, the time off in lieu should automatically be converted by the employer to pay after that four week period. At the end of a rotation, any untaken time off in lieu will be converted into pay.

75. Where a manager does not authorise payment, the reason for the decision will be fed back to the doctor and copied to the guardian of safe working hours for review.
76. Where a doctor is paid for additional hours worked while 'acting down', their pay will reflect their current nodal point and not the lower nodal point of the grade at which they are 'acting down'.
77. Where such additional hours are in breach of the below contractual requirements, the additional time worked causing the breach of hours limits or required rest periods will attract a penalty rate, according to the values set out in Annex A:
  - a. A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
  - b. A breach of the maximum 13 hour shift length; or
  - c. A breach of the maximum of 72 hours worked across any consecutive 168 hour period; or
  - d. where 11 hours rest in a 24 hour period has not been achieved (excluding on-call shifts); or
  - e. where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
  - f. where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved
78. These provisions also apply to additional hours of actual work over the prospective average estimate during non-resident on-call (as described in paragraph 14 above).
79. Where payment is the suggested outcome by an actioner, the report submitter should formally accept the outcome presented by the actioner as soon as is practicable to ensure prompt payment. Where the agreed outcome is not formally closed on the system, these reports will automatically be accepted and closed at the end of the doctor's rotation. Exception reports from doctors who are unable to review exception reporting outcomes, due to extenuating circumstances (e.g. doctors on parental leave or long-term sick leave), will be automatically accepted and closed after four weeks.
80. Where payment has been approved for an exception report, then the payment must be made to the doctor within a month, or within the next available payroll, following the report being approved for payment and agreed by the report submitter and actioner. In addition, there should be no additional administrative task required of the doctor to receive payment for an approved report.

## **Payment of annual salaries**

81. The annual salaries of full-time employees will be apportioned as follows:
  - a) For each calendar month: one-twelfth of the annual salary
  - b) For each odd day: the monthly sum divided by the number of days in the particular month
82. The annual salaries of less than full time doctors should be apportioned as above except in the months in which employment commences or terminates when they should be paid for the hours worked.
83. Where full-time doctors terminate their employment immediately before a weekend and/or a public holiday, and take up a new salaried post with another NHS employer

immediately after that weekend and/or that public holiday, payment for the intervening day or days, i.e. the Saturday (in the case of a 5 day working week) and/or the Sunday and/or the public holiday, shall be made by the first employer.

## **Locum pay**

84. Where a doctor carries out additional work through a locum bank, as described in Schedule 3, paragraphs 52-53 of these TCS, such work will be paid at the rates determined by that NHS staff bank.



# SCHEDULE 03

## WORKING HOURS

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### Principles

1. Contractual limits on working hours and protected rest periods, as set out in this schedule, are necessary to ensure both patient safety and the safety of the doctor.
2. The employer and the doctor must comply with the regulatory limits set out in the Working Time Regulations 1998<sup>8</sup> (the Regulations), as amended, or any successor legislation. The employer and the doctor should pay particular attention to the safeguards on hours and rest, including those related to night workers, as set out in the Regulations.
3. The employer has a contractual and statutory responsibility for ensuring the doctor is not contracted, or otherwise required, to work outside the limits covered in paragraph 1 and 2 above.
4. Individual doctors have a professional responsibility for ensuring that their total hours of work, including any work undertaken for any other employer, comply with the contractual and regulatory limits set out in paragraphs 1 and 2 above.
5. To provide assurance to both the employer and the doctor on safe working hours as described in paragraphs 1 to 4 above, a guardian of safe working hours will be appointed by the employer/host organisation. This role is described in Schedule 6.
6. The employer/host organisation should refer to jointly agreed national guidance on good rostering practice<sup>9</sup>, including the appropriate use of technology, and the correct way to roster shifts with hours worked during the night period, in designing the work schedule.

### Limits on hours

7. No doctor should be rostered for more than an average of 48 hours of actual work per week, as calculated over the reference period defined in the Regulations.
8. No more than 72 hours' actual work should be rostered for or undertaken by any doctor, working on any working pattern, in any period of 168 consecutive hours.

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<sup>8</sup> The Working Time Regulations 1998, <http://www.legislation.gov.uk/ukxi/1998/1833/contents/made>

<sup>9</sup> The Good Rostering Guidance is available from [www.nhsemployers.org](http://www.nhsemployers.org)

9. No shift (other than an on-call period) shall be rostered to exceed 13 hours in duration.
10. No more than four long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) shall be rostered or worked on consecutive days. Where four long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fourth long shift.
11. Where long shifts (as defined by these TCS) finish after 23.00, no more than four such shifts shall be rostered or worked on consecutive days. Where four such shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fourth such shift.
12. No more than four shifts where at least three hours of work falls into the period between 23.00 and 06.00 shall be rostered or worked consecutively.
13. Where shifts (excluding non-resident on-call shifts) as defined in paragraph 12 above are rostered singularly, or consecutively, then there must be a minimum 46-hour rest period rostered immediately following the conclusion of the shift(s).
14. A maximum of seven shifts of any length can be rostered or worked on seven consecutive days subject to the restrictions outlined in paragraphs 7-13 above. Where a shift contains hours of work across more than one day, the work on each day will be counted independently toward the total number of consecutive days.

Where seven shifts of any length are rostered or worked on seven consecutive days, there must be a minimum 48-hours' rest rostered immediately following the conclusion of the seventh shift.

15. The maximum number of consecutive shifts described in paragraphs 10 and 14 above can be increased by one to a maximum of five and eight respectively where both the employer and the doctors on the rota agree through local processes that it is safe and acceptable to both parties to do so. The guardian of safe working hours and the junior doctor forum must be consulted where any concerns around safety or acceptability are raised. Any agreement will be reviewed annually as per the original process and any doctor on such a rota will have the right to request a work schedule review at any time, as set out in Schedule 5. The minimum 48-hours rest described in paragraphs 10 and 14 above will apply following the conclusion of the increased maximum shifts where they are agreed.
16. All reasonable steps should be taken to avoid rostering doctors to work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of

greater than 1 in 3 weekends.

17. By exception, authorisation for a rota using a pattern greater than 1 in 3 can be granted if there is a clearly identified clinical reason agreed by the relevant clinical director for that rota and deemed appropriate by the Guardian of Safe Working Hours. Such rotas should be co-produced, and must be approved by the affected doctors, agreed via the JDF and reviewed annually. Trainees that wish to work at a frequency greater than 1 weekend in 3, by undertaking additional work, for example as a locum, are able to agree to do so but must not work an average weekend frequency of greater than 1 weekend in 2.
18. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2.
19. Other than as set out in paragraphs 10, 11, 13, 14 and 15 above where longer minimum rest periods may apply, under the Regulations there should normally be at least 11 hours' continuous rest between rostered shifts, other than on-call duty periods.
20. Any breaches of 11 hours' rest in a 24-hour period (excluding on-call shifts) will be subject to time off in lieu, which must be within 24 hours. In exceptional circumstances where, due to service needs as required by the employer, the rest period is reduced to fewer than eight hours, the doctor will not be expected to work more than five hours on the day following the day on which the breach occurred and pay will not be deducted for the time off.

## **Breaks**

21. A doctor must receive:
  - a. at least one 30-minute paid break for a shift rostered to last more than five hours,
  - b. a second 30-minute paid break for a shift rostered to last more than nine hours, and
  - c. A third 30-minute paid break for a night shift as described in paragraph 17 of Schedule 2, rostered to last 12 hours or more.
22. The breaks described in paragraph 21 above can be taken flexibly during the shift and should be evenly spaced where possible. These would normally be taken separately but may if necessary be combined into one longer break. Where the breaks are combined in to one break this must be taken as near as possible to the middle of the shift. No break should be taken within an hour of the shift commencing or held over to be taken at the end of the shift.
23. Breaches of the break requirement are addressed in schedule 5 paragraph 16.

## On-call periods

24. For the purposes of this Schedule, an on-call period is as defined in the definitions section of these TCS.
25. A doctor carrying an on-call bleep whilst already present at their place of work as part of the doctor's rostered duties does not meet the definition of on-call.
26. The maximum length of an individual on-call duty period is 24 hours, however the maximum length of an on-call shift can be extended by between 15 minutes and one hour to allow shift overlap and ensure there is adequate time for clinical handover.
27. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.
28. Unless agreed locally as described in paragraph 27 above, there must be no more than three on-call periods in any period of seven consecutive days.
29. The day following an on-call period (or following the last on-call period, where more than one 24-hour period is rostered consecutively) must not be rostered to last longer than 10 hours.
30. Whilst on-call, a doctor should expect to get eight hours rest per 24-hour period, of which at least five should be continuous rest between 22:00 and 07:00. Where this is not expected to be possible, then the provisions of paragraph 31 below apply.
31. Where it is expected that the rest requirements set out in paragraph 30 may not be met, rostered work on the day following the on-call period must not exceed five hours.
32. Where during an on-call period, a doctor's expected overnight rest is significantly disrupted, defined as causing a breach in the expected rest requirements, the doctor must inform their employer immediately, or as soon as reasonably practicable, and arrangements must be made for the doctor to take appropriate rest. Time off in lieu must be taken within 24 hours. If for any reason this is not achieved then the additional hours will be paid as set out in schedule 2 paragraphs 72-80.
33. If, as a result of actual hours worked during the on-call period, a doctor's rest has been significantly disrupted, as defined in paragraph 30 above, the default assumption is that the doctor may be unsafe to undertake work because of tiredness, and if this is the case, the doctor must inform the employer that the doctor will not be

attending work as rostered, other than to ensure safe handover of patients. No detriment to pay will result from the doctor making such a declaration. Arrangements for dealing with this issue must be agreed locally.

34. Rotas must overlap sufficiently to allow time for handover. This is critical for the safe transfer of patient information to deliver continuity of care and good quality patient management. Most services will require a minimum handover of 15 to 30 minutes, some services may need to allow for 60 minutes or (in rare cases) longer. Coming in specifically to attend handover or undertake telephone handover is classed as working time and is part of the duty period.
35. The work schedule of a doctor rostered to be on-call will contain an average amount of time, calculated prospectively, for anticipated work (at both the plain time and the enhanced time rates respectively) during the on-call period. Such work includes any actual clinical or non-clinical work undertaken either on or off site, including telephone calls, actively awaiting urgent results or updates, and travel time arising from any such calls. Any such work is defined as working time for the purposes of these TCS. Any time during the on-call period when the doctor is not undertaking such work, is defined as non-working time for the purposes of these TCS.
36. A doctor's work schedule should include an indication of the amount of the expected predictable and unpredictable work during enhanced hours and unenhanced hours.
  - a. Predictable work refers to routine activities which will occur at specific times during an on-call shift. This may include ward rounds, anticipated duties and clinical handovers. Such activities, along with the expected hours of work required, should be specified within a doctor's work schedule.
  - b. Unpredictable work refers to unscheduled activities that occur at unspecified times during an on-call shift, including telephone calls, actively awaiting urgent results or updates and travel time arising from any such calls. For these activities, the employer must provide a prospective estimate of the average amount of unpredictable on-call work that will occur during an on-call shift, using the calculation method described in paragraphs 37-39 below.
37. To inform the calculation of the prospective estimate of the average amount of work, in hours, performed during an on-call shift, employers should use all relevant available data. This includes a combination of but is not limited to actual data such as: activity data, calls through switchboard, bleeps, admissions, feedback from colleagues in the department, feedback from staff previously and currently rostered for on-call duties on the relevant rota, previous exception reporting data for the relevant rota, and recent diary activities or monitoring data. Prospective hours should be communicated to doctors in advance of starting work so they are aware when they may be risking a breach of limits on hours and rest requirements. Employers should provide clarity on when the on-call shifts may typically require unpredictable work in the working pattern, how the estimates were arrived at and what data sources informed the estimate.

38. Prospective hours should be calculated by totalling the number of hours of on-call work performed across an actual (and typical) week of on-call shifts across the rota reference period of a rota cycle, placement length or 26 weeks whichever is shorter. From this, an average amount of work for each weekday (Monday to Friday) and weekend (Saturday and Sunday) can be calculated. The total hours should then be divided by the number of on-call shifts from which the total number of hours were drawn, to provide an average amount of on-call work - at both the plain time rate and enhanced rate - a doctor can expect to undertake during their rostered on-call shift(s).
39. All rostered on-call shifts must have a prospective estimate of unpredictable work a doctor can expect to perform, even if it is a very low intensity shift pattern, with 15 minutes being the minimum prospective estimate for an individual on-call shift.
40. The result of the prospective hours calculation should be set out in the generic work schedule of the doctors due to work on the rota to ensure they are aware of when they may be experiencing an unexpected variation in the number of hours worked during an on-call shift.
41. Employers should also remind doctors to submit an exception report when they believe their performed on-call activity has varied from the prospective estimate for predictable and unpredictable work, as set out in their work schedule.
42. Where a doctor, or doctors, on an on-call rota are regularly exceeding or significantly below the prospective estimate for on-call shifts then a work schedule review is required. In the case of a doctor(s) regularly exceeding the prospective estimate then consideration should be given to alternative arrangements such as; having an additional doctor on the on-call rota, reducing the workload covered by the on-call doctor, or converting the on-call working pattern to a full-shift working pattern.
43. The prospective estimate of predictable and unpredictable hours to be worked during on-call shifts must be included in the calculation of a doctor's average weekly hours, as set out in paragraph 14 of Schedule 4, and factored into the leave adjustment calculation for employers using prospective cover.
44. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the provisions of paragraph 14 will not apply and a maximum of 12 days can be rostered or worked consecutively.
45. Where the doctor is required by the employer to be resident in the workplace, the entire period of residence will be counted as working time for the purposes of the Regulations. Only time anticipated and set out in the work schedule as working time will count towards the hours' limits, or for the purposes of pay, as set out in these TCS.
46. Where a doctor is required to work a night shift or a shift on a weekend as part of a rota for a department or service, the employer will not in addition roster a second

doctor working that same rota to be available non-resident on-call for the same night or weekend, unless there is a clearly identified clinical reason agreed by the clinical director and the work pattern is agreed by both the guardian of safe working hours as being safe and the DME as being educationally appropriate. A trainee asked to work such a rota who feels that this is inappropriate will have the right to request a work schedule review, as set out in Schedule 5.

## **Opting out of the Working Time Regulations (WTR)**

47. A doctor may voluntarily choose to opt out of the WTR average weekly limit of 48 hours, subject to prior agreement in writing with the employer. A decision to exercise this option is individual, voluntary and no pressure may be placed on the doctor to take this option.
48. Under these TCS, where a doctor has opted out of the WTR average weekly working hours, overall hours are restricted to a maximum average of 56 hours per week, across all or any organisations with whom the doctor is contracted to work or otherwise chooses to work. This must be calculated over the reference period defined in the WTR. Additionally, the maximum of 72 hours worked in any period of 168 consecutive hours applies, as described in paragraph 8 above.
49. Under these TCS, a doctor opting out of the WTR weekly hours limit is still bound by all of the other limits set out in the WTR and in these TCS.
50. A doctor's agreement to opt out may apply either to a specified period or indefinitely. To end any such agreement, a doctor must give written notice to the employer. The notice period shall be seven days, or a period up to a maximum of three months specified in the agreement, whichever is the longer.
51. Records of such agreements must be kept and be made available to relevant recognised unions and appropriate regulators on request.

## **Locum work**

52. Where a doctor intends to undertake hours of paid work as a locum, additional to the hours set out in the work schedule, the doctor must initially offer such additional hours of work to the service of the NHS via an NHS staff bank of their choosing. The requirement to offer such service is limited to work commensurate with the grade and competencies of the doctor rather than work at a lower grade than the doctor is currently employed to work at. Additional work, such as; event and expedition medicine, work for medical charities, non-profits, humanitarian and similar organisations, or sports and exercise medicine, do not fall under the scope of additional work as a locum.
53. A doctor can carry out the additional activity over and above the standard commitment set out in the doctor's work schedule up to a maximum average of 48 hours per week (or up to 56 hours per week if the doctor has opted out of the WTR). The doctor is required to ensure that any additional hours of work do not breach any of the safety and

rest requirements set out in Schedule 3. Rates of pay will be determined by NHS staff banks.



# SCHEDULE 04

## WORK SCHEDULING

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### Principles

1. These terms and conditions of service provide a framework for the safety of doctors in the training and service delivery domains of the working experience.
2. The employer or host organisation shall design schedules of work that are safe for patients and safe for doctors and shall ensure that work schedules are adhered to in the delivery of services.
3. Work scheduling for doctors allows employers to plan and deliver clinical services while delivering appropriate training.
4. Educational planning and clinical work scheduling are interlinked, reflecting the interdependence of training and service commitments of doctors. Where the doctor is on an integrated academic pathway, the academic components of the placement also need to be reflected in the work schedule, in accordance with Follett principles<sup>10</sup>.
5. The employer / host organisation will be responsible for ensuring that a generic work schedule is prepared for the post, which takes into account:
  - a. the expected service commitments, and
  - b. the parts of the relevant training curriculum that can be achieved in the post. This latter element must be consistent with the post's Application for Approval of a Training Post, which will be agreed with the postgraduate dean.
6. The generic work schedule will form the basis for a personalised work schedule.
7. A work schedule shall normally apply for the duration of a training placement and will identify the number and distribution of hours for which the doctor is contracted.
8. A work schedule may be subject to review from time to time.
9. Work schedules should be designed to meet the service delivery needs of the organisation and the education and training needs of the doctor. The employer/host organisation should refer to jointly agreed national guidance on good rostering practice, including the appropriate use of technology, in designing the work schedule.

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<sup>10</sup> A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties,  
<http://webarchive.nationalarchives.gov.uk/20060715145349/dfes.gov.uk/follettreview/>

## Generic work schedule

10. The generic work schedule must be provided to a doctor at least 8 weeks prior to them starting a placement, subject to the provisions of paragraph 8 in the introduction of these TCS, along with the other requirements associated with this deadline as specified in Annex C, to ensure that the doctor is informed of the work and range of duties that are expected to be undertaken during the placement.
11. The generic work schedule will list and identify the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.
12. Details of all statutory and mandatory training that is a requirement to work for an employer, or in a department, must be sent to doctors alongside their generic work schedule. These training requirements must then be arranged within a doctor's rostered hours of work.
13. Generic work schedules must account for the local trust induction required to be undertaken prior to, or at, the start of the placement. This must be reflected as hours of work and paid accordingly.
14. A standard full-time generic work schedule shall be for a minimum of 40 hours and a maximum of 48 hours per week, averaged over a reference period defined as being the length of the rota cycle, the length of the placement or 26 weeks, whichever is shorter. A less than full time generic work schedule shall not exceed 40 hours, averaged over this same reference period. When calculating the average total hours, the number of days' leave (including; annual leave, public holidays, and relevant study leave where prospective cover is in operation) that would be taken by a doctor, on average, across the length of the rota cycle will be deducted from the rota, and the remaining hours will be divided by the remaining weeks (including part-weeks) in the cycle. For example, in an eight-week cycle with six days' leave deducted, the total remaining hours would be divided by 6.8 weeks.
15. A mechanism, to be locally agreed, should be in place for doctors to plan and submit leave requests prior to starting in a post.<sup>11</sup> The agreed form for submitting advance leave requests should be issued with the offer of employment and work schedule for doctors to complete and return to the rota manager prior to the duty roster being issued.
16. The generic work schedule will include a description of the hours to be worked, any

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<sup>11</sup> A template form can be found on the NHS Employers' [website](#).

shift working or on-call arrangements for any and all employers, including any service commitment to unscheduled urgent or emergency care, and will set out in general terms when and where the doctor's duties and responsibilities will be delivered.

17. Where a work schedule contains on-call arrangements, then all non-resident on-call duties must be rostered as separate shifts within a rota, and on-call shifts cannot contain within them a resident shift.
18. When requested by a doctor, all reasonable attempts should be made to facilitate set working day patterns, in line with their statutory right to request flexible working provided that service needs can be met.
19. Unless agreed, no shift should be rostered on a non-working day in a fixed working pattern.
20. The duties and responsibilities set out in the generic work schedule will include, as appropriate:
  - a. clinical care and service duties
  - b. specific training
  - c. work in or for other organisations (if required by the employer / host organisation).
21. Where the doctor is required to participate in a service commitment to unscheduled, urgent or emergency care, the work schedule shall set out the expected requirements to contribute to a duty roster and/or on-call rota for the safe provision of service. The work schedule may include duties throughout the 24-hour day and the seven-day week, including work on statutory and public holidays. This will include a prospective estimation of anticipated actual work (as defined in schedule 3 paragraph 35) during the on-call period, which will be defined as working time for the purposes of these TCS.
22. The work schedule for a doctor on a general practice training programme working in a general practice setting shall reflect the 2012 COGPED guidance<sup>12</sup> or any successor document on the session split during the average 40-hour week that comprise a minimum full-time contract. Any additional hours of work above 40 must be included in the doctor's work schedule and linked through to the curriculum, as per those for doctors in hospital settings.
23. The work schedule must be designed to facilitate access to the full leave allowance, as outlined in Schedule 10, as well as appropriate training.

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<sup>12</sup> Guide to a session for GP trainees and trainers, July 2012, [https://heeo.e.hee.nhs.uk/sites/default/files/1395226128\\_jxmn\\_guide\\_to\\_a\\_session\\_for\\_gp\\_trainees\\_and\\_trainers\\_1\\_0.pdf](https://heeo.e.hee.nhs.uk/sites/default/files/1395226128_jxmn_guide_to_a_session_for_gp_trainees_and_trainers_1_0.pdf)

## Duty roster

24. The duty roster must be provided to a doctor at least 6 weeks prior to them starting a placement as specified in Annex C, subject to the provisions of paragraph 8 of the introduction of these TCS, to ensure that the doctor is informed of the work and range of duties that are expected to be undertaken during the placement.

## LTFT work schedules

25. Each LTFT doctor must have a bespoke work schedule built for them to ensure they are working the correct pro rata proportion of hours and shift types, for their LTFT percentage and working arrangements, and are being paid correctly.
26. The facilitation of bespoke work schedules is the responsibility of both the employer (or host organisation as locally agreed) and the doctor. This process must begin as soon as possible after notification of placement. It is the employer's responsibility to issue the mutually agreed bespoke work schedule to the doctor. This should be done as soon as reasonably practicable and in any event prior to the LTFT doctor starting in post, to allow sufficient opportunity to plan leave and other commitments.
27. When LTFT doctors are provided with their generic work schedule, it should include their individual pro-rata entitlement to study leave and annual leave (inclusive of pro-rated public holidays) to ensure they are able to plan in their leave at the earliest available opportunity.

## Personalised work schedule

28. The generic work schedule shall form the basis for a personalised work schedule which will be agreed between the educational supervisor and the doctor, in accordance with the Gold Guide<sup>13</sup> and/or other relevant documents, as amended from time to time. The personalised work schedule must be agreed before or within four weeks after the commencement of the placement during scheduled hours of work.
29. Where the personalised work schedule has not been agreed within four weeks after the commencement of the placement, the doctor may submit an exception report. This will be sent to the Director of Medical Education and Educational Supervisor (for trainees working in non-hospital settings, including – but not limited to – GP and

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<sup>13</sup> A Reference Guide for Postgraduate Specialty Training in the UK, also known as the Gold Guide, Eighth Edition, is accessible via the [COPMeD website](https://www.copmed.org.uk/images/docs/gold_guide_8th_edition/Gold_Guide_8th_Edition_March_2020.pdf) - [https://www.copmed.org.uk/images/docs/gold\\_guide\\_8th\\_edition/Gold\\_Guide\\_8th\\_Edition\\_March\\_2020.pdf](https://www.copmed.org.uk/images/docs/gold_guide_8th_edition/Gold_Guide_8th_Edition_March_2020.pdf)

Public Health trainees, this will be sent to the Head of School instead of the Director of Medical Education, as well as the Educational Supervisor).

30. The doctor and the educational supervisor are jointly responsible for personalising the work schedule, according to the doctor's learning needs and the opportunities within the post. Should a doctor have a significant caring responsibility, the doctor may raise it as part of the discussion of the personalised work schedule review. Where possible within the constraints of service delivery, adequate account should be taken of reasonable requests when agreeing the personalised work schedule.
31. The educational review with the educational supervisor will include a discussion of the work schedule to ensure that their workplace experience delivers the anticipated learning opportunities.
32. Each doctor provided with a written occupational health recommendation relating to the design of their rota or duty roster must have this discussed, mutually agreed and incorporated into its design as soon as possible, and within six weeks of the recommendation being provided. In subsequent rotations, relevant recommendations may need to be carried forward and incorporated into the duty roster from the start of the placement. These recommendations may be subject to review by the occupational health provider for the doctor's subsequent placements.
33. If the six-week timescale in paragraph 32 above cannot be met, or if a mutual agreement about a rota change cannot be reached between the employer and the doctor, the doctor must be provided with a documented explanation as to why the recommended change cannot be made or why the timescale cannot be met. A meeting should be arranged to discuss this and explore potential alternative solutions.
34. Doctors must have the ability to escalate to the HR department and/or named individual(s) within their host organisation to raise concerns when the occupational health recommendations have not been factored into the design of the duty roster within six weeks of the recommendations being confirmed.
35. The employer may need to make changes to a work schedule during the placement if there are significant changes in the facilities, resources or services. Every effort should be made to anticipate such changes in the work schedule and reach agreement on such changes.

## **Work schedule objectives**

36. The generic work schedule shall describe the training opportunities and the service commitments required to achieve the objectives of the placement.
37. The personalised work schedule shall add to the generic schedule the doctor's

personal objectives in:

- a. training (consistent with the education/training contract between the Deanery function and the doctor), and
  - b. service delivery, both to align the doctor's service commitments to the employer's objectives and to recognise not only that competencies can be achieved through service delivery but that some can only be achieved in this way.
38. The training objectives will set out a mutual understanding of the training needs of the doctor over the period of the work schedule, and of how, in working to achieve these objectives, the doctor will contribute to the objectives of the employer.
39. A doctor's individual objectives will depend in part on the specialty and the level of competencies achieved and may on occasion differ from the objectives set out in the generic work schedule.

## **Setting and maintaining the work schedule**

40. The work schedule brings together activities to achieve service and learning objectives.
41. As a minimum, there should be an educational review and work schedule discussion at the start and finish of the placement for which the work schedule applies.
42. The personalised work schedule will be discussed and agreed at the first formal meeting between the educational supervisor for the placement and the doctor.
43. The doctor and educational supervisor will regularly consider progress against agreed learning objectives determined by the curriculum, and the doctor's service objectives.
44. Work schedule discussions should establish whether any changes in support or resources, or in planned service duties, are needed to enable the doctor to achieve the objectives within rostered working hours.
45. Discussions shall take place if either the employer or the doctor consider that the training opportunities, duties, responsibilities, accountability arrangements or objectives have changed significantly, or need to change significantly, or that the agreed objectives may not be achieved for reasons outside the doctor's control.

## **Resolving disagreements over the work schedule**

46. The educational supervisor will make every effort to agree with the doctor appropriate changes to the work schedule, and to implement the changes within a reasonable time, taking into account the remaining duration of the post/placement. If it is not possible to reach agreement or achieve the agreed outcome the doctor may

invoke the provisions of Schedule 5.

# SCHEDULE 05

## EXCEPTION REPORTING AND WORK SCHEDULE REVIEWS

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### Purpose

1. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained. The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve concerns.

### Exception reporting

2. Exception reporting is the mechanism used by doctors to ensure compensation for all work performed and uphold agreed educational opportunities. The activities to which exception reporting applies include (but is not limited to):
  - a. all scheduled NHS work under this contract (e.g. any patient facing and non-patient facing activities that is required as part of the doctor's employment) and /or
  - b. any activities required for the successful completion of the doctors ARCP, including any additional educational or development activities explicitly set out in the doctors agreed personalised work schedule and/or
  - c. any activities that are agreed between the doctor and their employer, such as quality improvement, attendance at the JDF or patient safety tasks directly serving a department or wider employing organisation, and/or
  - d. any professional activities that the doctor is required to fulfil by their employer (e-portfolio, induction, e-learning, Quality Improvement and Quality Assurance projects, audits, mandatory training / courses)

Unless required by your employer or agreed with the educational supervisor, exception reporting does not apply to occasions where an individual may choose to undertake educational activities for personal development or career enhancing purposes which are outside of contractual requirements, the agreed personalised work schedule or are not an essential activity to pass ARCP.

3. Doctors can use exception reporting to inform the employer when their day-to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations are likely to include (but are not limited to):
  - a. differences in the total hours of work (including opportunities for rest breaks)
  - b. differences in the pattern of hours worked
  - c. differences in the educational opportunities and support available to the doctor, and/or
  - d. differences in the support available to the doctor during service commitments.
4. Exception reports allow the employer the opportunity to address issues as they arise, and to make timely adjustments to work schedules.



5. Exception reports should include:
  - a. the name, specialty and grade of the doctor involved
  - b. the identity of the educational supervisor
  - c. the dates, times and durations of exceptions
  - d. the nature of the variance from the work schedule, and
  - e. an outline of the steps the doctor has taken to resolve matters before escalation (if any).
6. The reviewal process for exception reports must be locally agreed by; the Guardian of Safe Working Hours, the JDF, and the Joint Local Negotiating Committee. Regardless of the reviewal process that is agreed, all reports should be copied to a trainee's educational supervisor irrespective of whether the educational supervisor is required to action the type of report.
  - a. When deciding who should be the actioner for the different types of report, consideration should be given to ensure the actioner is appropriate with significant insight into issues raised and be able to propose suitable resolutions.
  - b. In any locally agreed review process, it should not be a requirement for an in-person meeting between the doctor submitting the report and the report's actioner, to be held for all individual exception reports, except for reports relating to; educational issues, service support, or immediate safety concerns. However, a doctor or the actioner of a report, must be able to request a meeting to discuss any report they submit, or receive.
7. Where there is no local agreement on the exception report reviewal process (as described in paragraph 6), then:
  - a. all exception reports relating to additional hours worked should be sent to a nominated lead consultant or the consultant on-call for the shift from which the report originated. The designated consultant must have access to the local exception reporting system.
  - b. all other reports, not described in paragraph 7a, should be sent to the educational supervisor of the doctor raising the report.

For doctors in non-hospital settings, the default should be for all types of exception reports to be sent to the doctor's educational supervisor, unless there is a mutual agreement between the doctor and the employer or the host organisation, for that placement, for a differing process.<sup>14</sup>

8. The doctor will send exception reports electronically to the locally agreed actioner for the type of report submitted. This should be as soon as possible after the exception takes place, and in any event within 14 days (or 7 days when making a claim for additional pay, as per schedule 2 paragraph 72-80).
9. The doctor will copy the exception report to the director of medical education (DME) in relation to training issues, and to the guardian of safe working hours in relation to safe working practices. In some cases, the doctor may copy the report to both.

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<sup>14</sup> As part of the 2018 Review framework agreement it was agreed that NHS Employers and the BMA would jointly produce guidance on exception reporting in non-hospital settings. Once this guidance is available, non-hospital employers should make every effort to follow the recommendations within the guidance.

10. Upon receipt of an exception report, the locally agreed actioner for the report type submitted will within 7 days of receiving the report:
  - a. firstly, action the report, or discuss the report with the doctor (when felt necessary by the actioner or requested by the doctor submitting the report) to agree what action is necessary to address the reported variation or concern.
  - b. secondly, set out in an electronic response to the doctor their decision, or the agreed outcome of the report following a meeting with the doctor, including any agreed actions.
  - c. thirdly, copy the response to the DME or guardian of safe working hours as appropriately identified in paragraph 9 above.
11. Where an exception report has not received a response within 7 days, as per the above paragraph, the Guardian of Safe Working Hours will have the authority to independently action the report.
12. The DME will review the outcome of the exception report to identify whether further improvements to the doctor's training experience are required.
13. The guardian of safe working hours will review the outcome of the exception report to identify whether further improvements to the doctor's working hours are required to ensure that the limits on working hours outlined in these TCS are being met.

## **Breaches incurring a financial penalty**

14. The guardian of safe working hours will review all exception reports copied to them by doctors to identify whether a breach has occurred which incurs a financial penalty, as set out in paragraphs 15-16 below.
15. Where such concerns are shown to be correct in relation to:
  - a. A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
  - b. A breach of the maximum 13 hour shift length; or
  - c. A breach of maximum of 72 hours worked across any consecutive 168 hour period
  - d. where 11 hours rest in a 24 hour period has not been achieved (excluding on-call shifts); or
  - e. where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
  - f. where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved

The doctor will be paid for the additional hours at the penalty rates set out in Annex A, and the guardian of safe working hours will levy a fine on the department employing the doctor for those additional hours worked, at the rates set out in Annex A.

16. Where a concern is raised that breaks have been missed on at least 25% of occasions across a four week reference period, and the concern is validated and shown to be correct, the guardian of safe working hours will levy a fine at the rate of twice the relevant hourly rate for the time in which the break was not taken.
17. Additionally, to ensure that no further breaches occur, a work schedule review may be required as set out below.

## **Disbursement of fines**

18. The money raised through fines must be used to benefit the education, training and working environment of trainees. The guardian of safe working hours should devise the allocation of funds in collaboration with the employer/host organisation junior doctors' forum, or equivalent. 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.
19. The details of the guardian fines will be published in the organisation's annual financial report (accounts), which are subject to independent audit. The guardian's annual report will include clear detail on how the money has been spent.

## **Immediate safety concerns**

20. Where an exception report indicates concern that there is an immediate and substantive risk to the safety of patients or of the doctor making the report, this should be raised immediately (orally) by the doctor with the clinician responsible for the service in which the risk is thought to be present (typically, this would be the head of service or the consultant on-call). The doctor must confirm such reports electronically to the educational supervisor (via an exception report) within 24 hours.
21. The employer has a duty to respond as follows:
  - a. Where the clinician receiving the report considers that there are serious concerns and agrees that there is an immediate risk to patient and/or doctor safety, the consultant on-call shall, where appropriate, grant the doctor immediate time off from their agreed work schedule and/or (depending on the nature of the reported variation) ensure the immediate provision of support to the doctor. The clinician shall notify the educational supervisor and the guardian of safe working hours within 24 hours. The educational supervisor will undertake an immediate work schedule review, and will ensure appropriate (and where necessary, ongoing) remedial action is taken.
  - b. Where the clinician receiving the report considers that there are serious but not immediate concerns, the clinician shall ask the doctor to submit an exception report to the educational supervisor, describing the concern raised and requesting a work schedule review.
  - c. Where the clinician receiving the report considers that the single concern raised

is significant but not serious or understands that there are persistent or regular similar concerns being raised, the clinician shall ask the doctor to raise an exception report to the educational supervisor within 48 hours.

## **Work schedule review process**

22. Where a doctor, an educational supervisor, a manager, or the guardian of safe working hours has requested a work schedule review, the process set out in paragraphs 23-37 below will apply.
23. The educational supervisor shall meet or correspond with the doctor as soon as is practicable, ideally no later than seven working days after receipt of a written request for a review. Where this is in response to a serious concern that there was an immediate risk to patient and/or doctor safety as described in paragraphs 20-21 above, this must be followed up within seven working days.
24. The conversation between the doctor and the educational supervisor will lead to one or more of the following outcomes:
  - a. No change to the work schedule is required.
  - b. Prospective documented changes are made to the work schedule.
  - c. Compensation or time off in lieu is required.
  - d. Organisational changes, such as a review of the timing of ward rounds, handovers and clinics, are needed.
25. Organisational changes may take a reasonable time to be enacted. Where this is the case, temporary alternative arrangements, including amendments to pay, may be necessary.
26. The outcome of the conversation will be communicated in writing.
27. If dissatisfied with the outcome, the doctor may formally request a level 2 work review within 14 days of notification of the decision. The request must set out the areas of disagreement about the work schedule, and the outcome that the doctor is seeking.
28. A level 2 review discussion shall take place no more than 21 working days after receipt of the doctor's formal written request. A level 2 review requires a meeting between the educational supervisor, the doctor, a service representative and a nominee either of the director of postgraduate medical education (where the request pertains to training concerns) or of the guardian of safe working hours (where the request pertains to safe working concerns). Where the doctor is on an integrated academic training pathway, the academic supervisor should also be involved.

29. The discussion will first consider the outcome of the level 1 conversation and will result in one or more of the following outcomes:
  - a. The level 1 outcome is upheld.
  - b. Compensation or time off in lieu is required.
  - c. No change to the work schedule is required.
  - d. Prospective documented changes are made to the work schedule.
  - e. Organisational changes, such as a review of the timing of ward rounds, handovers and clinics, are needed.
30. The outcome shall be communicated in writing.
31. If dissatisfied with the outcome, the doctor may request a final stage work review within 14 days of notification of the decision. The request must set out the areas of disagreement about the work schedule, and the outcome that the doctor is seeking.
32. The final stage for a work schedule review is a formal hearing under the final stage of the employer's local grievance procedure, with the proviso that the DME or nominated deputy must be present as a member of the panel.
33. This shall take place in accordance with the ACAS Code of Practice on Discipline and Grievance in the workplace, and the hearing will take place within the timeframe specified in the local grievance procedure.
34. Where the doctor is appealing a decision previously taken by the guardian of safe working hours, the hearing panel will include a representative from the BMA or other recognised trade union nominated from outside the employer/host organisation and provided by the trade union within one calendar month.
35. The panel hearing will result in one or more of the following outcomes:
  - a. The level 2 outcome is upheld.
  - b. Compensation or time off in lieu is required.
  - c. No change to the work schedule is required.
  - d. Prospective documented changes are made to the work schedule.
  - e. Organisational changes, such as a review of the timing of ward rounds, handovers and clinics, are needed.
36. The outcome shall be communicated in writing and a copy provided to the guardian of safe working hours.
37. The decision of the panel shall be final.
38. Where at any point in the process of a work schedule review, either the doctor or the reviewer identifies issues or concerns that may affect more than one doctor working on a particular rota, it may be appropriate to review other schedules forming part of that rota. In this case, such reviews should be carried out jointly with all affected doctors and, where appropriate, changes may be agreed to the working pattern for all

affected doctors working on that rota, following the same processes as described in paragraphs 23-37 above.

## Reporting

39. The guardian of safe working hours shall report no less than once per quarter to the Board on all work schedule reviews relating to safe working hours. This report will also include data on all rota gaps on all shifts. The report will also be provided to the JLNC, or equivalent.
40. The guardian of safe working hours is also responsible for the reporting arrangements identified in Schedule 6, paragraphs 11-12 of these terms and conditions.
41. The DME shall report annually to the Board on all work schedule reviews relating to education and training.
42. The Board is responsible for providing a copy of these annual reports to external bodies as defined in these terms and conditions, including the local offices of Health Education England, the Care Quality Commission, the General Medical Council and the General Dental Council.
43. Employers must retain copies of all reviews for a period of two years from the date that an outcome is reached. Where remuneration is approved as part of this process, records shall be retained in line with the organisation's Standing Financial Instructions.

# **SCHEDULE 06**

## **GUARDIAN OF SAFE WORKING HOURS**

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1. The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to staff themselves. The safeguards around doctors' working hours in these terms and conditions are designed to ensure that this risk is effectively mitigated, and that this mitigation is assured.
2. There are three functions which oversee the safety of doctors in the training and service delivery domains of their working experience:
  - a. The employer or host organisation designs schedules of work that are safe for patients and safe for doctors and ensures that work schedules are adhered to in the delivery of services.
  - b. The director of medical education (DME) oversees the quality of the educational experience.
  - c. The guardian of safe working hours (hereafter referred to as the guardian) provides assurance to the employer, and host organisation if appropriate, on compliance with safe working hours by the employer and the doctor.
3. Doctors are also responsible for ensuring that both their pattern of work and their total hours of work, including any and all work undertaken for any employer, whether directly or indirectly (for example through an agency or limited company), comply with the limits set out in schedule 3, and that they remain safe to carry out clinical duties.

### **The role of the guardian of safe working hours**

4. The guardian is a senior appointment and the appointee will not hold any other role within the management structure of the employer / host organisation. The guardian shall ensure that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate. The guardian shall provide assurance to the Board that doctors' working hours are safe. (This assurance is in addition to the provisions and safeguards as set out in schedules 3, 4 and 5).

### **Appointment of the role of guardian of safe working hours**

5. The employer and/or host organisation must appoint a guardian of safe working hours to assure the safety of doctors. Appointment would normally be for a minimum of three years, subject to an annual performance review.
6. Where a lead employer arrangement exists, the guardian role will be established in host employers, and the arrangements made clear in the memorandum of understanding between the lead and host organisations. The host guardian shall ensure information is available to the host organisation board, and the lead employer guardian must see guardian reports for all of the doctors under their employment.

7. 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. Where lead employer arrangements are not in place and GP trainees are directly employed by practices, the responsibility for appointing the independent guardian rests with the employing practices. Employing practices with fewer than 10 GP trainees must either (a) jointly appoint an independent guardian with another similar employer or employers with fewer than 10 GP trainees such that an appointed guardian has responsibility for a minimum of ten trainees or (b) must enter into a contract with a neighbouring trust or foundation trust to provide the guardian function for the employer.
8. Other non-hospital employers with fewer than 10 trainees (this could include but is not limited to public health, occupational health medicine and palliative care) must contract with the guardian of safe working at a neighbouring NHS trust to oversee the safe working of their trainees.
9. The following principles shall be taken into account in appointing to the role:
  - a. It is the employer's responsibility to appoint the guardian.
  - b. The appointment panel for the guardian shall include the medical director or a nominated deputy, the director of HR/workforce or a nominated deputy, and two doctors in training, nominated by the joint local negotiating committee (JLNC) or equivalent. At least one, and if at all possible, both of the doctors in training must be based in the appointing employer (or host organisation, if appropriate).
  - c. The panel should reach consensus on the appointment.
  - d. The recruitment process for the appointment of the guardian should otherwise follow local recruitment processes.
  - e. The employer (and/or host organisation, if appropriate) will have discretion to set the guardian's time commitment, taking into consideration the number of rotas and the number of doctors in training for whom the guardian will have responsibility.
  - f. Employers / host organisations can choose to act collaboratively to make and share the appointment across a number of employers.

## **Responsibilities of guardian of safe working hours**

10. The guardian shall:
  - a. act as the champion of safe working hours for doctors in approved training programmes
  - b. provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of these terms and conditions of service
  - c. receive copies of all exception reports in respect of safe working hours. This will allow the guardian to record and monitor compliance with the terms and conditions of service



- d. escalate issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level
- e. require intervention to mitigate any identified risk to doctor or patient safety in a timescale commensurate with the severity of the risk
- f. require a work schedule review to be undertaken, where there are regular or persistent breaches in safe working hours, which have not been addressed
- g. have the authority to intervene in any instance where the guardian considers the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily; and
- h. distribute monies received as a consequence of financial penalties to improve the training and service experience of doctors.

## Reporting

11. The guardian reports to the Board of the employer (and host organisation, if appropriate), directly or through a committee of the Board, as follows:
  - a. The Board must receive a *Guardian of Safe Working Report* no less than once per quarter. This report shall also be provided to the JLNC, or equivalent. It will include data on all rota gaps on all shifts.
  - b. A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account, which must be signed off by the trust chief executive. This report shall also be provided to the JLNC, or equivalent.
  - c. Where the guardian has escalated a serious issue in line with paragraph 10(d) above and the issue remains unresolved, the guardian must submit an exceptional report to the next meeting of the Board.
  - d. The Board is responsible for providing annual reports to external bodies as defined in these terms and conditions, including Health Education England (Local office), Care Quality Commission, General Medical Council and General Dental Council.
  
12. There may be circumstances where the guardian identifies that certain posts have issues that cannot be remedied locally, and require a system-wide solution. Where such issues are identified, the guardian shall inform the Board. The Board will raise the system-wide issue with partner organisations (e.g. Health Education England, NHS England, NHS Improvement) to find a solution.

## Liaison with doctors

13. Each Guardian and Director of Medical Education shall jointly establish a Junior Doctors Forum (or fora) to advise them. This shall include junior doctor colleagues from the organisation and must include the relevant junior doctor representatives from the JLNC (or equivalent) as well as the Chair of the JLNC. Doctors on the fora will be elected from amongst the trainees. Where the guardian for safe working covers specialties that are small or have specific employment requirements, the fora shall include representatives of these groups. The group shall also include relevant educational and HR colleagues as agreed with the group. The junior doctors forum or

a sub-group it establishes will take part in the scrutiny of the distribution of income drawn from fines.

## **Accountability**

14. The guardian is accountable to the Board.
15. The line management arrangements for the guardian are for local determination but this reporting line should be to the appropriate executive director or equivalent, who will contribute to the annual appraisal of the guardian, in line with appraisal policy, to support medical revalidation.
16. There will be a system of performance management which will include the opportunity for representatives of the doctors in training to contribute to the assessment, for example, through a system of 360° appraisal. Where there are concerns regarding the performance of the guardian, the BMA or other recognised trade union, or the Junior Doctors Forum should raise those concerns with the Trust Medical Director or the relevant director with responsibility for managing the guardian. These concerns can be escalated to the senior independent director on the Board of Directors where they are not properly addressed or resolved.
17. The employing organisation shall seek to engage with all parties, as specified in the above paragraph, who are involved in performance management of the guardian. This is to assess and make recommendations on the time commitment and administrative support required for the guardian role. The number of rotas and number of doctors in training for whom the guardian will have responsibility will need to be taken into consideration. This will be an annual review process.

# **SCHEDULE 07**

## **CHAMPION OF FLEXIBLE TRAINING**

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### **Hospital Employers/Host Organisations**

1. It is the employer's/host's responsibility to appoint a Champion of Flexible Training. Paragraphs 2 to 9 of this schedule shall be followed in appointing to the role.
2. Employers/hosts should refer to the Champion of Flexible Training guidance, co-produced by NHS Employers and the BMA, for detail on the outputs, competencies, and review process of this role.
3. The appointment panel for the champion shall include: the medical director or a nominated deputy (or equivalent, for employers without a medical director); the director of HR/workforce or a nominated deputy (or equivalent, for employers with alternative management structures); and two doctors in training, nominated by the junior doctors' forum (JDF) or equivalent. At least one, and if at all possible, both of the doctors in training must be based in the appointing employer (or host organisation, if appropriate) and at least one of the doctors in training must work less than full time.
4. The panel should reach consensus on the appointment. If consensus is not reached, paragraph 7 applies.
5. The recruitment process for the appointment of the champion should otherwise follow local recruitment processes.
6. Employers and/or hosts can choose to act collaboratively to make and share the appointment across a number of employers, with the agreement of the appointed champion. The number of doctors covered by such an arrangement must not be so great as to detrimentally impact the champion's ability to provide support to doctors. Such an arrangement must include sufficient time and resources as per paragraph 9.
7. Where an employer is unable to appoint to, or share (as per paragraph 6), the role they must ensure that alternative arrangements to support less than full time doctors are in place. These arrangements should be jointly produced with the Local Negotiating Committee (LNC) and/or JDF and are intended to be interim arrangements with the aim of appointing a champion at the earliest possible opportunity in the future.
8. Champions who have already been appointed to the role through local recruitment processes prior to the publication of version 8 of these TCS will not be expected to reapply for the position and will continue as champions.
9. Employers must ensure that the champions have sufficient time and resources to undertake their responsibilities.

## **Non-hospital settings**

10. Where lead employer arrangements exist for non-hospital settings with fewer than 10 trainees (this could include but is not limited to GP practices, public health, occupational health medicine, and palliative care), the lead employer is responsible for appointing a Champion of Flexible Training, who must be familiar with the issues for trainees in non-hospital settings and be able to provide advice on relevant topics, including rota and contract specific issues. Where the doctor requires advice on non-contractual elements that the champion does not feel competent to advise on, such as specific training related issues, the Champion of Flexible Training should refer the doctor to the relevant individual(s) in that area.
11. The recruitment process for the appointment of the champion should be followed as per the above paragraphs 2 to 9.

# **SCHEDULE 08**

## **PRIVATE PROFESSIONAL AND FEE-PAYING WORK**

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### **Principles**

1. The doctor is responsible for ensuring that the employer is advised of any regular commitments the doctor has in relation to the provision of any private professional work.
2. The doctor is responsible for ensuring any private professional work undertaken by the doctor does not result in any detriment to NHS patients or services.
3. The doctor should be aware of the relationship between the hours of work undertaken under this schedule and the principles underlying the restrictions on total hours that the doctor can work under these terms and conditions of service as set out in Schedule 3.
4. A doctor must not earn fees during salaried time. In effect a doctor must not be paid twice for the same period of time.
5. When undertaking private professional or fee-paying work, doctors in training must make clear their trainee status on each occasion.
6. Doctors are solely responsible for the payment and management of the tax and insurance liabilities and any related costs in respect of any private professional or fee-paying work that the doctor undertakes, and for ensuring that they have adequate and appropriate insurance and indemnity for such work, as per GMC guidance. This applies whether or not the work is undertaken on the employer's premises, or elsewhere. The doctor agrees to indemnify the employer for any costs or demands that the employer incurs in relation to such liabilities referred to above.

### **Disclosure of information about private commitments**

7. The doctor must keep the educational supervisor informed of any regular commitments in respect of private professional clinical work. This information must be disclosed as part of the initial work schedule discussion and include details of the work involved and when it occurs. The doctor must also provide information in advance about any significant changes to this information.

### **Scheduling of work**

8. NHS or other contractual commitments must take precedence over the provision of private professional work, except where a doctor is asked at short notice to undertake

NHS work beyond their agreed work schedule and this would prevent them from meeting pre-existing and previously disclosed private professional commitments which cannot reasonably be rescheduled.

## Use of NHS facilities

9. The doctor must obtain the employing organisation's prior agreement to use NHS facilities, staff and/or resources for the provision of private professional or fee-paying work.
10. The employing organisation has discretion to allow the use of its facilities, staff and/or resources. The employer will make it clear which facilities, if any, a doctor is permitted to use for private purposes, and to what extent, and whether any charge will be levied for the use of these facilities, staff and/or resources.
11. If a doctor with the employing organisation's permission, undertakes private professional clinical work in any of the employing organisation's facilities, the doctor must observe the principles and relevant provisions in the *Code of conduct for private practice*<sup>15</sup>.
12. Doctors must also make themselves aware of and comply with their employing and/or host organisation's policies and procedures for private practice.

## Patient enquiries about private treatment

13. Where, in the course of the doctor's duties, a doctor is approached by a patient and asked about the provision of private professional clinical work, the doctor must refer the patient, without advice or comment, to the consultant responsible for the patient's care.

## Fee-paying services

14. Fee-paying work should normally be carried out in time for which the doctor is not being paid by the employer (i.e. in the doctor's own time). The employer may, but is not obliged to, agree with the doctor that fee-paying work can be undertaken in the circumstances set out in paragraphs 15 and 16 below.
15. If a fee is paid directly to the doctor for such work done during the time for which the doctor is paid by the employer, the doctor must remit the whole fee to the employing organisation.

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<sup>15</sup> A Code of Conduct for Private Practice, January 2004,  
[http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/DH\\_085195.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/DH_085195.pdf)

16. The employer can, but is not obliged to, agree that a doctor may retain the fee for such work carried out during time the doctor is being paid by the employer, provided that the doctor either:
  - a. authorises the employer to reclaim the salary for the time during which the fee-paying service was delivered, or
  - b. agrees with the employer to make up the time at a later date by carrying out additional NHS work for the requisite time during a period of time outside of the doctor's work schedule.

# SCHEDULE 09

## OTHER CONDITIONS OF EMPLOYMENT

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### Outside employment and financial interests

1. A doctor must declare:
  - a. any outside financial interest or any financial relationship with an external organisation they may have which may conflict or could be perceived to conflict with the policies, business activity and decisions of the employing organisation; and/or
  - b. any financial or pecuniary advantage they may gain whether directly or indirectly as a result of a privileged position within the employing organisation.
2. It is the responsibility of the doctor to ensure they comply with their corporate responsibilities as set out in the organisation's standing financial instructions.

### Research

3. All research must be managed in accordance with the requirements of the Department of Health research governance framework. Doctors must comply with all reporting requirements, systems and duties of action put in place by the employing organisation to deliver research governance. Doctors must also comply with the GMC guidance *Good practice in research*<sup>16</sup> as from time to time amended.

### Confidentiality

4. A doctor has an overriding professional obligation to maintain patient confidentiality as described by guidance from the regulatory bodies, and employer policies from time to time in force, subject to relevant legal exceptions.
5. A doctor must not disclose, without permission, any information of a confidential nature concerning other employees or contracted workers, except where there is an overriding public interest or legal obligation to do so.
6. A doctor must not disclose, without permission, any information of a confidential nature concerning the business of the employer or of contractors of the employer, save where there is an overriding public or patient safety interest or legal obligation to do so.

### Raising concerns

7. Should a doctor have cause for genuine concern about an issue (including one that would normally be subject to the requirements regarding information of a confidential

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<sup>16</sup> Good practice in research, [http://www.gmc-uk.org/guidance/ethical\\_guidance/5992.asp](http://www.gmc-uk.org/guidance/ethical_guidance/5992.asp)



nature set out in paragraph 4 above) the doctor has a professional obligation to raise that concern. A doctor should raise concerns, in accordance with local policy, and shall not be subject to any detriment for raising such concerns, including those regarding a third party (for example HEE).

8. If a doctor believes that a disclosure of any concern regarding malpractice, patient safety, the safety of doctors, other employees or contracted workers, financial impropriety or any other serious risk (including one that would normally be subject to paragraph 4) would be in the public interest, they have a right and a duty to speak out and be afforded statutory protection as required under the Public Interest Disclosure Act 1998<sup>17</sup> (PIDA) as amended from time to time. A doctor making such a qualifying disclosure, whether under PIDA or directly to Health Education England, shall also have the right not to be subject to any detriment by Health Education England for raising such concerns, via the provisions of the Learning and Development Agreement. As far as practicable, local procedures for disclosure of information in the public interest should be followed.

## Publications

9. A doctor shall be free, without prior consent of the employing organisation, to publish material and to deliver lectures or speak at an event, whether on matters arising out of NHS service or not. This freedom is subject to the requirements regarding information of a confidential nature set out in paragraph 4 above, and the requirements regarding research set out in paragraph 3 above. Such communications, whether or not these activities take place in the doctor's own time, must be in good faith and without malice, and are subject to the employing organisation's protocols and practices (including those on social media usage and the press). The doctor must also follow guidance from the relevant regulatory bodies.
10. The doctor should be aware of the employing organisation's local policy regarding intellectual property. Where payment is received, the doctor should comply with the requirements of Schedule 8 - private professional work.

## Intellectual Property

11. The doctor must comply with the employing organisations policies and procedures for intellectual property. These will reflect *The NHS as an innovative organisation: a framework and guidance on the management of intellectual property in the NHS*, as amended from time to time.

## Transfer of information

12. Where the doctor is required to rotate between employing organisations and/or host organisations, there will be a requirement on the employer/host organisations to transfer such personal and confidential information regarding the doctor's employment and training as is deemed necessary by the organisations for the completion of pre-employment checks and for the continuation of the doctor's training. It is a condition of employment that the transfer of such information occurs.

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<sup>17</sup> Public Interest Disclosure Act 1998, <http://www.legislation.gov.uk/ukpga/1998/23/contents>

13. The employer / host organisation is required under the terms of the Learning and Development Agreement between the employer / host organisation and Health Education England (or successor document) to send and receive information about doctors to and from Health Education England in order to facilitate the management of training programmes. The employer will make every reasonable effort to comply with the time frames set out in the Learning and Development Agreement wherever and whenever it is possible to do so. Doctors and employers have a mutual obligation to facilitate such data transfers so as to enable appropriate notification of deployment by employers to future appointees, as set out in the Learning and Development Agreement. It is a condition of employment that the transfer of such information occurs. The employer/host organisations shall comply with the provisions of the Data Protection Act 1998 and all relevant Codes of Practice at all times and shall ensure that they have in place appropriate systems to protect the security of any information being transferred.

# SCHEDULE 10

## LEAVE

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### Principles

1. It is in the interest of doctors' health and wellbeing and the continued safety of patients in their care, that they take their full annual leave entitlement.
2. Leave required by the Working Time Regulations must be taken in each leave year, subject to paragraph 54 of this Schedule.
3. The employer and the doctor must make every effort to work together to ensure that the doctor is able to take the full annual leave entitlement.
4. Study or professional leave must be used for the purpose for which it is granted.
5. Safeguards on hours and rest as set out in Schedule 3 continue to apply during any period of leave.
6. In the case of a doctor contracted by a lead employer, decisions to approve leave requests rest with the host organisation, unless expressly stated otherwise.
7. As set out in Schedule 4, the work schedule must be designed to facilitate access to the full leave allowance as well as appropriate training.

### Annual leave

8. The annual leave year runs from the start date of the doctor's appointment.
9. The annual leave entitlement for a full-time doctor is as follows, based on a standard working week of five days:
  - a. On first appointment to the NHS: 27 days
  - b. After five years' completed NHS service: 32 days.These leave entitlements include the two extra-statutory days previously available in England under the 2002 Terms and Conditions of Service.
10. As leave is deducted from the rota before average hours are calculated for pay purposes, as set out in paragraph 14 of Schedule 4, leave may not be taken from shifts attracting an enhanced rate of pay or an allowance, as set out in Schedule 2 of these TCS. Where a doctor wishes to take leave when rostered for such a shift or duty, the doctor must arrange to swap the shift or duty with another doctor on the same rota. It is the doctor's responsibility to arrange swaps. The employer will take all reasonable steps to facilitate the arrangement of the swap. However, the employer is not obliged to approve the leave request if the doctor does not make the necessary arrangements to cover the shift.

11. Where the doctor's contract or placement is for less than 12 months, the leave entitlement is pro rata to the length of the contract or placement.
12. A doctor working less than full time will be allocated leave on a pro rata basis.
13. It may be appropriate for leave to be calculated for some doctors in hours.
14. A doctor shall normally provide a minimum six weeks' notice of annual leave to be approved in accordance with local policies and procedures.
15. The employer shall, where possible, respond positively to all leave requests, and shall normally agree reasonable requests.
16. Employers must allow annual leave to be taken when it has been requested for a life-changing event, provided that the doctor has given notice to the employer in accordance with paragraph 14 of this Schedule. This provision does not apply to leave for circumstances covered by Section 15 of the NHS Terms and Conditions of Service Handbook or local policies such as special leave or bereavement.
17. If, due to circumstances beyond the doctor's control, a reasonable request is made for leave outside the minimum six weeks' notice period, then the employer will fairly consider this request while paying due regard to service requirements.
18. The doctor and the employer will work together to ensure that leave is appropriately planned and taken across the year. This is to ensure both access to training and the maintenance of service delivery, and to protect the safety of both doctors and patients.
19. In exceptional circumstances, where agreement on planning leave is not possible despite the best reasonable efforts of the doctor and the employer, some leave may need to be allocated to ensure that all doctors are able to take their full leave entitlement while maintaining safe coverage of services. However, leave should not be fixed into a working pattern for this or any other reason without agreement from the doctor.
20. In addition to the provisions of paragraph 19, a rota should not be so restrictive in its design to give the appearance of fixed leave being incorporated into the rota, where there is little or no flexibility over when leave can be taken. Where possible, rosters should be designed to contain periods of at least two or three consecutive weeks without shifts attracting enhancements or allowances, to provide doctors with the opportunity to take longer periods of leave.
21. In cases where exceptional circumstances or service demands have prevented a doctor from taking the full leave allowance, up to five days of leave per annum (pro rata for contracts or placements of less than 12 months' duration or for doctors who work less than full time), may be carried forward to the next post or placement with the same employer. This is not an entitlement and must be with the agreement of the relevant department, in line with the employer's local policy. With the agreement of the employer and in line with local policy, payment in lieu can be made for up to five

days' annual leave (pro rata as appropriate) which could not be taken before a move to a new employer.

## **Payment for annual leave**

22. Pay is calculated on the basis of what the doctor would have received had the doctor been at work, based on the doctor's work schedule and on any reference period that may be applied locally. Payment of annual salaries is referred to in Schedule 2 of these TCS.
23. Where the employer offers a local scheme for the purchase of additional annual leave, a doctor will be permitted to seek participation in such a scheme, subject to any training requirements. The impact of any additional leave must be considered by HEE (local office) and agreed on behalf of the postgraduate dean. Any such agreed additional annual leave can only apply to the placement with that specific employer.

## **Public holidays**

24. Public holiday entitlement, as recognised by the NHS and set out in the definitions at the front of these TCS, is additional to annual leave entitlement.
25. A doctor working less than full time is entitled to paid public holidays at a rate no less than pro rata to the number of public holidays for a full-time doctor, rounded up to the nearest half day.
26. Public holiday entitlement for a doctor working less than full time shall be added to annual leave entitlement, and any public holidays shall be taken from the combined allowance for annual leave and public holidays.
27. A doctor who in the course of their duty is required to be present in the hospital (or other place of work) at any time (from 00.01 to 23.59) on a public holiday, or who is rostered to be on-call on a public holiday, will be entitled to a standard working day off in lieu.
28. Where a doctor's working pattern includes scheduled rest days (sometimes known as zero hours' days) and such a day falls on a public holiday, then the doctor will be given a day off in lieu of the public holiday.
29. Where a public holiday, including Christmas Day (25 December), Boxing Day (26 December) or New Year's Day (1 January), falls on a Saturday or a Sunday, the public holiday will be designated instead as falling on the first working weekday thereafter. In such circumstances, no day in lieu then arises for the work undertaken on Christmas Day (25 December), Boxing Day (26 December) or New Year's Day (1 January).

## Study and professional leave

30. Study leave includes but is not restricted to participation in:
  - a. study (linked to a course or programme)
  - b. research
  - c. teaching
  - d. taking examinations
  - e. attending conferences for educational benefit
  - f. rostered training events.
31. Attendance at statutory and mandatory training (including any local departmental training) is not counted as study leave.
32. Professional leave is leave in relation to professional work, as described in the definitions section of these TCS. Job interviews for NHS, public health, academic, NHS commissioned community health and hospice appointments should be considered professional leave, with time off accommodated appropriately and a doctor should not be required to take annual or study leave to attend such interviews. Doctors should provide rota coordinators with as much notice as possible to effectively plan the roster.
33. All requests for study leave will be properly considered by the employer. Any grant of study leave will be subject to the need to maintain NHS services (and, where the doctor is on an integrated academic pathway, academic responsibilities) and must be authorised by the employer.
34. A doctor is obliged to use study or professional leave for the purpose for which it has been granted. Safeguards on hours and rest as set out in Schedule 3 will continue to apply.
35. Study leave up to the limits described in table 1 below will normally be granted flexibly and tailored to individual needs, in accordance with the requirements of the curriculum. Requests for study leave in excess of these limits should be considered fairly where circumstances indicate such requests to be reasonable and may be granted by the employer provided that the needs of service delivery can be safely met.

**Table 1: Study leave allowances**

<b>Grade</b>	<b>Days per annum</b>
Foundation Doctor Year 1	15 days
All other doctors in training	30 days

36. Study leave for Foundation Year 1 doctors will take the form of a regular scheduled teaching/training session (or similar arrangement) as agreed locally.
37. Study leave for doctors at Foundation Year 2 and above will include periods of

regular scheduled teaching/training sessions, and may also, with approval from the educational supervisor and service manager, include:

- a. undertaking an approved external course
- b. periods of sitting (or preparing for) an examination for a higher qualification where it is a requirement of the curriculum.

Requests for such leave shall be viewed positively in most circumstances, but with a view to ensuring that the needs of service delivery can be safely met.

38. Where shifts attracting an enhanced rate of pay or an allowance are required to be swapped to take study leave (as described in paragraph 10 above), or if doctors are required to provide internal cover for colleagues on the rota when they take study leave, then prospective cover is in operation. In such situations, doctors' study leave allowance for the rota must be factored into the calculation of the average weekly hours of work and pay for that rota. This must be calculated in the same manner as described in paragraph 14 of schedule 4.
39. Where employing organisations have alternative arrangements for covering study leave, where internal cover or swaps of shifts are not required, prospective cover does not apply.
40. A doctor on a contract of employment of less than 12 months' duration is entitled to study leave on a pro rata basis.
41. Where a doctor working less than full time is required to undertake a specific training course required by the curriculum, which exceeds the pro rata entitlement to study and /or professional leave, the employer will make arrangements for additional study leave to be taken, provided that this can be done while ensuring safe delivery of services.
42. Study leave should be prospectively sought for all teaching, courses and educational opportunities that fall on non-working days, and where study leave approval is granted it must be compensated with TOIL, or payment if the doctor prefers.
43. Where a doctor takes parental leave their entitlement to study leave continues, and this may be taken during 'keeping in touch' days<sup>18</sup> or will otherwise accrue to be taken at a later date.

## **Sickness absence**

44. A doctor who is incapable of doing his or her normal work because of illness shall immediately notify his or her employer in accordance with the employer's procedures. A self-certificate will cover days one to seven of the period of sickness

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<sup>18</sup> As defined in Section 15 of the NHS terms and conditions of service handbook available from [www.nhsemployers.org](http://www.nhsemployers.org)

(including any non-working days). The doctor must obtain a medical certificate for subsequent days.

45. There is no requirement for a doctor to compensate the employer, in time or pay, for any scheduled duties they were unable to perform due to sickness
46. A doctor who becomes ill whilst on annual leave, shall immediately notify their employer in accordance with the employer's procedures on the first day of sickness. Further annual leave will be suspended from the date of notification subject to provision of a medical certificate.
47. Doctors are required to notify their employer as soon as possible of any illness, disease or condition that prevents them from undertaking their duties.
48. Where the employer considers at any time that a doctor is unable to perform some or all of their duties as a consequence of illness, the employer can require the doctor to attend an examination by the organisation's occupational health services, in accordance with local procedures.
49. A doctor absent from duty owing to illness (including injury or other disability) shall, subject to the provisions of paragraphs 56-64 below, be entitled to receive an allowance in accordance with the following table:

**Table 2: Scale of allowances**

During the first year of service	One month's full pay and two months' half pay
During the second year of service	Two months' full pay and two months' half pay
During the third year of service	Four months' full pay and four months' half pay
During the fourth and fifth years of service	Five months' full pay and five months' half pay
After completing five years of service	Six months' full pay and six months' half pay

50. The allowances set out in table 2 above are in line with those for all staff in the NHS, as set out in the *NHS Terms and Conditions of Service Handbook*<sup>19</sup>, and will be amended where any such amendment is agreed by the NHS Staff Council.
51. For doctors on these terms and conditions the definition of full pay will include regularly paid enhancements, allowances, premia and London weighting. Sick pay is calculated on the basis of what the individual would have received had he/she been at work. This would be based on the previous three months at work or any other reference period that may be locally agreed. Local partnerships can use virtual rotas showing what hours the employee would have worked in a reference period had he or she been at work.
52. Employers will have discretion to extend the period of sick pay on full or half pay beyond the scale set out in table 2 above in exceptional circumstances and in line with local employer policies:

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<sup>19</sup> NHS terms and conditions of service handbook, available from: [www.nhsemployers.org](http://www.nhsemployers.org)



- a. where there is the expectation of return to work in the short term and an extension would materially support a return and/or assist recovery, particular consideration should be given to those staff without full sick pay entitlements
  - b. in any other circumstance that the employer deems reasonable.
53. During the rehabilitation period, employers should make the appropriate adjustments to allow the doctor to return to work. This may include working reduced hours, undertaking training or administrative activities without loss of pay. Any such arrangements need to be consistent with statutory sick pay rules.
54. Doctors who are unable to take their statutory annual leave (i.e. the leave to which they are entitled under the Working Time Regulations) in any leave year due to sickness absence will be permitted to carry over that leave to a subsequent leave year where employment is continuous. Any carried-over leave must be taken within 18 months of the end of the leave year in which it accrues. Where the doctor changes employer before taking this entitlement, the outstanding balance will be compensated through pay. The content of this paragraph does not apply to any leave granted under these TCS which exceeds the doctor's statutory entitlement under the Regulations, which will lapse if it is not taken in the leave year in which it accrues.
55. The period during which sick pay should be paid and the rate of sick pay for any period of absence is calculated by deducting from the doctors entitlement on the first day of sickness the aggregate periods of paid sickness absence during the 12 months immediately preceding that day. In aggregating periods of absence due to illness no account shall be taken of:
- a. unpaid sick absence
  - b. injuries, diseases, or other health conditions sustained or contracted in the discharge of the doctors duties of employment, as defined in Section 22 of the *NHS Terms and Conditions of Service Handbook*<sup>20</sup>
  - c. injury resulting from a crime of violence, not sustained on duty but connected with or arising from the doctor's employment, where the injury has been the subject of payment by the Criminal Injuries Compensation Authority (England, Wales and Scotland) and/or the Compensation Agency (Northern Ireland)
  - d. as above, but an injury which has not attracted payment of an award as it has not met the loss of earnings criteria or was not one for which compensation above the minimum would arise.
56. The employer may, at its discretion, take no account of the whole or any part of the period of absence due to injury (not on duty) resulting from a crime of violence, not arising from or connected with the doctor's employment or profession.
57. For the purpose of calculating the appropriate allowance of paid sickness absence under paragraph 49, previous qualifying service shall be determined in accordance with the doctor's statutory rights and all periods of service, (without any break of 12 months or more, subject to paragraph 58 below), with a National Health Service employer shall be aggregated. Previous service with a non-NHS employer where placement is required should be included when calculating the allowance.

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<sup>20</sup> NHS terms and conditions of service handbook, available from: [www.nhsemployers.org](http://www.nhsemployers.org)

58. Where a doctor has broken their regular service for one of the following reasons:
- a. in order to go overseas in a rotational appointment forming part of a doctors recognised training programme; or
  - b. for an approved period of time out of programme for clinical training (OOPT), clinical experience (OOPE) or research (OOPR); then

the doctor's previous NHS or approved service, as set out in paragraph 55 above, shall be taken fully into account in assessing entitlement to sickness absence allowance, provided that the employer considers that there has been no unreasonable delay between the training or OOP ending and the commencement of the subsequent NHS post.

59. For the purpose of sickness absence allowances, a doctor's previous contracted NHS locum service shall be recognised, subject to a minimum of three months' continuous NHS locum service.

## **Limitation of allowance when insurance or other benefits are payable**

60. The sickness absence allowance paid to a doctor when added to any statutory sick pay, injuries or compensation benefits, including any allowances for adult or child dependants, must not exceed the pay the doctor would have received had they been at work.

## **Recovering of damages from third party**

61. A doctor who is absent as a result of an accident is not entitled to sick pay if damages are received from a third party. Employers will advance to the doctor a sum not exceeding the amount of sick pay payable under this scheme, providing the doctor repays the full amount of sickness allowance to the employer, when damages are received. Once received the absence shall not be taken into account for the purposes of the scale set out in table 2 in this Schedule.

## **Accident due to sport or negligence**

62. An allowance shall not normally be paid in a case of accident due to active participation in sport as a profession, or where contributory negligence is proved.

## **Injury sustained on duty**

63. An absence due to injury sustained by a doctor in the actual discharge of their duty, for which the doctor was not liable, shall not be recorded for the purposes of aggregation against future sickness absence.

64. The injury allowance provisions will apply as set out in Section 22 of the *NHS Terms*

*and Conditions of Service Handbook*<sup>21</sup>, and should be read alongside the accompanying guidance issued by NHS Employers.

## **Termination of employment**

65. The sickness absence provisions of these TCS shall cease to apply to a doctor on the termination of employment by reasons of permanent ill health or infirmity of mind or body, of resignation, of age, or any other reason, provided that, where a doctor is in receipt of sickness absence allowance at the time of expiry of a contract, that allowance shall be paid during the doctor's illness, subject as a maximum to the doctor's entitlement to allowances under the provisions of table 2 in this Schedule.

## **Forfeiture of rights**

66. If it is reported to the employer that a doctor has failed to observe the conditions of Schedule 10, or has been guilty of conduct prejudicial to the doctor's recovery, and the employer is satisfied that there is substance in the report, the payment of the allowance shall be suspended until the employer has made a decision regarding the continued payment of the allowance. Before making a decision, the employer must give the doctor an opportunity of responding to the report. If the employer decides that the doctor has failed without reasonable excuse to observe the conditions of this Schedule, or has been guilty of conduct prejudicial to the doctor's recovery, then the doctor shall forfeit the right to any further payment of allowance in respect of that sickness or period of absence.

## **Special leave with or without pay**

67. Special leave may be granted in exceptional circumstances, on a short-term basis at the discretion of the employer. All requests for special leave will be considered by the employer in line with statutory requirements and local policy.

## **Parental leave**

68. General provisions can be found in Schedule 14 – Sections of the *NHS Terms and Conditions of Service Handbook* applicable to doctors and dentists in training.

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<sup>21</sup> NHS terms and conditions of service handbook, available from: [www.nhsemployers.org](http://www.nhsemployers.org)

# SCHEDULE 11

## TERMINATION OF EMPLOYMENT

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1. A doctor employed under these terms and conditions of service is employed on a fixed-term basis and the contract will terminate at the end of the fixed term without the need for further notice from either party. Upon termination of the contract in these circumstances the doctor is immediately entitled to receive the benefit of any Period of grace as set out in these TCS.
2. The contract of employment can be brought to an end prior to the expiry of the fixed-term arrangements. In such circumstances, either the doctor or the employer must give notice in writing, except where the provisions of paragraph 13 apply.

### Statutory notice periods

3. The employer shall give, as the minimum period of notice to terminate the employment of a doctor who has been continuously employed for at least four weeks (unless the period specified in paragraph 6 below is longer):
  - a. one week's notice if the period of continuous employment is less than two years; or
  - b. one week's notice for each year of continuous employment if the period of continuous employment is at least two but less than 12 years; or
  - c. 12 weeks' notice if the period of continuous employment is 12 years or more.
4. The minimum period of notice to be given to the employer by a doctor who has been continuously employed for at least four weeks, shall be one week (unless the period specified in paragraph 6 below is longer). The period of continuous employment shall be computed in accordance with the Employment Rights Act 1996, as amended from time to time.

### Contractual notice periods

5. The agreed minimum period of notice by both sides for doctors employed under these terms and conditions of service, unless the statutory minimum periods of notice as set out above, are longer, shall be as follows:

F1 F2 StR (Core Training) (CT) StR (Fixed Term Specialty Training Appointment) Dental Core Trainee (DCT)	One month
StR (Run-through) StR (Higher Specialty Training) GP Specialty Trainee SpR	Three months

## **Application of notice**

6. Shorter or longer notice periods can apply where agreed between both parties in writing and signed by both.

## **Doctors rotating from one NHS employer to join another**

7. Where a doctor terminates employment immediately before a weekend and/or a public holiday and take up a new salaried post with another NHS employer immediately after that weekend and/or that public holiday, payment for the intervening day or days, i.e. the Saturday (in the case of a five-day working week) and/or the Sunday and/or the public holiday, shall be made by the first employer.

## **Termination of employment**

8. Whilst it is accepted that the majority of doctors employed within the NHS do their best to achieve high standards of behaviour and practice, on occasion a doctor may fail to meet the standards required, and in some circumstances, this may lead to termination of employment.
9. The process for dealing with matters of conduct, competence, capability or performance will be detailed in the relevant policies of the employing organisation.

## **Grounds for termination of employment**

10. A doctor's employment may be terminated for the following reasons:
  - a. Conduct.
  - b. Capability (including as defined by HEE)
  - c. Redundancy.
  - d. In order to comply with a statute or other statutory regulation.
  - e. Failure to hold or maintain a requisite qualification, registration, place on a General Medical Council approved training programme and/or license to practise.
  - f. Where there is some other substantial reason to do so in a particular case.
11. Should the application of any of the above procedures result in the decision to terminate a doctor's contract of employment, the doctor will be entitled to invoke a locally recognised appeals process, as set out in the relevant policies of the employing organisation.
12. In cases where employment is terminated, a doctor may be required to work the notice period, or if the employer considers it more appropriate, the doctor may be paid in lieu of notice, or paid through the notice period but not be required to attend work. Such arrangements are at the sole discretion of the employer.

13. Employment can be terminated without notice in cases of gross misconduct, gross negligence, where a doctor's professional registration and/or license to practice has been removed or has lapsed (without good reason) or a doctor's removal from a GMC-approved training programme. The postgraduate dean will be informed immediately by the employer when this circumstance arises. In this circumstance the doctor will be entitled to invoke the locally recognised appeals process, as set out in the relevant policies of the employing organisation. This process must be in line with ACAS guidance.

# SCHEDULE 12

## EXPENSES

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### General

1. Expenses relating to travel, subsistence and other business expenses shall be paid to meet actual disbursements of doctors in the performance of their duties and shall not be regarded as a source of pay or reckoned as such for the purposes of pension.
2. Claims for expenses shall normally be submitted within one month and as soon as possible after the end of the period to which the claim relates, subject to local procedures.
3. The following terms are used throughout the provisions set out in this Schedule:
  - a. 'Principal place of work' means the place of work from which the doctor conducts their main duties. Where a doctor has a joint contract with more than one employer, the term 'principal place of work' means the place from which the doctor conducts their main duties within that joint contract, irrespective of employer.
  - b. 'Official journey' means a journey in the performance of a doctor's duties.

### Business travel expenses

4. Costs incurred by doctors shall be reimbursed when, with the agreement of their employer, they use their own vehicles or pedal cycles to make official journeys.
5. When doctors use their vehicles for official journeys, they must possess a valid driving licence, Ministry of Transport (MOT) test certificate and motor insurance that covers business travel. It is the doctor's responsibility to cover the costs of such licences, certificates and insurance. Doctors must be fit to drive, drive safely and obey the relevant laws e.g. speed limits. The doctor must inform the employer if there is a change in their fitness to drive status.
6. When authorising the use of a vehicle, the employer must ensure that the driver has a valid driving licence and MOT certificate and has motor insurance that covers business travel.
7. The employer and doctor will agree the most suitable means of transport for the routine journeys that the doctor has to make in the performance of their duties. If a particular journey is unusual, in terms of distance or purpose, the mode of travel and expenses payable will be agreed between the employer and doctor before it starts.
8. Where the use of a vehicle is essential to the job, the employer may wish to assist by providing a lease or pool vehicle. In exceptional circumstances the employer may provide an advance of basic pay. Principles underpinning lease vehicle policies are provided by local employers

9. The reimbursement of excess travel costs when doctors are required to change their principal place of work as a result of organisational change will be for local policy to determine.

## Rates of reimbursement

10. For doctors who use their own vehicles or pedal cycles to make official journeys, their travel costs shall be reimbursed at the appropriate rates.
11. The rates of reimbursement can be found in Section 17 of the *NHS Terms and Conditions of Service Handbook*<sup>22</sup> at table 7, which is updated from time to time as agreed with the NHS Staff Council. These rates are obtained by referring to costs for the average private vehicle user included in the AA guides to motoring costs. A summary of motoring costs which are taken into account is contained in the *NHS Terms and Conditions of Service Handbook* at Annex 12.
12. The rate of reimbursement for motorcyclists can be found in Section 17 of the *NHS Terms and Conditions of Service Handbook* in column 4 of table 7, and the reserve rate in column 4 will move in line with the rate for car users in column 2 (see Annex 12 of the *NHS Terms and Conditions of Service Handbook*).

## Review

13. The standard rate of reimbursement in Section 17 of the *NHS Terms and Conditions of Service Handbook* at Column 2 in Table 7 will be reviewed each year, soon after the new AA guides to motoring costs are published, normally in April or May. Any changes to the standard rate of reimbursement, the reserve rate and the rate for motorcycle users in table 7, resulting from this review, shall apply to all miles travelled from the following 1 July.
14. A second review will be conducted in November each year to ensure the rate in column 2 in table 7 (the standard rate) continues to reimburse doctors in line with motoring costs. Any changes to the standard rate of reimbursement, the reserve rate and the rate for motorcycle users in table 7, resulting from this review, shall apply to all miles travelled from the following 1 January.

## Eligible mileage

15. Doctors shall be reimbursed for official journeys that are in excess of their return journey from home to principal place of work (save for where paragraph 16 applies). Normally, the miles eligible for reimbursement are those travelled from the principal place of work to place visited and back. However, when the journey being reimbursed starts at a different location, for example home, the mileage eligible for reimbursement will be as set out in the example in table 8, contained in Section 17 of the *NHS Terms and Conditions of Service Handbook*.
16. Doctors working in a GP practice setting who are required to use their own vehicle on the expectation that home visits may be required to be undertaken shall be

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<sup>22</sup> NHS Terms and Conditions of Service Handbook, available from: [www.nhsemployers.org](http://www.nhsemployers.org)



reimbursed at the reserve rate, as specified in table 7 of the NHS Terms and Conditions of Service Handbook, for the mileage of their return journey from home to principal place of work, and any associated allowances as described in paragraph 23 below.

- a. The days on which a doctor may be expected to perform home visits should be specified within their generic work schedule, or an alternative document providing advance notification that home visits may be required. Further specificity, as required, around when a doctor is expected to perform home visits should be added to the personalised work schedule when the doctor agrees it with their educational supervisor.
- b. When submitting claims for home to base mileage, in line with local processes for claiming expenses, a doctor must either:
  - i. attach their work schedule to the claim form, or any alternative written advance notice they have been provided by their practice, which specifies the days on which they are expected to perform a home visit.
  - ii. or obtain validation from a GP practice staff member that they had been advised they would need their own vehicle available due to the potential requirement to perform a home visit that day, when claiming home to base mileage for a day not specified in their work schedule, or any alternative written advance notice the doctor has been received from their practice.
  - iii. where no detail has been provided within the doctor's generic and personalised work schedules, or any alternative written advance notice, then the doctor must submit a claim for all the days on which they took their vehicle into work due to the possibility of being required to perform a home visit. This claim must be validated by the practice manager or a member of staff who is authorised to validate claims from the GP Practice.

## Passenger rate

17. With the exception of lease, pool or hire vehicle users, where other doctors or members of an NHS organisation are conveyed in the same vehicle on NHS business and their fares would otherwise be payable by the employer, the passenger allowance in table 7 of Section 17 of the *NHS Terms and Conditions of Service Handbook* will be payable to the vehicle driver.

## Reserve rate of reimbursement

18. A reserve rate of reimbursement, as in table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*, shall apply to doctors using their own vehicles for business purposes in the following situations:
  - a. If the doctor unreasonably declines the employer's offer of a lease vehicle:
    - i. in determining reasonableness, the employer and doctor should seek to reach a joint agreement as to whether a lease vehicle is appropriate and the timeframe by which the new arrangements will apply. All the relevant circumstances of the doctor and employer will be considered including the doctor's personal need for a particular type of car and the employers' need to provide a cost-effective option for business travel
    - ii. if the doctor's circumstances subsequently change the original decision

will be reviewed. The agreed principles underlying local lease vehicle policies are contained in the *NHS Terms and Conditions of Service Handbook* at Annex 13;

- b. When a doctor is required to return to work on any day (e.g. when called out in an emergency), and thereby incurs additional travel to work expenses.
- c. If the doctor uses his or her own vehicle when suitable public transport is available and appropriate in the circumstances, subject to a maximum of the public transport cost which would have been incurred and the rules on eligible miles in paragraph 15 of this Schedule and table 8 in section 17 of the *NHS Terms and Conditions of Service Handbook*.

## **Attendance on training courses**

- 19. Additional travel costs incurred when attending courses, conferences or events at the employer's instigation shall be reimbursed at the standard rates in table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook* when the employer agrees that travel costs should be reimbursed.
- 20. Subject to the prior agreement of the employer, travel costs incurred when doctors attend training courses or conferences and events, in circumstances when the attendance is not required by the employer, or who are on professional or study leave, shall be reimbursed at the reserve rate in table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*, in line with the rules on eligible mileage in paragraph 15 of this Schedule and table 8 in section 17 of the *NHS Terms and Conditions of Service Handbook*.

## **Study leave expenses**

- 21. Doctors may be entitled to reimbursement of reasonable study leave expenses, in accordance with local policy, which must meet the minimum standards for provision set out in the Learning and Development Agreement (or any successor document) between the employer / host organisation and HEE.
- 22. This shall apply equally to doctors taking study leave during or accrued while on parental leave as per Schedule 10 paragraph 43.

## **Other allowances**

- 23. Doctors who necessarily incur charges in the performance of their duties, in relation to parking, garage costs, tolls and ferries, shall be refunded these expenses on production of receipts, whenever these are available. However, charges for overnight garaging or parking shall not be reimbursed unless the doctor is entitled to night subsistence. This does not include reimbursement of parking charges incurred as a result of attendance at the doctor's principal place of work, except for where the charge is in relation to the performance of the duties described in paragraph 16 above.

## Transporting equipment

24. Doctors who use their vehicles in the performance of their duties may be required to take equipment with them. Employers have a duty of care under the Health and Safety at Work Act 1974 and related legislation, to ensure that this does not cause a risk to the health and safety of the doctor. Doctors should not be allowed to carry equipment that is heavy or bulky, unless a risk assessment has been carried out beforehand. When, after the necessary assessment has demonstrated it is safe to carry equipment, an allowance (see table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*) shall be paid for all eligible miles (see paragraph 15 of this Schedule and table 8 in section 17 of the *NHS Terms and Conditions of Service Handbook*) for which the equipment is carried, provided that either:
- a. the equipment exceeds a weight that could reasonably be carried by hand
  - b. the equipment cannot be carried in the boot of the vehicle and is so bulky as to reduce the seating capacity of the vehicle.

## Public transport

25. If doctors use public transport for business purposes the cost of bus fares and standard rail fares shall be reimbursed.

## Relocation expenses

26. Assistance with relocation expenses, including removal or excess mileage, shall be provided to doctors who:
- a. need to move their home or incur extra daily travel expenses as a result of being required by their employer to transfer principal place of work.
  - b. Are required to change their employer or who otherwise have to move home or incur extra daily travel expenses in order to satisfy the requirements of their professional training i.e. change of principal place of work on a rotational training programme.
27. Assistance may also be granted, at the employer's discretion, to doctors who as a result of taking up employment either need to move their home or incur extra daily travel expenses i.e. on first appointment to principal place of work. In exercising their discretion, employers shall take into consideration the Equality and diversity statement (see Schedule 14 – Sections of the *NHS Terms and Conditions of Service Handbook* applicable to doctors and dentists in training).
28. If the doctor has a home convenient to the principal place of work in which the second or subsequent post in the rotational appointment is to be held they may decide to travel the extra distance to where the previous post or posts are held and in such cases the doctor may be paid excess travel expenses when travelling to the previous post or posts.
29. Except where another body has responsibility for providing the assistance, the employer and the doctor can agree either:
- c. assistance with removal expenses

- d. assistance with temporary accommodation and/or excess travel expenses where the doctor travels daily the greater distance between their home and second or subsequent principal hospitals.

## **Removal expenses**

30. Except where another body provides the assistance, the scope and level of financial assistance to be provided should be determined by the employer, in agreement with the prospective doctor, prior to the post being accepted. In agreeing the assistance to be provided, the employer shall have regard to all the individual doctor's circumstances, including the need to re-house dependants and the comparability of new and previous accommodation.
31. The employer shall clearly indicate to the doctor the level of assistance that will be provided, the aspects of removal costs that will be reimbursed and, where applicable, the upper limit of payment in all usual circumstances. In providing assistance, authorities should ensure equity, while balancing their own interests with the needs of prospective employees.
32. The employer shall stipulate in the agreement reached with the doctor the procedure to be followed and the costs that will be reimbursed in circumstances where an authority has entered into an agreement with solicitors or others to provide house purchase/conveyancing services, private structural surveys, estate agency services and/or a removal service at preferential cost.

## **Excess travel expenses**

33. As outlined in paragraph 27 above, excess mileage may be paid instead of relocation expenses where appropriate and this should be agreed by the employer and the doctor prior to the doctor starting in post.
34. Excess mileage is deemed to be the difference, for each single journey, between the distance from the doctor's home to their principal place of work (the first place of work in the doctor's current training programme except under the circumstances described in paragraph 27) and the distance from their home to any second or subsequent principal place of work. Excess mileage may be payable at the first appointment to a principal place of work under the circumstances described in paragraph 27.
35. The reserve mileage rate shall be paid in accordance with table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*.

## **Subsistence allowances**

36. The purpose of travel and subsistence allowances is to reimburse the necessary extra costs of meals, accommodation and travel and any other business expenses that arise as a result of official duties away from home (or principal hospital).
37. Where, locally, staff and employer representatives agree arrangements that are more appropriate to local operational circumstances, or which provide benefits to staff beyond those provided by these provisions, or are agreed as operationally preferable, those local arrangements will apply.

## Night subsistence

38. When doctors stay overnight in commercial accommodation with the agreement of the employer, the actual receipted cost up to the level set out in Annex 14 of the *NHS Terms and Conditions of Service Handbook*<sup>23</sup> shall be paid.
39. Where the maximum limit is exceeded for genuine business reasons (e.g. the choice of hotel was not within the employee's control or cheaper hotels were fully booked), additional assistance may be granted at the discretion of the employer.
40. Regardless of accommodation type, doctors staying overnight with the agreement of their employer shall be reimbursed for the cost of meals, excluding alcoholic drinks, up to the level set out in Annex 14 of the *NHS Terms and Conditions of Service Handbook*<sup>24</sup>, subject to the production of receipts. If meals are provided free of charge, the cost of meals cannot be reimbursed. Additional assistance may be granted at the discretion of the employer.
41. Where doctors stay for short overnight periods with friends or relatives a flat rate at the level set out in Annex 14 of the *NHS Terms and Conditions of Service Handbook*<sup>25</sup> is payable. This includes an allowance for meals. No receipts are required.
42. Where accommodation and meals are provided without charge to doctors e.g. on a residential training course, an incidental expenses allowance at the level set out in Annex 14 of the *NHS Terms and Conditions of Service Handbook*<sup>26</sup> shall be payable. All payments of this allowance are subject to the deduction of appropriate tax and national insurance contributions via the payroll system.
43. Travel costs between the hotel and any temporary place of work shall be separately reimbursed on an actual costs basis.

## Travelling overnight in a sleeping berth (rail or boat)

44. The cost of a sleeping berth (rail or boat) and meals, excluding alcoholic drinks, shall be reimbursed subject to the production of receipts.

## Other business subsistence

45. Any expenditure necessarily incurred by doctors on postage or telephone calls in the service of their employer shall be reimbursed subject to evidence of expenditure.

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<sup>23</sup> NHS terms and conditions of service handbook, available from [www.nhsemployers.org](http://www.nhsemployers.org)

<sup>24</sup> NHS terms and conditions of service handbook, available from [www.nhsemployers.org](http://www.nhsemployers.org)

<sup>25</sup> NHS terms and conditions of service handbook, available from [www.nhsemployers.org](http://www.nhsemployers.org)

<sup>26</sup> NHS terms and conditions of service handbook, available from [www.nhsemployers.org](http://www.nhsemployers.org)

# SCHEDULE 13

## FACILITIES

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### Principles

1. The principles enshrined in this contract have been developed to ensure both patient safety and the safety of the doctor.
2. The employer / host organisation will make every effort to provide educational workplace facilities for doctors in line with those set out as minimum standards in the Learning Development Agreement between the employer / host organisation and HEE.
3. This schedule outlines the type of facilities that should be made available for doctors who are required to work during the overnight period.

### Access to food and drink

4. Where doctors are required to work during the overnight period, they must be able to access both hot and cold food and drink.
5. Outside of the period when restaurant facilities are open, there should be a range of foods available for purchase from vending machines or via other means, as applicable locally. Employers shall make reasonable efforts to cater for various dietary requirements.
6. Where catering facilities are limited, organisations should identify alternative local establishments that can provide food during the night, or they may instead wish to consider providing facilities for the storage and preparation of food and drink brought in by the doctor.

### Access to rest facilities

7. Doctors who are rostered to work a night shift must have access to a space in which to take a meal and other rest breaks. This should ideally be provided in an area away from patients, where possible.
8. Employers are not required to provide a bedroom for doctors who are rostered to work a night shift.
9. Where a doctor advises the employer that the doctor feels unable to travel home following a night, long, or late shift due to tiredness, the employer shall where possible provide an appropriate rest facility where the doctor can sleep, without

charge. The hours when the doctor is resting in the hospital under these circumstances will not count as work or working time. Where the provision of an appropriate rest facility is not possible, the employer must cover the cost of alternative arrangements for the doctor's safe travel home. Where necessary, the employer must also cover reasonable expenses as determined through locally agreed policies for the doctor's return journey to work, either to begin the next shift or, where the doctor has left their personal vehicle at work, to collect the vehicle.

10. Where a doctor is rostered to work on a non-resident on-call working pattern and is required to return to work during the night period, and the doctor considers it unsafe to undertake the return journey home due to concerns over tiredness, the employer shall where possible provide an appropriate rest facility if requested where the doctor can rest, without charge. The hours when the doctor is resting in the hospital under these circumstances will not count as work or working time. Where the provision of an appropriate rest facility is not possible, the employer must cover the cost of alternative arrangements for the doctor's safe travel home. Where necessary, the employer must also cover reasonable expenses as determined through locally agreed policies for the doctor's return journey to work, either to begin the next shift or, where the doctor has left their personal vehicle at work, to collect the vehicle.
11. Where a doctor is rostered to work on a non-resident on-call working pattern and the doctor elects voluntarily, subject to the availability of accommodation, to be resident during the on-call duty period, a charge for any such accommodation shall be made and, provided that prior consent has been given, deducted from the doctor's salary.
12. Where a doctor is rostered to work on a non-resident on-call working pattern and must be resident in order to maintain a safe response time for the management of time critical conditions and emergencies, the employer shall provide the doctor with accommodation during the on-call duty period without charge. Where the provision of accommodation is not possible, the employer must make sure that arrangements are in place to provide and cover the cost of alternative accommodation.
13. Where a doctor is required to work overnight on a resident on-call working pattern, the doctor shall be provided with overnight accommodation for the resident on-call duty period without charge.

# SCHEDULE 14

## SECTIONS TO THE NHS TERMS AND CONDITIONS OF SERVICE HANDBOOK APPLICABLE TO DOCTORS AND DETISTS IN TRAINING

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1. The following sections of the *NHS Terms and Conditions of Service Handbook*<sup>27</sup> apply to doctors employed under these TCS
  - Section 15 Leave and pay for new parents
  - Section 16 Redundancy pay (England)
  - Section 22 Injury allowance
  - Section 23 Child bereavement leave
  - Section 25 Time off and facilities for trade union representatives
  - Section 26 Joint consultation machinery
  - Section 30 General equality and diversity statement
  - Section 32 Dignity at work
  - Section 33 Balancing work and personal life
  - Section 34 Employment break scheme
  - Annex 26 Managing sickness absences – developing local policies and procedures
  
2. In relation to the above sections:
  - a. In particular, when developing relevant policies and considering flexible working requests, employers must take into account the domestic and family circumstances of doctors, including but not limited to caring responsibilities and the working patterns of partners and dependents.
  
  - b. Employers will take into account any guidance issued by NHS Employers agreed through national collective bargaining arrangements.

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<sup>27</sup> NHS terms and conditions of service handbook, available from [www.nhsemployers.org](http://www.nhsemployers.org)



# SCHEDULE 15

## TRANSITIONAL ARRANGEMENTS

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1. The new contractual arrangements shall include an initial period of pay protection for some existing doctors. This Schedule describes how these transitional pay protection arrangements will apply for doctors who either
  - a. commence work as an F1 on 3 August 2016; or
  - b. were in NHS employment on 2 August 2016 as part of approved postgraduate training programmes under the auspices of:
    - **Health Education England**
    - **NHS Education for Scotland**
    - **Northern Ireland Medical and Dental Training Agency**
    - **Wales Deanery**
    - **Directorate of Healthcare Delivery and Training**
2. The transitional pay protection arrangements set out below will apply to those doctors and dentists in training who meet the criteria above if they either;
  - a. move through another post or series of posts on such training programmes under the terms and conditions of service set out above, on or after 3 August 2016.
  - b. move directly from such an appointment to an appointment to a post on such a training programme, on or after 3 August 2016
3. The transitional pay protection arrangements set out in this paragraph will apply from October 2019 to all doctors employed under the national 2002 terms and conditions of services who will be transitioned onto the national 2016 terms and conditions of service at the earliest available opportunity. This provision does not apply to doctors employed under locally agreed terms and conditions of service. The transitioning of these doctors onto the 2016 TCS must be conducted in accordance with the below requirements:
  - a. The existing process, as set out within this schedule, should be used for determining a doctor's eligibility for pay protection and the type of pay protection they are entitled to, which is either; Section one (paragraphs 5 – 26), or Section two (paragraphs 27 – 41)
  - b. Where a trainee is assessed as being eligible for Section one pay protection, the value of the banding supplement of the rota the doctor was working on the day before transitioning onto the 2016 TCS should be used. This provision is applicable to paragraphs 14(b) and 19(b) of this schedule.
4. The contract becomes effective on 3 August 2016 but doctors will transition to the new terms between 5 October 2016 and 5 February 2020.

## SECTION ONE: TRAINEES IN THE FOUNDATION GRADES, CORE TRAINING GRADES AND EARLY STAGES OF RUN-THROUGH TRAINING

5. The following doctors shall be entitled to transitional pay protection under the arrangements described in this Schedule 15 at paragraphs 6 to 22 with effect from 3 August 2016:
  - 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) on 3 August 2016.
6. Transitional arrangements shall also apply to doctors who complete a training programme on 2 August 2016, having already accepted the offer of their next training programme but who, as either a direct result of the differing start dates of different training programmes, or as a result of an agreed deferral of their start date, do not commence on 3 August 2016. In such cases, these transitional arrangements shall apply at the point at which the doctor re-enters training.
7. The transitional pay protection arrangements shall be based on the basic salary that the doctor was earning on the day prior to starting work under the new contract. These arrangements shall apply to all doctors in NHS employment on 2 August 2016 (or commencing employment as an F1 on 3 August 2016) as part of approved postgraduate training programmes as set out in paragraph 1, whose status is described in paragraph 5 above, and who remain employed whilst training on such programmes on 3 August 2016, either in the same post or following a rotation into a different post/placement.

### **Determination of pay protection**

8. A doctor's protected level of pay will be calculated and shall be used as a baseline or 'consistent cash floor' for each year until either the doctor exits training, or until four years of continuous employment have elapsed from the point that the doctor is first employed on these TCS, or until 6 August 2025, whichever is the sooner.

9. For doctors transitioning from training programmes set out in paragraph 1, (apart from those on OOP, or long-term sick leave already provided for under Schedule 15), pay protection should start from the point at which the trainee first took up post in England on the 2016 TCS. In order to provide equity for trainees within a cohort, it should be paid until either the doctor exits training, or until four years of continuous employment have elapsed from the point that the doctor is first employed on these TCS, or four years from the date at which that trainee would have transferred with their relevant cohort of trainees had they been in England, whichever is the sooner.
10. For the purposes of determining the cash floor for doctors transitioning from training programmes set out in paragraph 1, the doctor's basic salary on the day before transition shall be protected at the relevant English 2002 TCS equivalent value of the incremental pay point they moved from, as set out in the medical pay and conditions circular.
11. Doctors described in paragraphs 5 and 6 above who are subsequently absent from work on maternity leave, adoption leave, shared parental leave or long-term (more than three consecutive months) sick leave shall have the period of time during which they are absent from work, up to a maximum of two years, discounted for the purposes of calculating the four-year period described in paragraph 9 above, which may therefore be extended by a maximum of two years, in direct proportion to the amount of time in which the doctor was absent from work for the reasons given above.
12. In such circumstances as described in paragraph 11 above, the doctor's protected level of pay shall be used as a baseline or consistent cash floor for each year until either the doctor exits training, or until the extended period of continuous employment from the point that the doctor is first employed on these TCS described above has elapsed, or until 6 August 2025, whichever is the sooner.
13. Doctors described in paragraphs 1, 5 and 6 training on a less-than-full-time basis shall have the four-year period described in paragraph 9 above extended in direct proportion to the proportion of full time that they are employed. For example, a doctor employed on an 80 per cent basis shall have the four-year period extended to a five year period. Where the hours worked by a doctor (up to a maximum of an average of 40 hours per week) are increased or decreased between or during appointments, such that the proportion of full time that the doctor is training is formally adjusted, both the actual cash value of the level of protected pay but also the length of the period to which it applied shall be adjusted accordingly. In such circumstances, the doctor's protected level of pay shall be used as a baseline or consistent cash floor for each year until either the doctor exits training, or until the extended period of continuous employment from the point that the doctor is first employed on these TCS described above has elapsed, or until 6 August 2025, whichever is the sooner.
14. The protected level of pay for an individual doctor will only be calculated once, and shall be the sum of:
  - a. the incremental pay point for the doctor on the day prior to starting work under the new terms and conditions; plus

- b. for doctors described in paragraphs 5 and 6 above (other than those described in paragraph 14(c) below), the value of the banding supplement under the 2002 TCS as at 31 October 2015 for the rota on which the doctor was working on the day prior to starting work on the terms and conditions (or if the rota did not exist on 31 October 2015 the banding supplement which applied on appointment), up to a maximum banding supplement of 50 per cent (Band 1A) or, for those doctors who have opted out of the Working Time Regulations 1998 (WTR ), to a maximum of Band 2A (80 per cent). Where a doctor (other than on a Foundation programme) is working in a general practice placement on the day prior to starting work on the new terms and conditions, the GP supplement payable at the time (45 per cent) shall be used in place of any banding supplement for this purpose; or
  - c. for doctors described in paragraphs 5 and 6 above transitioning directly from the Foundation 2 grade on the previous (2002) terms and conditions and starting in the Foundation 2 grade on the these 2016 terms and conditions on either 7 December 2016 or 5 April 2017, who would otherwise if not for this paragraph have a cash floor set using no banding supplement (0%) or a 1C banding supplement (20%), should have their cash floor calculated using a sum equivalent in value to 40% of basic pay, in lieu of a banding supplement, to take effect from 5 April 2017 only.
15. The doctor's actual total 'new contract' pay (excluding London weighting) at appointment to the first post and subsequently at appointment to each new post under these TCS shall be calculated as per the provisions of Schedule 2 of these TCS.
16. The protected level of pay shall then be compared against the doctor's actual total new contract pay (excluding London weighting).
17. Where actual total new contract pay (excluding London weighting) is lower than the protected level of pay, the doctor shall receive actual total new contract pay (excluding London weighting) plus an additional amount in pay protection sufficient to return the doctor's total pay to the protected level of pay. Any relevant London weighting would then be added to the total pay once pay protection has already been included.
18. Whether new contract pay or the protected level of pay has the higher value may change over the course of a doctors training programme. It is possible that the protected pay may be higher than new contract pay in some training placements, but not in others. Doctors listed in paragraph 5 shall receive transitional pay protection as described in paragraphs 15-17 above for each placement / post in their training programme until the end of the transition period to which this Schedule applies or until the doctor exits training, whichever is the sooner.
19. 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 (OOP) purposes who return to training prior to 6 August 2025 in a post listed in paragraph 5, shall have their protected level of pay calculated as the sum of:

- a. the incremental pay point that the doctor might otherwise have reached had they not been absent; plus
- b. for doctors described in paragraphs 5 and 6 above (other than those described in paragraph 19(c) below), the value of the banding supplement under the 2002 TCS as at 31 October 2015 for the rota on which the doctor would have been working on at the point of transition, up to a maximum banding supplement of 50 per cent (Band 1A) or, for those doctors who have opted out of the WTR<sup>28</sup>, to a maximum of Band 2A (80 per cent); or
- c. for doctors described in paragraphs 3 and 4 above who would be transitioning directly from the Foundation 2 grade on the previous (2002) terms and conditions and would have started in the Foundation 2 grade on the these 2016 terms and conditions on either 7 December 2016 or 5 April 2017, who would otherwise if not for this paragraph have a cash floor set using no banding supplement (0%) or a 1C banding supplement (20%), should have their cash floor calculated using a sum equivalent in value to 40% of basic pay, in lieu of a banding supplement, to take effect from 5 April 2017 only.

20. Where a doctor described in paragraphs 5 or 6 above is training on a less than full time basis on 3 August 2016, then, irrespective of any pay protection arrangements that might apply under paragraphs 8 to 18 above, the doctor shall, in addition to any other sums paid in accordance with the provisions of paragraphs 14 to 19 above, be paid an annual pay premium of £1,500 for so long as the doctor continues to train on a less than full time basis, subject to the maximum period for which transitional arrangements apply to that doctor, as described in paragraphs 8 to 13 above. The provisions of this paragraph will also apply to a doctor absent on parental leave on 2 August 2016 who, following this period of parental leave, returns directly to training on a less than full time basis.

## Changes in hours during transition

21. For those doctors described in paragraphs 5, 6 and 19 above, who are working less than full time at the point of transition, the cash floor shall be calculated on a pro rata basis reflective of their actual hours of work. Those whose hours are subsequently increased or decreased (or who move from full time to less than full time) shall have their cash floor value increased or decreased on a corresponding pro rata basis.

22. Where pay increases as a result of changes to the work schedule, the doctor shall be paid the new increased level of actual total pay. Where this remains lower than the cash floor, the doctor shall continue to receive actual total pay plus a reduced amount of additional pay protection sufficient to return the doctor's total pay to the level of the cash floor.

23. Where changes to the work schedule of a doctor granted pay protection under these

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<sup>28</sup> The Working Time Regulations 1998, <http://www.legislation.gov.uk/ukxi/1998/1833/contents/made>

provisions are required by the employer, and total pay would be decreased as a result, the doctor shall continue to receive their previous pay, as specified in Schedule 2 paragraph 70.

24. Where a doctor requests and an employer agrees changes to the work schedule that result in hours being decreased, the value of the cash floor will be decreased in proportion to the decrease in hours.

## **Pay protection under previous arrangements**

25. Where, at the point of taking up an offer of appointment under these TCS, a doctor covered by the provisions of paragraphs 5 or 6 above has previously re-entered training from a nationally recognised career grade (defined for the purposes of this schedule as being an NHS medical practitioner appointed on national terms and conditions of service other than those for doctors and dentists in training) and is in receipt of pay protection on the basic salary (exclusive of any pay for additional hours / sessions, excellence awards or similar payments, on-call or other allowances, pay premia or any other supplementary payments paid or received) previously earned in that grade, this protected salary shall be taken into account in the calculation of the cash floor.
26. Once this has been taken into account in the calculation of the cash floor, any previously agreed pay protection arrangements will be discontinued.

## SECTION TWO: TRAINEES IN THE HIGHER TRAINING GRADES AND LATTER STAGES OF RUN-THROUGH TRAINING

27. The doctors identified below will be granted transitional pay protection under the arrangements described in this Schedule at paragraphs 27-41 with effect from 3 August 2016:
- Doctors already at ST3 or above 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.
28. Doctors outlined in paragraph 27 above shall continue to be paid a basic salary on the pay scale (MN37) on which they were previously paid under the 2002 TCS, and shall continue to receive annual increments on the anniversary of their previously agreed incremental date until they exit training or until 6 August 2025, whichever is the sooner. These arrangements do not apply to work carried out under the provisions in schedule 2 paragraph 72 which will be paid as set out in schedule 2.
29. Where the hours worked by a doctor (up to a maximum of an average of 40 hours per week) are increased or decreased between or during appointments, such that the proportion of full time that the doctor is training is formally adjusted, the actual cash value of the level of protected pay shall be adjusted accordingly. In such circumstances, the doctor shall continue to be paid in accordance with paragraph 28 above until either the doctor exits training or until 6 August 2025, whichever is the sooner.
30. Doctors described in paragraph 27 above, during the time that their basic salary is protected as described in paragraphs 28 to 29 above, continue to be paid, where appropriate, and based on the rota on which they are actually working, a banding supplement, as calculated under paragraph 31 below. However, where a doctor described in paragraph 27 above subsequently elects to re-enter training in a different training programme, any protection arrangements arising as a result of paragraphs 27 to 29 shall be discontinued and the doctor will instead be entitled the same level of pay protection as for a doctor described in paragraphs 5 and 6 above, until the end of the original period of pay protection applying at the point that the doctor first accepted an appointment under these TCS.

### **Working hours for the purposes of banding at transition**

31. For the purposes of calculating the banding supplement for this group of doctors only, refer to Annex B.
32. Monitoring and re-banding will not be used under these new TCS. Doctors continuing to be paid under the 2002 TCS will otherwise be subject to the terms of these TCS. If such a doctor experiences significant and/or regular variation between their day to day

work and their work schedule, they should submit an exception report and follow the process as set out in schedule 5 above. A work schedule review should be used to determine whether or not the banding supplement being paid is correct for the doctor's working pattern, and Annex B can be used to pay a different banding supplement to the individual doctor if necessary. Any disagreement between the doctor and their supervisor will be overseen by the guardian of safe working hours as set out in schedule 6 above.

## **Banding and the Working Time Regulations 1998**

33. Doctors working on patterns described in Annex B that require more than 48 hours of average weekly work must have opted out of the WTR<sup>29</sup>, as set out in Schedule 3 of these TCS. Doctors not wishing to opt out can only be contracted on rotas of no more than an average of 48 hours' actual work per week.
34. Rotas with a weekly average greater than 56 hours of actual work are not permitted under the terms of this contract. Employers must not create such working patterns, nor should doctors request to work such patterns.

## **Doctors out of programme during transition**

35. Doctors described in paragraph 27 above who are on a recognised out-of- programme experience (OOP), on maternity leave, adoption leave, shared parental leave or long-term sick leave at the point of transition, will upon return to the training programme be paid a basic salary on the same payscale and at the same incremental point that they would have been paid had they returned to take up an appointment under the 2002 TCS. Such doctors may also be entitled to receive a banding supplement, subject to a maximum of Band 2A (80 per cent of basic salary), in accordance with Annex B. Such doctors shall continue to receive annual increments on the anniversary of their agreed incremental date, and to receive banding supplements where these are appropriate, until they exit the training programme, or until 6 August 2025, whichever is sooner.

## **Changes in hours during transition**

36. Doctors described in paragraph 27 above who are training less than full time on appointment to a post under these TCS and who subsequently request to increase their hours of actual work shall have their pay and banding will be re-calculated as per paragraph 31 above.
37. Doctors described in paragraph 27 above who are training less than full time on appointment to a post under these TCS and who subsequently return to full-time working shall have their pay and banding re-calculated as per paragraph 29 above.
38. Doctors described in paragraph 27 above who decrease their hours on appointment to a post under these TCS shall have their pay and banding recalculated in line with

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<sup>29</sup> The Working Time Regulations 1998, <http://www.legislation.gov.uk/uksi/1998/1833/contents/made>



paragraph 29 above as appropriate. This may result in their pay being reduced on a pro rata basis.

## **Pay protection under previous arrangements**

39. Where, at the point of taking up an offer of appointment under these TCS, a doctor described in paragraph 27 above has previously re-entered training from a nationally recognised career grade (defined for the purposes of this schedule as being an NHS medical practitioner appointed on national terms and conditions of service other than those for doctors and dentists in training) and is in receipt of pay protection on the basic salary previously earned in that grade, this protected salary shall continue to be taken into account in the calculation of the doctor's earnings in line with the provisions of paragraph 28.
- a. Where a doctor was in receipt of a protected basic salary based on a point of the career grade scale, then their total earnings should continue to apply under the terms of this schedule for the duration of the transition period, and calculated as if they were undertaking those duties under the relevant terms of the career grade contract held before re-entry to training
40. Once this protected salary has been taken into account for the provisions of paragraph 28, any previously agreed pay protection arrangements will be discontinued.

## **Limits on application**

41. In all aspects other than the pay arrangements described in this Schedule, doctors described in paragraphs 5, 6 and 27 will fall within the scope of these TCS.

The arrangements in this schedule shall cease to apply at 23.59 on 6 August 2025 subject to review by the joint negotiating Committee (Juniors).

## Annex A

Please see the latest pay circular which deals with pay and conditions of service of NHS doctors and dentists training. This is available on the NHS Employers website [www.nhsemployers.org](http://www.nhsemployers.org)

## Annex B

### **Banding questionnaire for junior doctors (updated May 2016)**

#### **Introduction**

This banding questionnaire document has been updated jointly between the BMA and NHS Employers, to provide the banding supplement payable to doctors being paid under Schedule 15, section 2 of the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training.

#### **Definitions**

The following definitions are used for the purpose of this questionnaire only and do not apply to any other aspects of the 2016 terms and conditions of service:

Band 2 rotas (Working Time Regulations)	<p>In order to achieve a Band 2 supplement, the doctor must have opted out of the Working Time Regulations. Doctors not wishing to opt out can only be contracted on rotas of no more than an average of 48 hours work per week.</p> <p>Rotas with a weekly average greater than 56 hours of work are not permitted under the 2016 terms and conditions of service.</p>
Hours of work	Hours of work per week will be the number of actual hours to be worked over the cycle of the rota, divided by the number of weeks in the cycle of the rota.
On-call	For the purposes of on-call, work begins when a doctor is disturbed from rest and ends when that rest is resumed. It includes, for example, time spent waiting to perform a clinical duty, time spent giving advice on the telephone, and time spent travelling.
Out of hours	Out of hours is defined as any hours outside of 7am to 7pm Monday to Friday. The weekend is defined as 7pm Friday to 7am Monday.
Rest	Rest is defined as all time on duty when not performing or waiting to perform (this would include, for example, a doctor waiting for the operating theatre to be prepared; not a doctor on duty who has been notified of a need to return to the hospital or unit, but not immediately a clinical or administrative task, and not undertaking a formal educational activity; but including time spent sleeping. Natural breaks (as defined in Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002) do not count as rest.
Work	Work for the purposes of banding as used in this questionnaire is defined as in the New Deal (Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002). This includes all time carrying out tasks for the employer (i.e. "on your feet" working) but does not include rest while on-call.
Working patterns	<p>Working patterns described under the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002 (i.e. the New Deal) as partial shifts, 24-hour partial shifts or hybrid shifts, are classified as on-call working patterns for the purpose of this questionnaire.</p> <p>Any working pattern that does not fall under the definition of an on-call working pattern is defined as a shift working pattern.</p>

Please tick either Yes or No to each of the questions as appropriate.

**Once your answers have led to a Band being allocated DO NOT continue completing the questionnaire.**

1. Are you a Less than Full Time trainee?

Yes: Go to Q2

No: Go to Q3

2. Do you work 40 hours or more of work per week?

Yes: Go to Q3

No: Go to Q21

3. If you work

- an on-call working pattern - Go to Q4
- a shift working pattern - Go to Q15

**ON-CALL WORKING PATTERNS (note this includes any shift working pattern which includes any period of on-call working)**

4. Does your total working week consist of a maximum of 40 hours duty entirely between 7am and 7pm Monday to Friday with no other out-of-hours work or duty?

Yes: **No supplement**

No: Go to Q5

5. Do you work more than 48 hours of work per week?

Yes: Go to Q6

No: Go to Q10

6. Are you on duty at the weekend (any time between 7pm Friday and 7am Monday) 1 in 3 or more frequently?

Yes: Go to Q8

No: Go to Q7

7. Are you on-call 1 in 6 or more frequently?

Yes: Go to Q8

No: **Band 2B (50%)**

8. When on-call, are you resident (for clinical or contractual reasons) and carrying out any work after 7pm on 50% or more of occasions?

Yes: **Band 2A (80%)**

No: Go to Q9

9. When on-call, are you non-resident and working for 4 hours or more after 7pm on 50% or more of occasions?

Yes: **Band 2A (80%)**

No: **Band 2B (50%)**

10. Are you on-call 1 in 6 or more frequently?

Yes: **Band 1A (50%)**

No: Go to Q11

11. Are you on-call 1 in 8 or more frequently?

OR

on duty at the weekend (any time between 7pm Friday and 7am Monday) 1 in 4 or more frequently?

Yes: Go to Q12

No: Go to Q14

12. When on-call, are you resident (for clinical or contractual reasons) and carrying out any work after 7pm on 50% or more of occasions?

Yes: **Band 1A (50%)**

No: Go to Q13

13. When on-call, are you non-resident and working for 4 hours or more after 7pm on 50% or more of occasions?

Yes: **Band 1A (50%)**

No: **Band 1B (40%)**

14. Are you are on-call 1 in 10 (1 in 9 for F1 doctors) or less frequently and not required to be resident (for clinical or contractual reasons) when not on-call?

Yes: **Band 1C (20%)**

No: **Band 1B (40%)**

## **END OF QUESTIONNAIRE FOR DOCTORS WORKING ON-CALL WORKING PATTERNS**

### **SHIFT WORKING PATTERNS**

15. Does your total working week consist of a maximum of 40 hours duty entirely between 7am and 7pm Monday to Friday with no other out-of-hours work or duty?

Yes: **No supplement**

No: Go to Q16

16. Do you work more than 48 hours of work per week?

Yes: Go to Q17

No: Go to Q19

17. Are you on duty at the weekend (any time between 7pm Friday and 7am Monday) 1 in 3 or more frequently?

Yes: **Band 2A (80%)**

No: Go to Q18

18. Do more than one third of your duty hours fall outside the period 7am to 7pm Monday to Friday?

Yes: **Band 2A (80%)**

No: **Band 2B (50%)**

19. Are you on duty at the weekend (any time between 7pm Friday and 7am Monday) 1 in 4 or more frequently?

Yes: **Band 1A (50%)**

No: Go to Q20

20. Do more than one third of your duty hours fall outside the period 7am to 7pm Monday to Friday?

Yes: **Band 1A (50%)**

No: **Band 1B (40%)**

## **END OF QUESTIONNAIRE FOR DOCTORS WORKING SHIFTS**

### **LESS THAN FULL TIME TRAINEES**

The proportion of basic salary is determined by the actual hours of work per week. The pay for each band is based on the lower hours limit as follows:

F5 is 20 or more and less than 24 hours of work a week and attracts 0.5 of full time basic salary.

F6 is 24 or more and less than 28 hours of work a week and attracts 0.6 of full time basic salary.

F7 is 28 or more and less than 32 hours of work a week and attracts 0.7 of full time basic salary.

F8 is 32 or more and less than 36 hours of work a week and attracts 0.8 of full time basic salary.

F9 is 36 or more and less than 40 hours of work a week and attracts 0.9 of full time basic salary.

A supplement may be added to this figure, paid as a proportion of the basic salary identified above. The questionnaire below identifies what the supplement for LTFT trainees should be:

21. Do you do any work outside 7am to 7pm Mon–Fri?

Yes: Go to Q22

No: **No supplement**

22. Do you work an on-call rota?

Yes: Go to Q23

No: Go to Q28

23. Do you do a 1 in 10 or more frequently?

Yes: **Band FA (50%)**

No: Go to Q24

24. Do you do a 1 in 13.5 or more frequently **OR** work 1 weekend in 6.5 or more frequently?

Yes: Go to Q25

No: Go to Q26

25. Are you resident and carrying out any work after 7pm, or non-resident and doing 4 hours work after 7pm on 50% or more occasions?

Yes: **Band FA (50%)**

No: **Band FB (40%)**

26. Do you do a 1 in 16.88 (1 in 15.4 for F1 doctors) or less frequently?

Yes: Go to Q27

No: **Band FB (40%)**

27. Are you resident for clinical or contractual reasons?

Yes: **Band FB (40%)**

No: **Band FC (20%)**

28. Do more than 1/3 of your duty hours fall outside 7am to 7pm Mon–Fri, **OR** do you work 1 weekend in 6.5 or more frequently?

Yes: **Band FA (50%)**

No: **Band FB (40%)**

**END OF QUESTIONNAIRE FOR LESS THAN FULL TIME DOCTORS.**

## Annex C

1. Please see the '*Code of Practice: Provision of Information for Postgraduate Medical Training*', as of 30th October 2017, for further information on the requirements that this document places on Health Education England, employers and trainees. This is available on HEE's website <https://www.hee.nhs.uk/our-work/medical-recruitment/code-practice-medical-recruitment>
2. Any subsequent revisions to the above document which affect the timeframes for the provision of information by employers to doctors, as referenced in schedule 4 of these TCS, will require collective agreement between NHS Employers the British Medical Association before any such changes can be reflected in these TCS.