Draft heads of terms for negotiations to achieve a new contract for doctors and dentists in training

June 2013

This document relates to all doctors and dentists in approved postgraduate training programmes in the UK, including:

- doctors in training including GP training
- dentists in dental core and higher training posts when employed on hospital terms and conditions, and dental public health trainees when also employed on national hospital terms and conditions
- less than full time trainees (which can be doctors or dentists)
- academic and public health doctors in training when they are employed on national terms and conditions and where they have an NHS employment contract

For ease of reading, this document will use the term 'doctor in training' throughout to represent all the groups above.

Background

NHS Employers and the British Medical Association have held exploratory talks about possible changes to the contracts which cover the employment terms and conditions for the UK's doctors and dentists in training. The talks have included representatives from all the devolved nations.

The current contract was agreed in 2000. There have been increasing concerns that it is not working as well as it could for either NHS employers or doctors in training.

At the end of 2012, NHS Employers published a 'scoping report'. It proposed working towards an affordable new contract which ensures doctors in training feel valued and engaged, leads to better patient outcomes and improves the relationship between doctors, employers and deaneries. On behalf of doctors in training, the BMA has raised a number of areas for exploration including working hours, the fairness and stability of pay, quality of life and training.

The exploratory talks have resulted in this draft heads of terms – a document that sets the scope for possible formal negotiations to achieve a new contract. NHS Employers and the BMA are considering the heads of terms to determine whether or not they wish to proceed to formal negotiations and to seek the necessary mandates for such negotiations.

For further information please visit:
bma.org.uk/juniorcontract
www.nhsemployers.org

NHS Employers

BMA

1. Preamble

1.1 Doctors in training are professionals[1] whose first responsibility, like that of their employers, is the care of patients. A new contract will respect and support this.

1.2. The contract must promote safe care for patients and safety for doctors in training, and be fair for doctors in training, employers and other NHS staff.

1.3. The contract must be affordable for employers now and in the foreseeable future; this means that any proposals for a new contract must not result in changes to the pay bill compared with keeping the current contracts. Average gross pay across the doctors in training workforce should not change.

The discussions will include potential changes to the way some junior doctors' pay is calculated but new contractual arrangements will not reduce or increase the total amount of money available for junior doctors' pay.

1.4. It is intended to apply to employers in all four UK nations.

1.5. This draft heads of terms document has been agreed through discussion between NHS Employers and the BMA. In order to receive a mandate to commence negotiations the document will require approval by Ministers in the four Health Departments and by the BMA.

The contract must:

1.6. Be consistent with all aspects of UK law, including working time regulations and the Equalities Act.

The working time regulations incorporate the European Working Time Directive (EWTD) into UK law. They limit workers to a maximum 48-hour week, averaged over a six month period. Junior doctors can opt out of the regulations on an individual basis.

The Equalities Act 2010 prevents direct or indirect discrimination by employers on the grounds of age, disability, sex, sexual orientation, race, religious belief, marital or parental status and against those who are pregnant or have undergone gender reassignment. In some circumstances this may have a bearing on the shift patterns employees are expected to work. However, the law does not apply if the employer can justify the discrimination.

1.7. Facilitate high quality NHS patient care through sustainable service provision, delivered by suitably trained doctors and dentists, working in an approved training environment. GP trainees work in an environment where work is split into sessions and this needs to be accommodated in the new contract. They are an integral part of the practice team but are additional, not intrinsic, to the practice workforce. At no point should the effective running of the practice be dependent on the GP trainee's attendance and they will not be used as a substitute for a locum in the practice.

Training-related issues form almost no part of the existing contract. We will discuss how any new contract can better facilitate training for junior doctors.

1 As defined in the GMC's Good Medical Practice guidance

Service reconfiguration and new ways of working will continue to affect many parts of the NHS. Any new junior doctors' contract should recognise and encompass those changes, now and in the future.

1.8. Accommodate likely future changes in the training and working practices of doctors in training in the medical and dental professions, and in the location and nature of NHS services. This will include any qualified provider.

1.9. Ensure that the pay system remains fit for purpose in the future by basing arrangements on robust modelling.

Any contract negotiations will take into account detailed analysis of the way junior doctors are paid and the impact of any proposed changes. This will be jointly undertaken by all those involved, including the BMA and NHSE.

The introduction of a work schedule for every post would be new to doctors in training. The details of its aims and contents remain open to discussion and would form part of any contract negotiations.

1.10. Recognise that training and service provision by doctors in training are interrelated and be clear that the work schedule for the post will include service provision, training, periods of formal and organised study (other than study leave), rest breaks and prospective cover where applicable.

The contract will:

1.11. Promote professionalism and an environment where doctors in training are engaged and valued.

Progress has been made under the existing contract towards addressing the issue of junior doctors' working hours. It remains important for doctors in training, their employers and for patients to ensure that sufficient safeguards (such as minimum rest periods) are in place.

1.12. Deliver both safe working patterns and safe total hours of work.

1.13. Address the current dissonance between New Deal and EWTD.

The New Deal for junior doctors was introduced in 1991 to set standards in areas such as working hours, the nature of work and food and accommodation provision. The current junior doctors' contract, agreed in 2000, was designed partly around the New Deal. However, the European Working Time Directive sets some limits and definitions which are different from those in the New Deal. We would discuss these differences as part of contract negotiations.

1.14. Promote transparency around both the expected working patterns and the total hours of doctors in training.

1.15. Reflect reasonable expectations around work-life balance.

1.16. Offer fair rewards for work done, without exploitation and offer value for money in the administration of the contract.

There is sometimes a significant difference between junior doctors' job descriptions and the reality of their working lives. This does not help doctors, employers or patients. We want to make sure that everyone is clear what will be expected of a junior doctor right from the start of his or her post. We will also discuss the amount of notice and information doctors in training should expect before they move to a new role.

1.17. Minimise conflict and misinterpretation so as to facilitate good relations between doctors in training and their employers.

The current contract is complex and not always clear about what is expected from junior doctors and employers. This can lead to damaging disputes. We want to address the issues that can cause tension and ill feeling.

2. Scope of talks

We agree that:

For example, academic doctors in training also have contracts with universities. Our negotiations will not cover these contracts.

2.1 The contract will cover all doctors in approved postgraduate training programmes in the UK, including those in GP training and approved less than full time training programmes, and academic and public health doctors in training where they have an NHS employment contract. It will exclude regular[2] doctors and dentists in the armed forces.

2.2 The contract will cover dental core and higher training posts offering hospital terms and conditions of employment and include those in approved less than full time training programmes, as well as dental public health trainees when employed on hospital terms and conditions. It will exclude those for whom remuneration is specified in the Dental Statement of Financial Entitlement or the Statement of Dental Remuneration and those employed on salaried primary and community dental care service terms and conditions.

3. Overall design of the contract

We agree that:

3.1 The contract must be as simple as possible to understand, administer and implement, and be suitable for all specialties and for all four UK administrations.

A more straightforward contract would help to minimise the disputes which can arise between doctors in training and their employers over working arrangements and pay.

3.2 Each of the administrations will apply the contract with agreed necessary adjustments to reflect local circumstances.

As far as possible, any new contract should contain all of the information required for doctors in training and employers to enter an agreement with confidence.

3.3 The contract will minimise reference to extra documents in the interest of simplicity, and to ensure that employers and doctors in training are able to maintain the contract in an effective way in the future.

3.4 The contract will be designed in line with other NHS employment contracts if the parties agree it is appropriate.

It is important that contracts for different groups of health professionals fit together to ensure the smoothest and safest possible operation of the NHS. There are also proposals about changes to the consultants' contract.

2 Regular in this context means doctors and dentists employed in the armed forces who are neither civilians nor reservists.

Current arrangements allowing a nationally-agreed contract to be implemented locally will remain in place. Any further changes to a new contract would be negotiated through these channels.

3.5 We will continue to use the existing national negotiating mechanisms to ensure that the contract can be maintained at a UK-wide and national level. This will include provision for maintenance of the contract at a local level through existing local negotiating committee (LNC) structures.

3.6 The contract will be adaptable to changes in medical and dental policies and practices and future organisational and training structures.

4. Work planning

We agree that:

4.1 The contract will support forward planning providing for a more predictable pay bill for employers and more predictable earnings for doctors in training.

The current use of banding supplements can lead to significant variations in pay between comparable junior doctors' roles, and to wide fluctuations in employers' costs from one financial period to another.

4.2 Both employers and doctors in training benefit from receiving adequate notice about where doctors in training will be working and what they will be doing.

In some areas of England, junior doctors enter into a contract with a single 'lead employer' trust for the duration of their training. That contract remains in force even when they take up roles within other trusts, so they do not have to sign a new contract each time they move posts.

4.3 The contract will be useable in a number of employment models, allowing for both lead employer and local employer arrangements.

4.4 The contract should seek to make it easier for employers to offer longer contracts of employment than the present contracts do.

4.5 This is an employment contract which encompasses training, personal development and service delivery required as part of the job.

4.6 Jobs should come with a work schedule describing how a doctor in training in a job is expected to spend their time and the duties of the post holder, including the available training provision and learning opportunities.

The junior doctors' contract has not previously required a work schedule for every post. The shape and purpose of the schedule has not been finalised and would be open to further detailed discussion during any negotiations.

4.7 The work schedule for a post should be based on hours of work, rather than sessions, and should be prospectively designed in partnership between employers and doctors in training.

The Work Review would be new to junior doctors. Details of its mechanism would form part of our negotiations. It would be designed to ensure that a junior doctor's rota accurately represented the reality of his or her post.

4.8 The work schedule must be adaptable to allow adjustments in response to changes in numbers of doctors in training, the training curricula, or service needs. Where an adjustment cannot be mutually agreed, doctors in training or employers will be able to seek a 'Work Review'.

4.9 Doctors in training and employers will have access to robust Work Reviews where the agreed work schedule no longer matches the duties being undertaken. Where a doctor or doctors in training are consistently exceeding their work schedule hours through unplanned changes to their working hours, a review will be triggered by exception reporting. This will ensure unsafe working patterns are addressed and that the training aspects of the placement remain at an appropriate level.

The detail of exception reporting arrangements as a trigger for a Work Review would be discussed further during negotiations.

In 2010 a Code of Practice for England and Wales on the provision of information for postgraduate medical training was agreed jointly by NHSE, the BMA, the Department for Business Innovation and Skills and Medical Education England. It sets out in detail what doctors in training can expect to be told when they are offered employment. The code is not part of the current contract. Scotland and Northern Ireland also have a Code of Practice.

4.10 The group will explore the information currently contained within the Code of Practice to determine how much of the information specifically relating to employers and doctors in training could be included in the contract.

4.11 The amount of, and access to, study leave will be discussed in the negotiations.

5. Working hours

5.1 The working hours and pattern of working hours for doctors in training need to:

- comply with relevant legislation
- be safe for patients and for doctors in training
- recognise that both service delivery and training will continue to take place throughout the seven day week

A seven-day rota is already the norm for most doctors in training.

5.2 The contract will provide safeguards against unsafe working hours and patterns.

5.3 There will be a whole time working week of 40 hours. The working hours of a job may be up to 48 hours on average to meet the needs of the service, provided that this is consistent with statute, safety and the demands of the training programme.

5.4 Negotiations will determine how average working hours are defined and the period over which they are referenced.

Under the working time regulations, a junior doctor's average weekly working hours are calculated over 26 weeks. This formula will be discussed.

Monitoring is currently carried out regularly (typically twice a year) over two-week periods. During this time junior doctors keep detailed diaries to record how many hours they are working and how much rest time is available. The resulting information is used to set pay rates. Monitoring has been an issue of contention between employers and doctors in training. We would seek a better way to ensure rotas and remuneration accurately recognise what a post entails and to identify when changes are necessary.

5.5 We will explore a model based upon a work schedule, hours based contract and exception reporting, aiming to replace the current practice of routine monitoring of working hours. This will require agreement of a robust mechanism for ensuring appropriate payment and / or compensation for additional work over and above that in the work schedule.

5.6 Where it is possible to opt out of all or part of statutory working hours limits, the employment contract will enable doctors in training who wish to opt out to do so, but they will not be required by employers to opt out.

5.7 We will investigate limiting the number of actual working hours (as defined by statute) in a defined (in days) period.

Working time regulations state that doctors in training should work on average no more than 48 hours a week over a 26-week period. This formula means that in some weeks, a junior doctor may work for far longer. Similarly, the rules governing time off (which stipulate two complete days away from work in any two-week period) could entail 12 consecutive days on duty. Any contract negotiations will discuss this issue.

5.8 Where agreed patterns of hours are regularly altered in terms of start or finish times or breaks within shifts, then that working pattern should be reviewed to ensure it is appropriately designed.

The issues surrounding junior doctors' working hours are complex. We will discuss whether jointly-agreed guidelines about what is and is not acceptable could help to reduce the potential for dispute.

5.9 The parties will consider agreeing guidance on the rights and obligations of both employers and doctors in training under UK working time regulations.

6. Pay

We agree that:

We have agreed that any new contract must not increase or decrease the total amount of remuneration available for the current junior doctors' workforce. However, all of those involved in any negotiations also recognise that if the number of doctors in training were to go up, there would have to be some flexibility in the total pay 'envelope'.

6.1 Cost modelling must demonstrate that proposed new pay arrangements would not (of themselves) change the pay bill compared to a scenario in which the contracts do not change.

6.2 For the purpose of cost modelling, that pay bill comprises the following, using staff numbers appropriate for the 2012/13 financial year:

- Total value of current basic pay
- Total value of current additional earnings (including banding payments but excluding non-contractual fees)
- Total value of employer National Insurance contributions as at 31.3.13
- Total value of employer pension contributions as at 31.3.13

Planned changes to National Insurance contributions outside the scope of these negotiations will take place regardless of whether a new contract is negotiated. Modelling (and the counterfactual) will take into account any planned changes to contributions.

Additional employer pension contributions arising from any increase to basic pay as a result of a new contract will be funded separately, from outside the doctors in training pay bill.

The CARE (career average revalued earnings) scheme calculates a person's pension based on his or her average earnings over the entire time he or she has belonged to the pension scheme, instead of on his or her salary at retirement. This system is due to be introduced for junior doctors and other NHS staff next year. It will have a significant impact on junior doctors as banding supplements do not count towards their pensionable salary. Any change in their level of basic pay would have an impact on both their own pension contributions and those of their employer.

6.3 Joint analysis and modelling by analysts from the BMA, NHSE and the devolved administrations will be undertaken to explore the range of options available.

Any changes to pay arrangements will be based on a joint analysis by junior doctors' representatives and employers of existing arrangements and of different ways forward.

6.4 Negotiations will also include assessment of the way in which any changes would interact with the move to a CARE pension scheme.

6.5 There should be a higher than basic rate for OOH work and the negotiations will determine which periods are considered OOH.

Under the current contract, out-of-hours work is generally defined as taking place between 7pm and 7am and at weekends.

Currently, junior doctors' progress up their pay scale automatically every year.

6.6 We will agree rules within the new contract for pay progression.

7. Other

Fixed leave

We agree that:

7.1 We recognise that the use of fixed leave is a concern for doctors in training. We will explore the reasons why fixed leave arrangements are currently used, the consequences for doctors in training and for employers and how the position could be improved.

Facilities

We agree that:

7.2 We will review the existing contractual arrangements for facilities bearing in mind changes in working practices and the importance of safety.

This might include somewhere to rest, mess rooms and catering facilities.

Salary packaging

We agree that:

7.3 We will consider whether the contract could make it easier to have the legitimate professional costs of doctors in training recognised.

Some of the costs incurred by junior doctors as they progress are categorised by HMRC (the tax office) as an integral part of their training. Others, such as certain college examination fees, are not. That means some are tax deductible and others are not. We will discuss possible changes to this system.

For further information please visit:

bma.org.uk/juniorcontract

www.nhsemployers.org

British Medical Association
BMA House, Tavistock Square, London, WC1H 9JP

NHS Employers
2 Brewery Wharf, Kendell Street, Leeds, LS10 1JR

CODE: 53435