

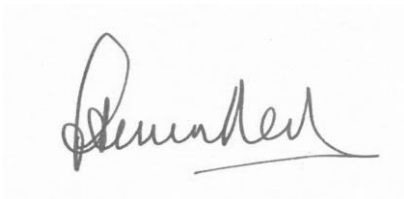
## Scope and status

This framework agreement is adopted by the Joint Negotiating Committee Juniors (JNC(J)) following agreement with all constituent parties.

This framework is adopted following the confirmation of the relevant funding received from the Department of Health and Social Care and NHS England on 10 June 2019.

It is intended that this agreement covers all NHS employers in England employing doctors in training.

This framework document sets out a four-year agreement covering the years from 1 April 2019 to 31 March 2023. It sets out both the pay investment that will be made and the amendments to the 2016 junior doctors contract that employers, the British Medical Association (BMA) and the Department of Health and Social Care (DHSC) are agreeing to implement over the period of the agreement and going forward.



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## **FRAMEWORK AGREEMENT: AMENDMENTS TO 2016 JUNIOR DOCTORS CONTRACT**

### **Context for the 2018 contract review**

The new junior doctor contract<sup>1</sup> was introduced in England without the BMA's agreement in 2016. The intention of the negotiations on this new contract was to introduce for doctors in training new and improved safe working arrangements, more support for their education and a new modernised pay system. The BMA and NHS Employers agreed during negotiations on this contract to jointly commission in August 2018 a review of its efficacy, to identify any areas for improvement to the contract terms. In 2018, the BMA Junior Doctors Committee, NHS Employers and DHSC agreed to take forward the contract review with the intention of negotiating changes to the contract that would be put to a new referendum of the BMA Junior Doctor membership. Members will be asked to consider whether they accept the 2016 contract, including the amendments that have been negotiated. If members vote to accept the amended contract, it will be collectively agreed.

**The changes set out in this framework document represent the outcomes of this review.**

To note:

- NHS Employers has agreed these changes in negotiations on behalf of employers.
- The BMA Junior Doctors Committee will now put this agreement to their membership with their endorsement.
- This will mean that, subject to confirmation of the collective agreement, all doctors in training in England will move to the new terms from August 2019.  
***NB:** This will put the junior doctors' contract onto the same basis as all national NHS pay contracts with changes agreed in partnership between staff and employer representatives.*
- The parties together support the amended contract and are committed to partnership working to ensure that the contract effectively supports the delivery of high-quality patient care by supporting recruitment and retention and enabling high quality training for the NHS's future consultants and GPs.

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<sup>1</sup> This covers doctors and dentists in approved postgraduate training programmes under the auspices of Health Education England (HEE)

- In future, the Joint Juniors Negotiating Committee (JNCJ) made up of the BMA and employer representatives will become the vehicle through which any further changes are agreed collectively.
- The Government has agreed to the changes set out in this document.

## **Equalities Impact Assessment**

The Secretary of State has an Equality duty under s.149 of the Equality Act 2010 to consider the impact of any changes in relation to the protected characteristics. A comprehensive equalities impact assessment on the proposed amendments to the contract is being carried out in line with the Secretary of State's public sector Equality Duty, and the DHSC will publish this analysis. In line with best practice the department has engaged with the BMA and NHS Employers as key stakeholder in this process, who are content with the approach taken and methods used.

In light of how seriously the BMA takes equality and diversity, they will commission an independent review of the draft equalities impact assessment as part of this stakeholder engagement, to ensure that it addresses members' equalities concerns and to analyse the outcome for members.

## **Overview of pay**

### **Context: 2016 Contract Funding and Transitional Arrangements**

- The 2016 contract was based on planned changes being implemented on a cost neutral basis.
- On introduction, doctors below ST3 in 2016 moved onto the new nodal point payment system.
- Doctors at ST3 and above continued to be paid increments and banding supplements until 2022 to enable them to complete training under the old payment system given their expectations.
- There was an expectation that some savings would be released to enable additional investment in the 2016 contract to be made in future years.
- Provision was made for a senior decision makers allowance to be paid to the most senior doctors in training, reflecting the level of responsibility they took on.
- It was the intention for this allowance to be paid to those senior trainees who are responsible in the out of hours period for making decisions about patient care with light touch consultant telephone supervision, and all parties recognised the importance of rewarding these senior trainees who are working at close to consultant level

- However, the partners agreed that it would be more appropriate to introduce a 5<sup>th</sup> Nodal point onto the pay structure to recognise this position for senior trainees in the later years of their training.

### 2018 Review: financial context and additional investment

Extensive analytical work has been carried out on the contract implementation; this has identified that the contract for doctors in training will be recurrently cost neutral. However, there are not expected to be any savings.

In response to this position the Government and NHS England have agreed to make available a pay envelope which supports further investment into the contract.

The proposed investment is over 4 years and consists of a total of 2.3% in 2019/20 and 3% in each of the three years 2020/21, 2021/22 and 2022/23. Of this total investment, junior doctors will receive an annual pay uplift of 2%.

	18/19	19/20	20/21	21/22	22/23
NP1 - F1	£27,146	£27,689	£28,243	£28,808	£29,384
NP2 - F2	£31,422	£32,050	£32,691	£33,345	£34,012
NP3 - ST1-2	£37,191	£37,935	£38,694	£39,467	£40,257
NP4 - ST3-5	£47,132	£48,075	£49,036	£50,017	£51,017
NP5 - ST6-8	£47,132	£48,075	£52,036	£56,077	£58,398

\*Values based on 2% uplift per annum.

\*\*NP5 includes additional investment of £3k in 20/21, £3k in 21/22, and £1.2k in 22/23 on top of the 2% uplifts to salaries

\*\*\*Note that these represent substantive pay values and increases may be implemented part way through the year.

The remaining investment (around £90 million) will be used to fund other specific changes which are set out in detail in the pay and transitional arrangements section. These cover the following:

- **A new nodal point 5:** This will be introduced for trainees at ST6 and above through a staggered approach and will replace the Senior Decision Makers allowance as set out in the 2016 terms and conditions of service (see paras 5 and 5.1 for details)
- **Weekend allowance uplift** to ensure those working the most frequent weekends are remunerated more fairly (see paras 7 and 7.1)

- **An enhanced rate of pay for shifts that finish after midnight and by 4am** (see paras 6 and 6.1)
- **An LTFT allowance** to recognise the additional costs LTFT doctors incur throughout training (see paras 1 and 1.2)
- **Changes to the academic flexible pay premium** (see paras 13 and 13.1)
- **Extension of Section 2 transitional pay protection** (see paras 9 and 9.1)

### **Equalities, LTFT, and flexible training**

#### **1. LTFT allowance**

1.1 Any doctor who is training less-than-full time will be paid an annual allowance of £1,000 for as long as they continue to train less-than-full-time. This is a fixed amount which will apply to any LTFT trainee regardless of their LTFT percentage and will be paid on top of their usual salary/any other pay elements. The allowance will be spread out over the year and paid in monthly instalments. This will come into effect from December 2019.

1.2 Those trainees who are already in receipt of the £1,500 transitional LTFT allowance will continue to receive this as per Schedule 14, but will not receive the £1,000 permanent allowance on top of this. Once their entitlement to the transitional £1,500 allowance ends, they will then receive the £1,000 allowance.

#### **2. Shared parental leave and adoption leave**

2.1 The 2016 contract shares a number of common schedules with the NHS Staff Handbook. As a result of negotiations via the NHS Staff Council, with full BMA involvement, shared parental leave will now be available as an enhanced occupational benefit as opposed to the basic statutory entitlement. This means that the rate of pay will be equivalent to that for occupational maternity leave, and doctors who rotate between different employers will be eligible to receive both this occupational pay and the statutory pay where relevant. There is also clarity that rotating doctors are eligible for occupational adoption leave and pay, and a requirement to receive time in lieu when a keeping in touch (KiT) or shared parental leave in touch (SPLiT) day is worked on a day of paid leave. Breaks in service while on approved OOP (out of programme), on an honorary contract or in a placement with a non-NHS employer in a crown dependency will now be disregarded so they don't affect eligibility for maternity, adoption and shared parental leave.

#### **3. Champion of flexible training**

3.1 Employers and/or host organisations will be required to appoint a champion of flexible training. The following principles shall be taken into account in appointing to the role:

- a) It is the employer's responsibility to appoint the champion of flexible training
- b) The appointment panel for the champion 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 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 LTFT.
- c) The panel should reach consensus on the appointment.
- d) The recruitment process for the appointment of the champion should otherwise follow local recruitment processes.
- e) Employers / host organisations can choose to act collaboratively to make and share the appointment across a number of employers.
- f) Employers must ensure that the Champions have sufficient resources to undertake their responsibilities.
- g) 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 champion of flexible training at a neighbouring NHS trust to offer support to LTFT trainees as and when required.

3.2 Where an employer is unable to appoint to the post they must ensure that alternative arrangements to support less than full time trainees are in place. These arrangements should be jointly produced with the Local Negotiating Committee (LNC) or JDF and are intended to be interim arrangements with the aim of appointing a champion in the future.

Those champions who have already been appointed in post through local recruitment processes prior to the publication of the updated TCS will not be expected to reapply for the position and will continue as champions.

#### **4. Good rostering guidance**

4.1 Selected principles encapsulated within the GRG guidance will be contractualised and employers must continue to adhere to them when designing work schedules.

4.2 The following sections relating to non-resident on-call working (found on pages 17 to 21 of the GRG) will be included in the contract:

- Calculating prospective hours
- Predictable and unpredictable work
- NROC design process
- Exception reporting for NROC
- Effective management of rotas

4.3 The following principles pertaining to LTFT working patterns will be included in the contract:

- Each LTFT doctor must have a personalised (*read as 'bespoke'*) work schedule built for them to ensure they are working the correct proportion of hours and shift types, included in the full-time template for their LTFT percentage, and are being paid correctly.
- 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 trainee prefers.
- Unless agreed, a normal day, long day or twilight shift should not be rostered on a non-working day in a fixed working pattern.
- It should be highlighted to the doctor the individual pro-rata entitlement to study leave and annual leave (inclusive of pro-rated public holidays) to ensure the earliest opportunity to allow the planning of leave. This should be specified in the work schedule.
- All attempts should be made, where possible, to facilitate set working day patterns where requested by the doctor in line with the statutory right to request flexible working, provided that service needs can be met.
- Where a doctor is working LTFT for health reasons, recommendations made by occupational health must be factored into the design of the roster.

4.4 The parties also agreed that the JNC(J) will look at the last principle in more detail, including how best to ensure reasonable adjustments are made for all trainees with disabilities (LTFT or full-time) in a timely way. The JNC(J) should refer to GMC guidance on supporting doctors with health issues or disabilities in medical education and training and relevant findings of the GMC's Health and Disability Review.

4.5 The following principles related to cover arrangements and leave (found on pages 10, 14 and 15 of the guide) will be included in the contract

- Additional clarity on emergency and unforeseen circumstances where doctors may be required to provide cover for colleagues
- There being no requirement to pay back shifts missed due to sick leave
- A mechanism should be in place for planning and submitting leave requests prior to a doctor starting in a post and the duty roster being issued
- A rota should not be so restrictive in its design that it gives the appearance that fixed leave is incorporated into the rota
- 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 should not require annual or study leave for these interviews to take place

- Where at all possible, a roster should be designed to have at least two, if not three, consecutive weeks without out-of-hours duties, to be able to grant requests for longer periods of leave

## **Pay and transitional arrangements**

### **5. Fifth nodal point**

5.1 The 2016 contract provided for a senior decision makers' allowance to be introduced. The parties agreed that instead of an allowance, a fifth nodal point will be introduced for trainees at ST6 and above in order to recognise the significant high service contribution these trainees make. This will be introduced through a staggered approach from October 2020 as follows:

- In October 2020 the value will be £3,000.
- In October 2021 the value will increase to £6,000.
- In April 2022 the value will increase to £7,200.

### **6. Shifts ending after midnight and by 4am**

6.1 Where a shift ends after midnight and by 4am, the entirety of the shift will attract an enhancement of 37% of the hourly basic rate. This change will come into effect in December 2019.

### **7. Weekend frequency allowance**

7.1 The weekend frequency allowance rates for those working 1 in 2, 1 in 3, and 1 in 6 weekends will be uplifted in order to ensure these trainees are not paid less per hour for working more intense frequencies. The rate for those working 1 in 2 weekends will be **15%** of their basic salary; for those working 1 in 3 weekends it will be **10%** of their basic salary, and for those working 1 in 6 it will be **5%** of their basic salary. This change will come into effect in December 2019.

### **8. Annual pay uplifts**

8.1 There will be an annual pay uplift of 2% over the next four years. The DDRB terms of reference allow them to make further pay recommendations or observations should one of the parties request it, or indeed where they consider it appropriate.

### **9. Transitional pay protection**

9.1 Trainees who are currently in receipt of 'Section 2' transitional pay protection under Schedule 14 will have their pay protection extended until 2025. This means that those trainees who would otherwise lose their pay protection due to the four-year cut-off period or the 2022 end date would continue to be paid under the 2002 payscales until 2025. The parties will review this 2025 end date at a future JNC(J), balancing the position of trainees who may remain in type 2 protection with the responsibility to consider issues of equal pay and the equality duty and allowing for extension of this



date it if there remain trainees who are still pay protected under Section 2. As is currently the case, these trainees will continue to be paid according to the 2002 contract payscale.

## **10. Pay protection on changing specialty**

10.1 When a trainee switches into an identified hard-to-fill specialty, pay protection will be based on what they would have earned had they not switched, provided that they have achieved an Outcome 1 or 2 at their most recent ARCP. If a trainee switches half-way through the year without an Outcome 1 or 2 at their most recent ARCP, their pay protection will not be based on the next salary point but the salary for the grade they are currently on.

10.2 For example, a trainee who switches from ST2 in paediatrics into GP training without having completed the year and/or attained an Outcome 1 or 2 will be pay protected at their ST2 salary in their first year of GPST (GPST1). They will need to successfully progress onto the second year of GPST (GPST2) in order to receive the ST3 salary and continue to progress through the pay system as though they had not switched.

10.3 The contract will provide for the JNCJ to agree to extend pay protection to additional specialties, that currently do not receive a flexible pay premia, where there is clear evidence that the specialty has difficulties in recruiting and where the JNCJ agree that pay protection may help address the issues. The JNCJ will consider if any additional specialties should be eligible for pay protection on an annual basis. Once a specialty has been classed as hard-to-fill by the JNCJ, this designation will be reviewed every three years in order to determine whether or not it still constitutes a hard-to-fill specialty. If the parties agree at the JNCJ that this specialty should no longer be deemed hard-to-fill, those trainees who are already training in that specialty will continue to be pay protected until they complete their training.

## **11. Pay protection on re-entering training from a career grade – non-shortage specialties**

11.1 The parties recognise that the clause limiting pay protection to hard-to-fill specialties does not encourage SAS doctors to re-enter training. Doctors who are employed under SAS national terms and conditions of service currently are not eligible for pay protection if they return to training in any specialty that isn't classed as hard to fill, unless the return is due to circumstances related to disability. The parties commit to exploring a time limited arrangement to provide pay protection for SAS doctors re-entering training, pending the planned reform of arrangements informed by the SAS Strategy. Funding issues will need to be fully considered. The parties will undertake work through JNC(SAS) to propose an approach.

## **12. Individualised and rota averaged pay**

12.1 The parties are committed to the introduction of individualised pay. The parties recognise the dependencies with work NHS Improvement and England are leading on Workforce Development Systems, including the aim of having universal e-rostering by 2021 as in the Long Term Plan. DHSC will

commission NHS Improvement and England to establish a Working Group, involving NHS Employers and the BMA, to develop a work programme and timeline with contingencies to ensure individual pay functionality can be implemented effectively and as soon as is practicable, coming together to review progress towards this in 2020.

### **Flexible pay premia**

#### **13. Academic FPP**

13.1 The parties agree that the eligibility criteria for the academic flexible pay premium should reflect more closely the way in which academic careers progress during training. The following changes will be made to the eligibility requirements for non-integrated academic pathways, set out under the 'other academic pathways' heading in Schedule 2 of the terms and conditions of service:

- The criteria for eligibility will now apply to research undertaken during core and run through training programmes, as well continuing to apply during higher training programmes.
- The criteria for eligibility will continue to apply to research undertaken as part of an approved out of programme activity for research (OOPR) that has been approved by the postgraduate dean. In addition, eligibility will be extended to doctors who have undertaken research on a less than full-time basis whilst continuing to undertake training also on a less than full-time basis.
- The criteria for eligibility will continue to require a trainee to return to the same training programme upon completion of the research, but will now also cover instances where a trainee returns to a different programme (provided that programme is related to their research qualification).
- Where a doctor returns to employment on a different training programme, the presumption will be that the research qualification is related to that programme. If an employing organisation is in disagreement over the relationship between the research qualification and the new programme, this will be escalated to the relevant post graduate dean to validate whether the premium should be removed.

This change will come into effect in December 2019.

### **Safety and rest limits**

#### **14. Maximum of 72 hours work in any 7 consecutive day period**

14.1 The reference period for this rule will be measured as a maximum period of 72 hours work in any consecutive period of 168 hours, rather than calendar days referenced from midnight to midnight. This reflects the interpretation outlined in Good Rostering Guide produced by the BMA and NHS Employers.

## **15. Rest after night shifts**

15.1 The 46-hours of rest currently required after working 3-4 consecutive night shifts will be applied to any number of rostered night shifts. For example, if two consecutive night shifts or a single night shift are rostered, 46-hours of rest will also apply at the conclusion of either of those shifts.

## **16. Weekend frequency exemption for nodal point 2**

16.1 All trainees will be covered by the maximum weekend frequency rule and definition. The exemption to the maximum weekend frequency rule that could be applied for one placement in foundation year two will no longer be in operation,

## **17. Maximum 1 in 2 weekend frequency**

17.1 All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends. Authorisation for a rota using a pattern greater than 1 in 3 should require a clearly identified clinical reason agreed by the clinical director and be deemed appropriate by the guardian of safe working. Such rotas should be co-produced with junior doctors, agreed via the JDF and reviewed annually. Trainees that wish to work in excess of 1:3 weekends by undertaking additional work, for example as a locum, are able to agree to do so but must not work at a frequency of greater than the maximum 1 in 2 weekend limit.

## **18. Maximum of 8 consecutive shifts rostered or worked over 8 consecutive days**

18.1 The maximum number of consecutive shifts that can be rostered or worked will be reduced to seven as standard over a period of time. The arrangements to alter existing rotas to meet this provision should commence as soon as is reasonably practicable but, in any event, must have concluded by 5 August 2020 as set out in the implementation timetable.

18.2 Employing organisations and trainees can agree through local processes and in consultation with those affected by the rota, to maintain or increase this limit to eight. Agreements will be on a rota by rota basis and must be reviewed annually as per the original process and additionally reviewed if requested via a work schedule review. Any disagreement on a change to a working pattern must be escalated to the guardian of safe working and the JDF, and where necessary further escalated through the work schedule review appeals processes. Any affected trainee may request a work schedule review in accordance with schedule 5.

18.3 For the purpose of this rule where a shift, such as a night shift, results in work occurring across two separate days as part of one shift, the work on each day is counted independently toward the maximum consecutive limit.

## **19. Maximum of 5 consecutive long day shifts**

19.1 The maximum number of consecutive long day shifts that can be rostered or worked will be reduced to four as standard over a period of time. The arrangements to alter existing rotas to meet this provision should commence as soon as is reasonably practicable but, in any event, must have concluded by 5 August 2020 as set out in the implementation timetable.

19.2 Employing organisations and trainees can agree through local processes and in consultation with those affected by the rota, to maintain or increase this limit to five. Agreements will be on a rota by rota basis and must be reviewed annually as per the original process and additionally reviewed if requested via a work schedule review. Any disagreement on a change to a working pattern must be escalated to the guardian of safe working and the JDF, and where necessary further escalated through the work schedule review appeals processes. Any affected trainee may request a work schedule review in accordance with schedule 5.

## **20. Breaks**

20.1 The parties remain committed to addressing fatigue, in particular in relation to night working, and to ensuring that trainees are supported to take their contractually entitled breaks.

20.2 Any doctor that works a night shift (a shift that attracts the 37% hourly pay enhancement) of twelve or more hours in duration will now receive a third 30-minute paid break. Furthermore, the review and mitigation of missed breaks and other safety critical breaches should be a standing item on JDF agendas.

## **Leave**

### **21. Calculation of annual leave**

21.1 The parties are jointly committed to addressing the inequities and inconsistencies that can occur in relation to how annual leave is calculated and applied. While every endeavour has been made to find an agreeable solution within the timeframe of this review, it is felt that greater time and resource is needed to achieve the desired outcome. A dedicated joint working group will be convened via the JNC(J) for this purpose.

### **22. Leave for life changing events**

22.1 The clause requiring that employers must allow annual leave to be taken for life-changing events has been amended to make clear that this clause relates only to annual leave and should not be conflated with other forms of leave, and to remove the example of a wedding day, to prevent the misinterpretation of this clause that a wedding is the only type of event that can be considered life-changing. It is also supplemented by guidance to clarify that it is for doctors to define what events

are life-changing for them, and that the default assumption is that these requests will be approved – with an escalation process including the guardian where this is necessary.

### **23. Study leave and mandatory training**

23.1 The terms and conditions of service will now be explicit to ensure that study leave is not used by employers for statutory and mandatory training that is a requirement to work in that trust or departmental setting. By doing this, study leave will remain preserved for training or other opportunities that are required to progress through the postgraduate training programme of the specific curriculum that the doctor is enrolled in. The required statutory and mandatory training activities of the doctor will now be sent to doctors alongside their work schedule, which will then be able to be arranged during the placement.

23.2 The contract will have a specific provision to ensure that any time required outside of the work schedule is either paid or given back as time off in lieu, thereby ensuring that trainees will always will always have recognition for this activity, regardless of when it is completed.

### **24. Prospective cover for study leave**

24.1 Employing organisations locally determine the processes for how study leave is managed and taken. Where trainees are required to provide internal cover for colleagues on the rota when they take study leave or if shifts attracting an enhanced rate of pay or an allowance are required to be swapped for study leave, prospective cover is in operation. This must be factored into the calculation of the average weekly hours of work and pay for that rota. Where employing organisations have alternative arrangements for covering study leave where internal cover or swaps are not required, prospective cover does not apply.

## **Locum work**

### **25. National locum rates**

25.1 NHS Improvement will continue to work collaboratively with employing organisations in line with their national mandate to reduce expenditure on temporary staffing and agency locums. The parties acknowledge that this work is extraneous to the national terms and conditions for doctors in training, and therefore the national locum rates outlined in the pay circular and referenced in the terms and conditions of service will be removed. NHS staff banks continue to have the authority to set the rates of payment they offer for locum work.

### **26. The locum clause**

26.1 It is agreed that greater clarity within the terms and conditions of service is necessary to reflect the intended process for undertaking locum work. If trainees wish to do work additional to their work schedule, they will continue to be required to offer their spare time to the service of any NHS

staff bank, for work commensurate to their current grade and competencies. Activities 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.

26.2 The parties are committed to longer term work with NHS Improvement to review the efficacy of current staff bank processes and to make recommendations on improvements that can be made to the benefit of both trainees and employing organisations.

### **Guardian fines**

#### **27. Breaches that attract a financial penalty**

27.1 Guardian fines will be extended to include breaches of:

- The minimum non-resident on-call (NROC) overnight continuous rest of five hours between 22:00 and 07:00
- The maximum 13-hour shift length
- The minimum 11 hours rest between resident shifts
- The minimum 8 hours total rest per 24-hour NROC shift

27.2 Where a fineable breach arises that may cause a further breach to occur, for example in the next consecutive shift, it is intended that systems and processes will be developed to mitigate against the further breach occurring or against future occurrences.

#### **28. Rates of the guardian fine**

28.1 The total rate of the guardian fine will be based on a 4x multiplier of the 2019 NHSI locum rates, rather than the standard hourly rate paid to the doctor. The apportionment of the fine monies will continue to be paid at a rate of 1.5x the hourly locum rate to the doctor and the remaining funds paid into the guardian fine pot to be disbursed via agreement at JDFs.

### **Exception reporting**

#### **29. What can be exception reported**

29.1 The parties agree that the terms and conditions of service should provide greater clarity on the types of activity that can be exception reported. While it is not possible to outline an exhaustive list within the contract, there are a number of overarching principles and examples of activities that will provide a useful steer to trainees and employers which will be included as set out below.

29.2 Exception reporting is the mechanism by which trainees can guarantee compensation for all work performed and uphold agreed educational opportunities, this includes but is not limited to:

- All scheduled NHS work under this contract (e.g. any patient facing and non-patient facing activities that your team or supervisor requires you to do as part of your employment)
- Any activities required for the successful completion of ARCP and any additional educational or development activities explicitly set out in the agreed personalised work schedule
- Activities that are agreed between the doctor and their employer, such as quality improvement or patient safety tasks directly serving a department or wider employing organisation, or their doctors (e.g. attending a JDF, activities related to rota management, delivering teaching, or setting up training programmes)
- All professional activities that doctors are 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, this does not include 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.

### **30. Reviewal process for exception reports**

30.1 Since the adoption and roll out of exception reporting some organisations have adopted different processes for who reviews exception reports further to agreement with their trainees. This has resulted in individuals other than the educational supervisor being nominated as the reviewer/actioner for certain types of exception report. To reflect this existing practice, the reviewal process for exception reports should be a locally agreed process, which is jointly agreed by; the Guardian, the JDF, and the Joint Local Negotiating Committee. Regardless of the 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 all types of report.

### **31. Response time for educational supervisors**

31.1 The terms and conditions of service will mirror the response times referenced in the exception reporting flowcharts produced by NHS Employers and the BMA. In line with this, the educational supervisor (or other nominated reviewer) must respond to exception reports within 7 days of a report being submitted in order to review the report and discuss the reasons with the trainee, and progress to agreeing an appropriate outcome.

31.2 The guardian of safe working will have the authority to action any exception reports that have not been responded to.

### **32. Pre-authorisation for additional hours of work**

32.1 Doctors in their professional judgement may consider that it is necessary to work beyond the hours set out in their work schedule, in order to secure patient safety. The parties acknowledge that doctors will endeavour to seek approval for this with their clinical manager before or during the event but recognise that this will not always be possible and fully support that doctors should be empowered to exception report whenever pre-authorisation is not possible. Once an exception report has been submitted it will continue to be subsequently validated by the clinical manager, and an outcome agreed within 7 days, to allow for payment for the additional hours worked.

### **33. Payment for exception reports**

33.1 Payment must be made for approved exception reports within a month, or within the next available payroll, of a report being approved for payment and agreed by all parties. There should be no additional administrative burden, such as submitting additional forms outside of the exception reporting process, to receive payment for an approved exception report.

### **34. Conversion of untaken time off in lieu (TOIL) into pay**

34.1 Where TOIL is agreed by all parties as the outcome of an exception report, there will be a 4-week window from the outcome being agreed for the trainee and rota manager to discuss and allocate the TOIL to a future shift in their working pattern before the end of that placement. In the instances where this does not occur, the TOIL should automatically be converted to pay after that 4-week period. At the end of a placement, any untaken TOIL will be converted into pay.

### **35. Automatic acceptance of exception reporting outcomes**

35.1 To ensure prompt payment the doctor should formally accept the exception reporting outcome presented by the employer as soon as is practicable. Where agreed outcomes are not formally closed on the system following discussion with the relevant supervisor these will automatically be accepted and closed at the end of the trainee's rotation. Exception reports for trainees with extenuating circumstances will be automatically be accepted and closed at four weeks.

35.2 The parties will produce supporting guidance for trainees and employing organisations to assist in defining examples of extenuating circumstances, such as long-term sickness or maternity leave

### **Work scheduling**

#### **36. Induction**

36.1 Generic work schedules must account for the local trust induction required to be undertaken prior or at the start of the placement. This must be reflected as hours of work and paid accordingly.



### **37. Host and lead employer responsibilities**

37.1 As the number of lead employers grow and the lead/host employer relationship normalises for many trainees, it has been agreed that the educational roles of both of these organisations will be clarified by guidance from NHS Employers and the BMA. This guidance, albeit not in the contract, will instruct both host and lead employers of their educational responsibilities towards trainees, and providing assurances for trainees about which of these two groups will be responsible for their work scheduling.

### **38. Personalised work scheduling meetings and off-site educational supervisors**

38.1 Trainees must be able to meet with their Educational Supervisor in the 4 weeks following their start date. It is important that this meeting takes place to personalise the trainee's work schedule, but for a variety of other educational reasons, such as reviewing the curriculum requirements of the post. Even if their allocated Educational Supervisor is off site, trainees will now have the opportunity to meet with them and must be released from clinical duties to do so.

### **39. Exception reporting for missed personalised work scheduling meetings**

39.1 In the event that this does not happen within the first 4 weeks of their new jobs, doctors or dentists in training will now be able to file an exception report, which 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 Public Health trainees, this will be sent to the Head of School instead of the Director of medical Education).

### **40. Code of practice**

40.1 The parties have agreed that the requirements for the provision of information from employing organisations to trainees at 8 weeks and 6 weeks prior to commencement in post, as contained within the Code of Practice will be made contractual. This will come into effect following the collaborative development of the legal mechanisms and processes to enact it.

### **Guardian of safe working hours**

#### **41. Administrative time and support**

41.1 The parties are committed to ensuring that discussions and reviewal of the administrative time and support available to the guardian are undertaken on a comprehensive and inclusive basis.

41.2 It is agreed that employing organisations shall seek to engage with all parties involved in performance management of the guardian to assess and make recommendations to set time commitment and administrative support required for the role, taking into consideration the number of rotas and the number of doctors in training for whom the guardian will have responsibility. This will be an annual process.

## **GP trainees**

### **42. Supernumerary status of GP trainees**

42.1 The terms and conditions of service will reflect the longstanding principle contained in the previous contractual arrangements for GP trainees prior to 2016, that trainees in general practice settings are supernumerary to the workforce of the practice.

### **43. Additional mileage/expenses for GP trainee home visits**

43.1 GP trainees that are required to use their personal vehicle on the possibility of a home visit being required on any working day shall be eligible for reimbursement for the cost of mileage and associated costs from their home to the principal place of work.

## **Facilities**

### **44. Too tired to drive home provisions**

44.1 Where a trainee feels too tired to drive home following a night shift, a long late shift or attending work at night when non-resident on-call, employing organisations are already required cover the cost of an appropriate rest facility or alternative arrangements for the trainee's safe travel home. This provision will now also provide for reasonable expenses to be paid for the trainee's return journey to work, either to begin their next shift or, where they have left their personal vehicle at work, to collect the vehicle.

### **45. Payment for accommodation when non-resident on-call**

45.1 Emergency response requirements may necessitate that trainees working non-resident on-call must be able to travel back to work within a specified time and/or must be based within a specified distance from their workplace. Where it necessary to be resident in order to maintain a safe response time for the management of time critical conditions and a trainee is based outside of these, and as a result must obtain accommodation to be resident during the on-call duty period, employers will provide this without charge. If appropriate on-call accommodation is not available, the hospital must make alternative accommodation arrangements. In this circumstance, any extra cost incurred may not be passed onto the doctor.

## **Commitment to future work**

### **46. Working groups**

46.1 The parties remain committed to the ongoing maintenance of the 2016 terms and conditions of service through future meetings of the Joint Negotiating Committee for Junior Doctors (JNCJ) and to

continue make improvements for the benefit of trainees and employers. There are a number of areas where longer term and more dedicated review were felt necessary.

46.2 The parties agree that the JNCJ will commission further thematic working groups to review the following:

- Health and wellbeing of doctors in training
- Non-resident on-call
- Annual leave
- Recruitment and retention of trainees in general practice, and pay parity with hospital medicine

#### **47. Supporting guidance**

47.1 In addition to the above, the parties have also agreed to jointly produce and/or update guidance on a number of areas.

<b>Item</b>
Guidance on champion of flexible training
Less than Full Time templating tool
Less Than Full Time work schedule
2005 flexible training guidance
Good rostering guidance
Guidance on exception reporting
Guidance on improving access to breaks being taken within shifts
Best practice guidance on reducing fatigue during night shifts, and appropriate facilities
Guidance on Non-Resident On-Call, building on that in the Good Rostering Guidance
Guidance on the impact of regular work at maximum shift limits and technological solutions such as consultant led and/or digital handover
Update the Good Rostering Guidance in relation to workforce planning and tools
Guidance on the minimum number of doctors required to roster sustainable, training-compatible rotas
Guidance on generic work schedules
Guidance on personalised work schedules
Guidance on work schedule reviews, to supplement flowcharts
Guidance on visibility of exception reporting payment on payslips
Guidance on best practice for exception reporting in non-hospital settings
Guidance on administrative support for guardians

Guidance for guardians and the Junior Doctor Forum on the use of fine money
Guidance on best practice for the guardian role in non-hospital settings
Guidance for employing organisations in relation to the Follett principles and ensuring that joint academic/NHS appointments are covered by honorary contract arrangements
Guidance in conjunction with relevant stakeholders on ascertaining expected hours of work for public health trainees
Guidance on the exceptional Flexible Pay Premia
Guidance on educational requirements of every postgraduate training programme by training grade
Update the NHS Employers factsheet for Educational Supervisors
Continue to work with Academy of Medical Royal Colleges on recognition of transferrable competencies framework
Guidance on use of recognition of transferrable competencies for Health Education England and Employers
Guidance on use of educational exception reporting, including the need for Director of Medical Education reports to the board
Guidance on protections for trainees who undertake Out of Programme activities