Department of Health

Equalities Statement proposed junior doctors' contract

May 2016

EQUALITIES STATEMENT

PROPOSED JUNIOR DOCTORS' CONTRACT

27 May 2016

1. The ACAS confirmation of agreement (attached in Annex A) followed an intensive period of reconsideration of the junior doctor contract between the BMA, NHS Employers and the Secretary of State for Health. A resolution was found for outstanding issues taken forward from previous discussions, areas already agreed were finalised and confirmed, and further measures were developed which address the wider concerns of junior doctors.

2. ACAS set out that the detailed contract would include a combination of agreed terms from February negotiations and new provisions. Issues resolved in the February talks and presumed to remain the basis for the contract include:

    - an agreement to replace the banding system for rewarding unsocial hours with payment for all work done to support seven day service delivery
    - a series of new limits on working hours
    - the replacement of an incremental pay system with a series of nodal pay points based on attainment and responsibility rather than time served.

3. ACAS explained that this agreement reflects the commitment of the parties to the following:

    - the safety of patients and junior doctors
    - terms and conditions which appropriately respond to the diverse characteristics of the junior doctor community
    - a healthy working environment for junior doctors which values their contribution throughout the week
    - a high-quality training experience for junior doctors
    - revisions and improvements to terms and conditions to address the on-going need to properly reward, protect and retain a valued workforce.

4. **As ACAS recorded, the Government, employers and the BMA are committed to supporting equality of opportunity for all medical staff and the wider NHS team. A particular focus of the new terms has been to enhance family friendly working in the context of the Government's commitment to deliver seven day services. There is a recognition that junior doctors with caring responsibilities can face particular challenges during their training, but also that the NHS is committed to becoming an**

increasingly modern employer and to creating the best working environment for all its staff. The parties have therefore considered together what more might be done, and agreed to support a range of initiatives designed to be beneficial. ("Caring responsibilities" includes, throughout this statement, caring for children and other caring responsibilities, eg, for elderly or disabled relatives etc).

5. **There are proposals which are to be included in the contract terms coupled with commitments to be taken forward by Health Education England and others to improve the junior doctor training experience. These should be considered as a package of measures, designed to alleviate any impacts on junior doctors with protected characteristics and to support equality of opportunity for all.**

6. **It was agreed at ACAS that the Secretary of State would publish an equalities analysis document prior to publication of the contract; this Statement considers the new proposals and their impact on junior doctors with particular reference to those with protected characteristics (see Annex B). As part of the proposals, employers, Health Education England and the BMA will put in place comprehensive equalities monitoring mechanisms for all protected characteristics to be signed off via the Joint Negotiating Committee on Juniors (JNC(J)) for implementation from April 2017.**

Summary

7. Several of the new proposals will benefit all junior doctors, such as the clarification of the role of the Guardian of Safe Working Hours and the processes supporting that role, the proposals on whistleblowing and the "period of grace" funding after completion of specialist training.

8. In addition, the following measures will, in particular, also help those with caring responsibilities (predominantly women) who might include part time workers taking longer to complete their training (and some of the proposals will also be of benefit to those with disabilities):

    - accelerated training support for those taking time out;
    - the NHS Employers/BMA review of good rostering practice supporting greater flexibility of working and the Health Education England review of deployment processes;
    - an extension of the pay protection period;
    - pay protection for those who change training path for caring reasons or for reasons related to disability;
    - the unsocial hours package which gives a weekend allowance for those working more than 6 weekends per annum and increased money to be spent for on call availability;
    - nodal adjustments which will front load pay levels (so as to give more pay earlier); and
    - comprehensive equalities monitoring systems.

Overall, the new proposals should improve on the previous proposals of March by advancing equality of opportunity for those with caring responsibilities – who may often work part time and will predominantly be women; they should also be of benefit to those with disabilities.

Accelerated Training support

9. There is an agreement to develop innovative approaches to training, to remove as far as possible the disadvantage of those who take time out due to, for example, caring responsibilities. This approach would include targeted accelerated learning with the prime intention of enabling the person who has taken time out to catch up. This will include measures such as access to mentorship, study leave funding and specially developed training inputs.

10. The Secretary of State has confirmed that this provision will be separately funded from outside the contract pay bill. The importance is also recognised of ensuring that these arrangements do not disadvantage a junior doctor who does not take time out of training.

11. The proposal would build significantly on the Academy of Royal Colleges' guidance ('Return to Practice – April 2012') which explains how to plan a safe and effective return for doctors who have taken time out.

12. This proposal has positive benefits for those who take time out – who are likely to be predominantly women (eg, for maternity leave and caring responsibilities) and those with disabilities. It will enhance equality of opportunity and make better use of staff without disadvantaging others.

Rostering and flexible working

13. NHS Employers will jointly review with the BMA approaches to good rostering practice, including the proper use of technology, which support greater flexibility for junior doctors and employers. To ensure that best practice can be applied, rostering experts will be engaged in this work, which will be completed by January 2017.

14. In addition, the new Guardian role would include liaison with the Director of Medical Education to ensure that a member of the educational faculty in the Trust is designated as a champion for flexible training. Joint guidance is to be developed by the BMA and NHS Employers to ensure the effective delivery of elements of the NHS-wide staff handbook for doctors on rotation. The guidance is to cover Caring for children and Adults, Flexible working and balancing work and personal leave and will be explicitly referenced in the contract.

15. Every employee already has the statutory right under the Flexible Working Regulations 2014 to ask their employer to work flexibly after 26 weeks of employment.

16. Better rostering is aimed at enhancing work/life balance and improving the training experience, by for example, ensuring that shifts are not organised in an unduly onerous way. This is to the benefit of all junior doctors, but should particularly help those with caring responsibilities (predominantly women) and those with disabilities, who may have found poor rostering practice to have been especially burdensome.

Deployment

17. Health Education England will lead 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, by the end of March 2017.

18. This will enhance equality of opportunity for those with caring responsibilities (predominantly women) and should also be beneficial with respect to those who are married or in civil partnerships.

Pay Protection

19. **Extension of pay protection by one year** – this will be pro-rated to longer periods for those who work part-time.

20. We believe this proposal will be beneficial as it will help those who take longer to progress through training – these junior doctors are likely to be those who work part-time (predominantly women who have caring responsibilities and may include those with disabilities). This should help to support equality of opportunity for those with protected characteristics.

21. **Pay protection (of previous nodal point) for doctors changing training and career path due to a circumstance related to disability –** this includes for example, caring for disabled relatives. The original proposal was for the doctor to have been in the previous specialty for 13 months and the proposal now is that there should be no qualifying period. This will improve equality of opportunity for those with disabilities and for those caring for them (who may predominantly be women).

22. **Pay protection (of previous nodal point) for doctors changing training and career path for caring reasons**, provided they have been working in the previous specialty for at least 6 months (and this is to be the case for changes to shortage specialty also rather than the original proposal of 13 months). This is a similar arrangement as was previously proposed for those changing training programme due to disability related circumstances (see paragraph 21 above). This will improve flexible working opportunities. It will particularly benefit women, as they are more likely to have caring responsibilities (eg a

lone parent may prefer a specialty which requires less work during unsocial hours rather than one needing lots of nights and late shifts).

Period of Grace

23. Health Education England has committed to provide its share of salary funding for 6 months after any doctor has successfully completed their specialist training. This continued employment will not necessarily be in the same place of work as their final training placement but should be in the same Local Education and Training Board, unless the doctor agrees otherwise. This will benefit all junior doctors in hospital based specialties.

Flexible Pay Premia

24. **Flexible Pay Premia (FPP**) paid to those undertaking training in Emergency Medicine, Psychiatry and Oral-Maxillofacial Surgery will be an increased payment of £20,000. It will be paid for the expected period of training (e.g. four year training programme, undertaken full time, at £5000 per annum; for someone training part-time over a longer period, the payment would be spread over those years, eg someone training at 50% over eight years would get £2500 per annum). Annual payments are to be received based on the averaged annual rate for the expected duration of the respective programme, except where the training is combined with that in another specialty, where the FPP would be paid for the duration of the training in the shortage specialty.

25. This will help to ensure that doctors are incentivised to work in some areas of particular need for patients and services. In relation to psychiatry, it can be seen that there are significantly more female than male juniors, and slightly more in A&E at the more junior levels. This proposal would encourage all juniors to consider these specialities and support equality of opportunity.

Work Protections

Hours and Guardians

26. The new contract reduces the maximum hours a doctor can be asked to work in any one week from 91 to 72, reduces the number of nights a doctor can be asked to work consecutively to four and reduces the number of long days a doctor can be asked to work to five. It also introduces a new post, a Guardian of Safe Working Hours, in every Trust to guard against doctors being asked to work excessive hours.

27. The agreement has clarified some important details of the Guardian's role and the way the Guardian system is to work, such as:

- an increase in the frequency of the Guardian's report to the Board to at least once a quarter;
- a consolidated annual report on rota gaps and the plan for improvement to be signed off by the Trust Chief Executive;
- additional liaison with junior doctors;
- fines are to be used to benefit the education, training and working environment of trainees in collaboration with junior doctors;
- further financial penalties are proposed where breaks are missed;
- the appointment of a Guardian for GP trainees;
- arrangements for Guardians for small employers;
- appeal arrangements; and
- performance management of the Guardian.

These new arrangements will be of benefit to all junior doctors, in particular those working the most intensive shifts where overruns of time are common. The Guardian will ensure that work schedules reflect the work requirements being made of junior doctors so that if shifts regularly overrun, then that would lead to a review of the work schedule and either a change to working patterns or an adjustment to hours and pay.

The Guardian's oversight of safe working practices will also include associated equality and diversity issues.

Whistleblowing

28. The agreement indicates that all NHS staff must be able to raise concerns, and be protected for doing so in line with public interest disclosure (whistleblowing) legislation. This right is enshrined in the contract for junior doctors. They will also be given the ability to raise concerns regarding the work of Health Education England without detriment, from either the employer or Health Education England.

29. This proposal will be of benefit to all junior doctors.

Mutual recognition of curricula

30. Following a discussion with the Secretary of State, the GMC has agreed to lead a review with the Royal Colleges, representatives of junior doctors and the organisations funding postgraduate medical education in the four countries across the UK to support appropriate recognition of competence where junior doctors change training paths. This review should enable quicker progress through training programmes and through the salary structure for doctors changing training path for reasons other than related to a disability or caring responsibility, or transferring into a shortage specialty. The GMC will complete this work by 31 March 2017. The results should benefit all junior doctors who wish to change their training path.

Pay

Unsocial hours package: weekends, nights and on-call

31. A new approach has been taken to reward for and acknowledgment of the various demanding working patterns of doctors. The proposed adjustments should balance the strategic priorities of the Government and the NHS, to deliver the agreed NHS Clinical Standards for seven day care (assuring all patients can receive the same high standard of care whatever the day of the week), with the contribution that junior doctors make across the week, particularly recognising that contribution at weekends.

32. An aim of the new contract was to replace low levels of basic pay as a proportion of total income (which make doctors rely heavily on unpredictable unsocial hours supplements to boost their income) with higher and more predictable levels of basic pay (which is pensionable). This general principle has been retained in the recent negotiations, (with an average pay increase of between 10 and 11%), while maintaining cost neutrality of the contract; this will benefit all junior doctors in that they will receive an increase in pensionable pay. It will also benefit those who work part-time (of whom a greater proportion are women) and who do not work additional hours.

33. A weekend allowance is to be paid when any doctor is rostered to work more than 6 weekends (for example, constituting but not limited to 12 weekend days/nights across a period of 6 weekends) per annum. The highest percentage of junior doctors across the board work at least 1 in 8 weekends a year, and they will be rewarded for those weekends by pay increases as a percentage of salary, rising the more weekends they work (as set out in paragraph 2 of Section E of the ACAS confirmation of agreement in Annex A), up to a maximum of 1 in 2 (with a consequent 10% of salary increase). (Junior doctors will not be required to work more frequently than 1 in 2 weekends).

34. Increasing pay for unsocial hours working will benefit those working more than one weekend in eight (thought to be the majority of junior doctors) and will include those working in the specialties of Obstetrics and Gynaecology and Paediatrics, which have a disproportionate number of female doctors.

35. Apart from rewarding those who work unsocial hours, which will be of benefit to all doctors who work more than 6 weekends per annum, this proposed allowance system should be beneficial for those with caring responsibilities (whom we assume are disproportionately women) - it will help with any higher childcare and other caring costs (on Saturdays as well as Sundays). This new allowance should help to support equality of opportunity for a number of women.

36. The proposal is not thought to have a differential impact on individuals according to their religion or beliefs.

Night rate

37. An integral part of the pay proposal with respect to unsocial hours is a change to the night rate; it recognises that doctors should be rewarded for working nights. It very slightly reduces the overall sum received for the night as compared to the March proposals, because a slightly reduced rate is payable for an increased number of hours (any shift which starts at or after 8pm, lasts more than 8 hours (and within the 13 hour cap) and finishes at or by 10am the following day should attract an enhanced pay rate of 37% for all hours worked). This should be seen as part of the overall beneficial unsocial hours proposals.

On-call

38. More money will be spent on on-call, an increase from £8 to £12 million; this will be taken from a slight reduction in basic pay, ie, a re-distribution of the pot to target better those who will work unsocial hours. The proposal is to give a flat rate of 8% of basic pay for being available on call.

39. Under the March proposals, the rate was either 5% (for less than 1 in 4 week days and weekends), or 10% for 1 in 4 or more. The result of this change is that the majority of junior doctors will receive an increase in payment to 8% (rather than the 5% previously proposed) as very few junior doctors work 1 in 4. In effect therefore there will be a redistribution and increase in money available for on-call, for the majority of junior doctors.

40. It is recognised that a junior doctor with sole caring responsibilities (predominantly women) would have to make care arrangements whilst on call, whether or not they were called out so the extra amount of allowance will be beneficial to those with caring responsibilities who work less than 1 in 4. This change recognises the particular demands that those with caring responsibilities may face.

41. On-call is a particular feature of certain specialties. If the on-call or rota demands of a specialty prove to be unduly burdensome for those doctors who have sole caring responsibilities for example, they will benefit from the new pay protection when they change specialty to one with less onerous rotas. That is another element of this family friendly package to be seen alongside the higher spend available to more juniors on on-call. Other specialties such as, for example, psychiatry, which has more female than male juniors, with relatively high on-call demands, will benefit from the higher 8% rate for on-call which should assist carers (predominantly women) working in that area.

42. The unsocial hours package as a whole, to include nights, on-call and weekends, has been designed to address concerns in respect of night-time and weekend working and improve the offer overall from an equality and family friendly perspective. Slightly reduced spending on night time work will release some money for other unsocial hours payments – weekends and on-call availability, which should increase equal opportunities for those with caring responsibilities who have to pay for child care and other costs during

unsocial hours (likely to be disproportionately women). Furthermore, the unsocial hours payments should be seen alongside the increase in basic pay.

43. The flexible working/good rostering proposals discussed earlier, should also benefit all junior doctors by encouraging a better work/life balance by avoiding unduly onerous rostering, and should benefit those junior doctors trying to balance training and caring responsibilities. These different elements should be seen as different parts of the same package which is designed to increase options and flexibility for junior doctors, whatever their situation but particularly aimed at those with caring responsibilities, those who work part-time (predominantly women) and those with disabilities.

Nodal system adjustments

44. Several adjustments to front-load pay levels are proposed as follows:

- adjusting down Nodal point 4 in order to distribute pay more fairly and increasing the pay point for F2/nodal point 2; and
- within cost neutrality envelope, investing in new nodal points 1-3 as the priority for spending up to £75m released from senior trainees who secure their Certificate of Completion of Training by the end of transition.

The nodal system itself is considered to be fairer than the current contract, by replacing automatic pay increments, which do not reward those junior doctors who take on greater responsibility, with a new system that links pay to competence and responsibility.

45. The proposals should be beneficial to those with certain protected characteristics. By frontloading pay levels, it is likely to increase the relative level of pay for those who take time out of training or work part time and so take longer to achieve higher levels of competency and hence higher associated pay (eg women who take maternity leave, those with disabilities and those with caring responsibilities who may be disproportionately women). This should also help to support equality of opportunity for women.

46. It is also proposed to remove Nodal point 5 (£52,000 for ST8) and introduce an allowance for Senior Clinical Decision Makers who are not yet consultants (in the context of meeting the clinical standards for Seven Day Services). This proposal should be beneficial for doctors with greater levels of responsibility and appears to be neutral as regards those with protected characteristics.

Fidelity Clause

47. The proposal is to revise the current provision where doctors must give their employer ‘first refusal’ over any additional work outside their work schedule as a locum, by extending the clause to give ‘first refusal’ to the NHS, i.e. any other NHS employer, via an NHS staff bank. In addition, junior doctors would

be paid 22% above the prevailing hourly rate. This provision does not prevent paid work for non-locum activities outside the NHS.

48. This proposal enables doctors who work some distance from their homes to find locum work in more convenient locations, and this can be of particular benefit to junior doctors with caring responsibilities. The proposal should also be beneficial both in terms of added flexibility and a higher rate, for any junior doctor who wishes to carry out locum work.

49. The new proposals show the value attached to the role of junior doctors and the Government's commitment to safe care for patients. They also aim to encourage a diverse workforce and enable equality of opportunity for all.

The Family Test

The fresh proposals are likely to provide further support for strong families and relationships, as envisaged by the family test. We believe that the new proposals will have a positive impact on the provision of care to patients and their families and on the family life of doctors particularly in the light of the following:

- accelerated training support will minimise the impact on some junior doctors' training pathways, making it easier for them to make family enhancing decisions;
- the joint review by NHS Employers and the BMA of good rostering practice to support greater flexibility;
- the joint guidance to be developed to include caring for children and adults, flexible working and balancing work and personal leave;
- the champion of flexible training;
- the Health Education England review of the processes which allow transfer between the regions, joint applications between married couples (or those in a civil partnership) and training placements for those with caring responsibilities;
- amendments to the process surrounding the Guardian of Safe Working Hours will provide further safeguards against the working of long hours by junior doctors; and
- change to pay protection arrangements for doctors who need to change training path (to make special provision for those with caring responsibilities) will make it easier for those caring within the family (including the extended family) structure to work in areas with less challenging patterns of night work and late shifts.

● average pay for all doctors will not change, but there will be a slight redistribution as a result of the small reduction from the previous increase in basic pay, which will support

(i) those working on weekends – pay enhancements will be made to those working more than 6 weekends per year which will make it easier to pay for required childcare;
(ii) a larger number of doctors who will receive a higher percentage of basic pay for non-resident on call (8% instead of 5%) which will make it easier for some to pay for required childcare; and
(iii) a further flattening and front-loading of the nodal structure which should assist those who step off training for (e.g.) maternity or caring reasons.

Annex A

ACAS confirmation of agreement of 18 May 2016

BMA, NHS EMPLOYERS, DEPARTMENT OF HEATH: 18 MAY 2016

JUNIOR DOCTORS CONTRACT AGREEMENT

ACAS confirms the agreement between the BMA, NHS Employers and the Secretary of State for Health of negotiated terms which, subject to a referendum of relevant BMA members, form the basis for a new contract in 2016.

Over the last ten days both parties have resolved the outstanding issues taken forward from previous discussions, finalised and confirmed areas already agreed, and developed further measures which address the wider concerns of junior doctors. These are covered in this summary as per the ACAS agenda we followed in the process.

A full contract agreed between the parties will be published at the end of May. The detailed contract will include a combination of agreed terms from February negotiations and the new provisions included in this statement. Issues resolved in the February talks and presumed to form the basis for these additional provisions include:

- an agreement to replace the banding system for rewarding unsocial hours with payment for all work done to support seven day service delivery

- a series of new limits on working hours

- the replacement of an incremental pay system with a series of nodal pay points based on attainment and responsibility rather than time served

This agreement reflects therefore the commitment of the parties to the following:

- the safety of patients and junior doctors

- terms and conditions which appropriately respond to the diverse characteristics of the junior doctor community

- a healthy working environment for junior doctors which values their contribution throughout the week

- a high-quality training experience for junior doctors

- revisions and improvements to terms and conditions to address the ongoing need to properly reward, protect and retain a valued workforce

This agreement is positively supported by all those involved in what have been constructive talks.

A. Equalities

The government, employers and the BMA are committed to supporting equality of opportunity for all medical staff and the wider NHS team. There is a recognition that junior doctors with caring responsibilities can face particular challenges during their training, but also that the NHS is committed to creating the best working environment for all its staff.

The parties have therefore agreed to support a range of initiatives:

1. Accelerated Training support

There is an agreement to develop innovative approaches to training, to remove as far as possible the disadvantage of those who take time out due to, for example, caring responsibilities. This approach would include targeted accelerated learning with the prime intention to enable the person who has taken time out to catch up. This will include access to mentorship, study leave funding and specially developed training inputs.

The Secretary of State has confirmed that this enhancement will be additionally funded from outside the contract pay bill. Both parties recognise the importance of ensuring that these arrangements do not disadvantage a junior doctor who does not take time out or training.

2. Deployment

HEE will lead 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. The delivery of this work will form part of the mandate set by the Secretary of State for HEE to be completed by the end of March 2017.

3. Improving practice

NHS Employers will jointly review with the BMA approaches to good rostering practice, including the proper use of technology, which support greater flexibility for junior doctors and employers. Rostering experts will be engaged in this work to ensure that best practice can be applied, which will be completed by January 2017

4. Contractual terms

The parties have agreed to improve the terms and conditions of service to make it clear that where trainees have to change training path due to caring responsibilities, then their previous nodal point pay will be protected. This is the same arrangement as put in place for those changing training programme due to disability related circumstances.

5. Governance

The Guardian role will include proper oversight of safe working practices, including associated diversity and equality issues. This will include liaison with the Director of Medical Education to ensure that a member of the educational faculty in the Trust is designated as a champion for flexible training.

Employers, HEE and the BMA will put in place comprehensive equalities monitoring mechanisms for all protected characteristics to be signed off via the JNCJ for implementation from April 2017.

6. Equalities Guidance & Schedules

Joint guidance will be developed by the BMA and NHS Employers to ensure the effective delivery of elements of the NHS-wide staff handbook for doctors on rotation. This guidance will cover Caring for children and Adults, Flexible working and balancing work and personal leave and will be explicitly referenced in the contract.

7. Pay System Improvements

In order to distribute pay more fairly the parties have agreed to further revise the nodal pay point structure.

B. The Guardian of Safe Working

The BMA JDC, the government and employers confirm their strong commitment to the jointly appointed Guardian, recognising the role's importance in ensuring safe working for doctors in training. The parties have been able to work together to clarify some important details of the role. This aspect of the package of measures will be reviewed by the parties in August 2018.

1. Guardian Reporting

The frequency of the Guardian report to the board will be increased to at least once a quarter. It will include data on all rota gaps on all shifts. A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps should be included in a statement in the Trust's Quality Account, which must be signed off by the Trust Chief Executive.

2. Liaison with doctors

Each Guardian and Director of Medical Education will jointly establish a Junior Doctors Forum (or fora) to advise them. This will include junior doctor colleagues from the organisation and must include the relevant junior doctor representatives from the LNC (or equivalent) as well as the Chair of the LNC. Doctors on the fora will be elected from amongst the trainees employed in the organisation (or organisations who share the same guardian). Where the guardian for safe working, covers specialties that are small or have specific employment requirements, the fora will include representatives of these groups. The group will also include relevant educational and HR colleagues as agreed with the group. The junior doctors forum or a sub-group it establishes will play a vital role in the scrutiny of the distribution of income drawn from fines.

3. Disbursement of Fines

The money raised through fines must be used to benefit the education, training and working environment of trainees. The guardian should devise the allocation of funds in collaboration with the trust 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 trust as standard.

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 what the money has been spent on.

4. Financial Penalties

In addition to the financial penalties already proposed in the contract, the parties have agreed that where breaks are missed on 25% or more of occasions, across a 4 week reference period, a guardian fine will apply at two times the rate for the time not taken as a break. Additionally, a work schedule review may be required to ensure that at least 75% of breaks are taken.

5. GP trainees

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, 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.

6. Guardian and Lead Employers

All Trusts and FTs must appoint a guardian. 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 will ensure information is available to the host organisation board as per this agreement, and the lead employer guardian must see guardian reports for all of the doctors under their employment.

7. Small Employers

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 the guardian of safe working at a neighbouring NHS trust to oversee the safe working of their trainees. The trainees affected by these arrangements will be represented in the Junior Doctors Forum, and the Guardian must either be familiar with the issues faced by doctors working in the relevant setting or have access to support and advice on such issues.

8. Appealing the decision of the guardian

The final stage is a formal hearing under the final stage of the employer's local grievance procedure. This will be as per the ACAS guidance for grievances. Any appeal against the decision of the guardian will involve a representative from the BMA or other relevant trade union nominated from outside the Trust, and provided by the trade union within one calendar month.

9. Performance Management of the Guardian

It is agreed that 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 relevant trade union) or the Junior Doctors Forum or any individual doctor in training should raise those concerns with the Trust Medical Director. These concerns can be escalated to the senior independent director on the Board of Directors where they are not properly addressed or resolved.

C. Recruitment and Retention

This new contract ensures that doctors are incentivised to work in some areas of particular need for patients and services, whilst commencing and completing and training in ways which respect their skills and time.

1. FPP

The parties have agreed to increase the Flexible Pay Premia presently to be paid to those with a training number in OMFS, Emergency Medicine and Psychiatry to £20,000 for the duration of the training period, paid for the defined expected period of training (e.g. four year training programme = £5000 pa). The entitlement is to be pro-rata'd for less than full time trainees, and will remain within the £20,000 envelope. Where training takes longer, annual payments are to be received based on the averaged annual rate for the respective programme, except where the training is combined with that in another speciality where the FPP would be paid for the duration of the training in the shortage speciality. None of the FPP payments would be pensionable.

2. Streamlining

The parties acknowledge that the way that the NHS recruits and inducts all its staff can be improved in ways which are more considerate of the time of the employee as well as more efficient. They are grateful that NHS Improvement and HEE have undertaken to mandate all employers to establish regional streamlining processes by April 2017.

3. Period of Grace

HEE commits to provide its share of salary funding for 6 months after any doctor has successfully completed their specialist training, though this continued employment will not necessarily be in the same place of work as their final training placement (though should be in the same LETB, unless the doctor agrees otherwise)

4. Changing Training Path

It is agreed that where a trainee changes training and career path due to a circumstance related to disability then the protection of their entitlement to nodal pay does not have a qualifying time period. In all other circumstances (change due to caring responsibilities, change to a shortage speciality) then the qualifying period is six months service. Where in this circumstance a trainee has missed the relevant application round, then they must gain a place within twelve months of leaving the original programme.

5. Mutual recognition of curricula

Following a discussion with the Secretary of State, the GMC has agreed to lead a review with the Royal Colleges, representatives of junior doctors and the organisations funding postgraduate medical education in the four countries across the UK to support appropriate recognition of competence where junior doctors change training paths. This review should enable quicker progress through training programmes and through the salary structure for doctors changing training path for reasons other than related to a disability or caring responsibility, or transferring into a shortage speciality. The GMC will complete this work by 31 March 2017.

D. Terms of Service

Through constructive discussion a number of clarifications and revisions have been made to terms and conditions of service which respond to questions raised by doctors.

1. Breaks

An agreement that breaks can be taken flexibly during a shift, and should be evenly spaced where possible. However where breaks are combined the contract will make clear that 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.

2. Pay for additional hours of work

The parties recognise that a doctor may consider that there is a professional 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 an appropriate person. This authorisation would be given before or during the period of extended working, or afterwards if this is not possible. These provisions will, it is agreed, also apply to additional hours of actual work over the prospective average estimate during non-resident on-call (as described in the work schedule).

Compensation will be made to the doctor by additional payment or by time off in lieu (TOIL), or by a combination of the two. Where payment is not authorized, the reason for the decision will be fed back to the doctor and copied to the Guardian for review.

TOIL arising from breaches in rest requirements 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. TOIL arising from breaches of hours but not rest can be accrued. Accrued TOIL can be "banked" but should normally be taken within three calendar months of accrual.

In any circumstances where TOIL cannot be taken, payment will be made in lieu, at the prevailing hourly rate for the time where the additional work was undertaken.

Employers will introduce systems to support claims for payment which are simple to use.

3. Fidelity to the NHS

The parties have agreed that 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 offer such additional hours of work exclusively to the service of the NHS via an NHS staff bank. The requirement to offer such service is for work commensurate with the grade and competencies of the doctor, though the doctor may choose to accept work at a lower grade, if they wish.

The doctor can carry out 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 Working Time Regulations). The employer will agree with the LNC local processes for the doctor to inform their employer of their intention to carry out such work.

This provision does not prevent paid work for non-locum activities outside the NHS. Rates of payment for such work have been improved so that the doctor would receive a 22% premium above the prevailing hourly rate.

4. Payment for work undertaken while on call

The work schedule of a doctor rostered to be on call will contain an average amount of time, calculated prospectively, for anticipated work during the on-call period. Such work includes any actual clinical or non-clinical work undertaken either on or offsite, including telephone calls and travel time arising from any such calls. Any such work is defined as working time for the purposes of the 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 the TCS.

5. Senior Decision Making

The parties recognise that there will be circumstances where the most senior trainees will be designated by their employer to undertake roles as senior decision makers, in line with appropriate clinical standards. It is agreed that there will therefore no longer be a fifth nodal point in the pay system, and this money will be used from [October 2019] to recognise those trainees who undertake a role as a senior decision maker.

6. Whistleblowing

All NHS staff must be able to raise concerns, and be protected for doing so in line with public interest disclosure (whistleblowing) legislation. This right is enshrined in the contract for junior doctors. They will also be given the ability to raise concerns regarding the work of HEE without detriment, from either the employer or HEE.

E. Working Week: Affording and Valuing Weekends, Nights and NROC

A new approach to the reward for and acknowledgment of the various demanding working patterns of doctors has been taken. This balances the strategic priorities of the government and NHS, to deliver the agreed NHS Clinical Standards for seven-day care,

(assuring all patients can receive the same high standard of care whatever the day of the week), with the contribution that junior doctors make across the week, particularly valuing that contribution at weekends. This approach:

1. Recognises the working and completion of work overnight, with an agreement that any shift which starts at or after 8pm, lasts more than 8 hours (and within the 13 hour cap) and finishes at or by 10am the following day, should attract an enhanced pay rate of 37% for all hours worked;

2. Establishes a weekend allowance paid when any doctor is rostered to work more than 6 weekends (in practice it is assumed that this will constitute but not be limited to 12 weekend days/nights across a period of 6 weekends) per annum, with the supplement increased as the number of weekends worked increases. This supplementary allowance is applied as a percentage of basic pay. These rates will be set in accordance with the rates set out in the table below:

Frequency	Percentage
1 weekend in 2	10%
<1 weekend in 2 – 1 weekend in 4	7.5%
<1 weekend in 4 – 1 weekend in 5	6%
<1 weekend in 5 – 1 weekend in 7	4%
<1 weekend in 7 – 1 weekend in 8	3%
<1 weekend in 8	No weekend allowance

3. Responds to the need for some doctors to be available for on call duties, with a system of payment which recognises the impact on lifestyle of availability for duty. This supplementary allowance is applied as 8% of basic pay over and above any weekend allowance payable.

Frequency	Weekend allowance	On-call availability allowance	Total allowances
1 weekend in 2	10%	8%	18%
<1 weekend in 2 – 1 weekend in 4	7.5%	8%	15.5%
<1 weekend in 4 – 1 weekend in 5	6%	8%	14%
<1 weekend in 5 – 1 weekend in 7	4%	8%	12%
<1 weekend in 7 – 1 weekend in 8	3%	8%	11%
<1 weekend in 8	No weekend allowance	8%	8%

4. Ensures an average basic pay increase of between 10 and 11% (subject to final modelling of values), maintaining the cost neutrality of the contract. At this stage it is proposed that nodal point values will be increased by at least 1% in 2017/18, 0.9% in 2018/19 and 0.8% in 2019/20 reflecting the need to fund the national living wage in the NHS.

5. The rest periods which ensure the safe working of doctors will be as previously developed between the parties, with amendments to reflect feedback from doctors and their employers:

- there will be a 46 hour rest period after the completion of three or four night shifts
- junior doctors will not be required to work more frequently than 1:2 weekends
- Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of actual 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 working pattern a maximum of 12 shifts of any length can be rostered or worked on 12 consecutive days.

F. Implementation Process

1. BMA Referendum

Agreed TCS Complete PSED Agreed communications materials	31 May 2016	
JDC Meets	3 June 2016	
Roadshows (with jointly agreed materials)	17 June 2016	Completed by this date
Referendum	17 June to 1 July 2016	Result by 6 July 2016

2. Contract Implementation

July 2016	All guardians appointed
26 July 2016	Guardian conference
3 August 2016	New contract "effective date"
October 2016	Transition to the new terms and conditions of service for: • F1s (all specialties) • F2 (when sharing a rota with F1s) • ST3/4 in general practice • ST3+ in obstetrics and gynaecology training programmes.
February – April 2017	All grades in: • Psychiatry • Public health • All pathology and lab based specialties • Paediatrics • All dental training programmes (excluding orthodontics) • Any F2 and GP trainees who share a rota with trainees above in this category
April 2017	• All grades in all surgical specialties (including orthodontics) • Any F2 and GP trainees who share a rota with trainees above in this category
August 2017	• All remaining existing trainees • All new entrants

3. Public Sector Duties

The S of S will publish an equality analysis document prior to the publication of the contract.

4. Transition

In order to support the effective implementation of the contract, the parties have agreed to extend the period of transitional pay protection by one year.

5. Ongoing role of JNC(J)

The agreement of this new contract would mean that the present employer based variation clause in the model contract would be replaced by a clause which confirms the national collective bargaining arrangements between employers and recognised trade unions vested in the JNC(J).

6. Seven-day Services

The BMA will, along with other trade union colleagues, the professions and NHS representative bodies, be asked to join a group advising NHS England on the policy direction relating to seven-day services. In addition a sub-group of the Social Partnership Forum will be established to consider and monitor how seven day service policy impacts on the workforce.

7. Joint Contract Review

It is agreed that the regular review and updating of the contract is vital so that none of the parties find themselves in a protracted dispute. It is agreed therefore that the BMA and NHS Employers jointly commission in August 2018 a review of the efficacy of the contract, to identify any areas for improvement to the contract terms. Priority areas for inclusion in this review have been agreed but there is no wish to restrict the terms of any review at this stage.

Annex B

The relevant protected characteristics are—

age;

disability;

gender reassignment;

pregnancy and maternity;

race;

religion or belief;

sex;

sexual orientation.