BMA

British Medical Association Summary of Position as at 4 January 2016

Executive summary

Background

The British Medical Association (BMA) has been consistent in its determination to agree a contract that continues to deliver safe and high quality care for patients, while protecting the working conditions of all junior doctors in England.

In December, the BMA re-entered negotiations with the Department of Health (DH) and NHS Employers (NHSE) following conciliation talks at Acas, as initiated by the BMA. This resulted in a memorandum of understanding for negotiations.

Negotiations have included:

- Contractual terms governing safe working hours and contractual safeguards that ensure patient care and working conditions for junior doctors are protected
- New models of pay progression
- A tripartite group involving Health Education England (HEE) and DH to address the quality of training and the educational needs of trainees

Current position

The following are the areas of the significant disagreement which still exist between the BMA and the government (as at 4 January 2016):

1. Safety

We do not feel that the safety provisions summarised in the 4 January offer document are comprehensive. The guardian role, which was the subject of constructive discussions has been diluted. It now appears to lack teeth and would not command the confidence of junior doctors in the form described. Progress has been made, but there remain serious and worrying omissions which mean that the BMA still has concerns about patient and doctor safety.

2. Pay progression

The BMA has worked constructively with DH to meet their requirements for pay progression based on position of responsibility, doing so in a way that minimises potential exacerbation of the growing gender pay disparity amongst doctors in training. We hope this significant concession on the part of junior doctors would be recognised as part of an overall pay package that we developed to meet the policy aims of both sides. The final version is yet to be agreed.

3. Pay for all work done
The two sides are aligned on the principle of pay for all work done, but no system or mechanism for implementing this is yet definitively agreed.

4. Plain time/premium time
The BMA fundamentally rejects the idea that Saturday is a normal working day and should be paid as a weekday. In the context of the Government's desire to move to services across seven days, without committing to the necessary increase in resources, junior doctors are willing to work with Government to deliver this policy but only in a sustainable way that does not make a career in medical practice in the UK less attractive. This is a significant area of disagreement.

Appendix One is a summary of the position reached by HEE, the DH and the BMA on training issues. Although significant progress has been made, key issues have not been resolved or contractualised, and as such require further discussion.

1. Safe hours of work and maintaining patient safety

BMA position
Ensuring patient and junior doctor safety must be the primary focus of any new contract. The BMA has been clear with the government that, in order to achieve these aims, the negotiations must result in:
- A set of safe limits on junior doctors' working hours, to ensure that patients are not treated by tired, overworked doctors; this includes limits on hours worked per shift, the number and type of shifts worked in each rolling seven-day period, and provision for adequate breaks
- Requirements for rest periods.
- A system of robust safeguards that ensures any breaches of these limits are swiftly identified and effectively tackled.
- An assurance mechanism that will comprise exception reporting and a financial penalty for employers for breaches of limits. This will ensure that there is a strong incentive to design and enforce safe rotas.
- A clear, agreed definition of what constitutes a night shift, including its length and the appropriate rest interval between consecutive night shifts.

The need for safer working hours and conditions for junior doctors was jointly agreed between the BMA and Government. However, when discussing shift length, night shifts and working hours, NHSE stated that current challenges with service delivery and workforce dictated what was achievable in time for the government's planned implementation date of August 2016.

Non-resident on-call duty
There is disagreement on hours, rest breaks and shift patterns for non-resident on-call duty. The BMA's concerns about the lack of adequate definition of breaks and rest periods have not yet been addressed. Specifically, we were concerned that doctors may be forced to work the day following a non-resident on-call shift without adequate rest overnight, and also about the risk that doctors would be used to facilitate 'shadow rotas'.

The BMA is concerned that the employer proposal could facilitate extremely detrimental rotas for non-resident on-call shifts, with doctors working these patterns potentially being paid below minimum wage to cover services.

Night shifts
There is disagreement as to what constitutes a night shift. The BMA believes a night shift to be any shift that includes any hours between 10pm and 6am. NHSE/DH's position is that a night shift is any shift which includes three hours between 11pm and 6am. This is an area of strong disagreement: the BMA's position is that any shift occurring at 2am clearly constitutes a night shift.

The BMA believes that the employers have confused or conflated the legal definitions of when counts as a 'night period', and who counts as a regular 'night worker'. Junior doctors' shift patterns span the hours of day and night, and juniors need robust protections for their night working - despite not normally counting as night workers for purposes of the Working Time Regulations - because of fatigue caused by their working patterns frequently changing times.

Final negotiation summary

November Firm Offer	NHSE/DH January Proposed Final Offer	BMA position
	Guardian of Safe Working	An independent Guardian for safe working hours jointly appointed with BMA
	Safe working hours enshrined as a KPI for organisations' performance management framework	
Exception Reporting	Exception reporting	Exception reporting, with the proper mechanism for submitting reports available at the point of implementing a new contract
Work Scheduling	Work scheduling	Work scheduling, including annual leave, study leave, professional leave
Work Reviews	Work reviews	Work reviews can be requested at any time and repeated or unresolved breaches should trigger a work review
Maximum 48 hour week	Maximum 48 hour week	Maximum 48 hour week
Opt out capped at 56 hours	Opt out capped at 56 hours	Individual professional responsibility to ensure no unsafe working beyond 56 hours as per GMC regulations in Good Medical Practice
Maximum 72 hours in seven days	Maximum 72 hours in seven days	To reduce the maximum hours worked to 70 hours in any seven-day rolling period
13 hours maximum shift length	13 hours maximum shift length	To reduce maximum shift length, in particular night shifts
Maximum five consecutive long shifts	Maximum five consecutive long shifts	To reduce maximum number of long shifts to three consecutive shifts in any working week
Maximum four consecutive night shifts	Maximum four consecutive night shifts	Maximum four consecutive night shifts
		A night shift is defined as any work done past 10pm
	48 hours off after three or four consecutive night shifts	48 hours off after three or four consecutive night shifts
	48 hours off after five long days	
	Maximum eight consecutive days work with a 48 hour break after eight days	Maximum seven consecutive days work with a 48 hour break after seven days
	Flexible on call arrangements linked to intensity of work, rather than fixed through rigid shift patterns.	Non-resident availability duty patterns: – Maximum roster of one consecutive non-resident on call – Maximum of 3 non-resident duties per rolling 7 day period – 5 hours continuous rest, during duty, between 10pm and 8am
	Joint best practice guidance on rostering.	Changes to roster need to be prospectively approved by the Guardian
		Rest periods – Minimum rest period of 12 hours between consecutive shifts – Increase to minimum rest periods between consecutive night shifts

The BMA position is that minimum break requirements in the current contract should be retained – these are continuous 30 minute breaks after approximately four hours of work.

Additional points

Guardian role

The role of the Guardian will be to safeguard against threats to safe working practices, as well as those to junior doctors' training. This role will need to have a degree of prospective responsibility for the rosters that govern the working patterns of junior doctors, as well as ensuring safe adherence to scheduled work. Where exceptions to scheduled work occur repeatedly, the Guardian will be responsible for ensuring that underlying causes are properly and promptly addressed, whilst at the same time escalating concerns to relevant internal and external bodies, including Trust boards. This will complement local systems for work reviews following exception reporting.

It was agreed at Acas that the Guardian role should be appointed jointly by the BMA and the respective Trust. However despite this agreement NHSE have since sought to dictate how the BMA can have confidence in the role.

Work schedules and reviews

A work schedule should be introduced which lists the duties of a doctor in training, their educational opportunities in a post and their intended learning outcomes, and the number of hours for which they are contracted, as proposed by NHSE in their evidence to the DDRB in December 2014.

Exception reporting may trigger extraordinary work schedule reviews. Timely, effective and accountable mechanisms for work schedule reviews (carried out by Educational/Clinical Supervisors) will help to safeguard against unsafe working hours and ensure that every junior doctor receives the high standard of training they need. If the report is not actioned, the Guardian will then step in to address the issue.

The Guardian will review the aggregated exception reports on a monthly basis and take appropriate action. Every four months the Guardian will submit an aggregated summary of exception reports to the Local Education and Training Board (LETB) and BMA, with copies to the General Medical Council (GMC) and Care Quality Commission (CQC). The Guardian will produce an annual report for the Trust Board and Executive.

Exception reporting

The BMA starts from the position that junior doctors who work beyond their rostered hours should be paid for the work they do. Should doctors be asked to cover for absent colleagues and gaps in the rota, they should be paid at an internal locum rate. Any such doctor should also be provided with adequate compensatory rest.

The BMA does not agree that time off in lieu is an adequate mechanism to recompense juniors for time worked beyond rostered hours, as doctors are often unable to to take time off or and carry over time off in lieu across rotations. Nor do we believe that this provides an adequate disincentive to Trusts.
When a junior doctor breaches his or her work schedule, they should submit an exception report. This will safeguard against work schedule breaches that threaten safe practices. A robust system needs to be developed to enable junior doctors to report exceptions simply and promptly, and this is a prerequisite for implementing these new contractual arrangements

The BMA envisages that this would trigger the following:

- The exception report will be sent to their educational supervisor, clinical supervisor, and the newly-created guardian role.
- The relevant supervisor should review this, and conclude any required action as a result, within a week.
- The Guardian has responsibility to monitor this, and take steps in the event that exceptions are not addressed or repeatedly occur. For example, if exception reports are generated for 10% or more of duties worked over a 1-month period, or 5% over a 6 month period, this would trigger an evaluation of the rostering mechanism within a given unit or department and provision would need to be made to ensure ongoing safe limits are achieved.
- Where consistent exceptions are reported in any given unit or department within a (host) employer, the Guardian will initiate a roster review exercise to evaluate the rostering mechanisms that are failing to prevent regular exceptions. The results will be reported to the LETB and BMA, with copies to the GMC and CQC.
- A roster review exercise would involve the Guardian, a BMA-appointed junior doctor representative, the relevant HR rota coordinator, a consultant from the department, and/or the director of Postgraduate Medical Education.

When a roster review exercise is triggered according to the thresholds above, the Guardian will produce a report to be submitted to the postgraduate dean/LETB copied to the GMC, CQC and BMA.

The BMA believes the Guardian should be involved prospectively in rota review exercises in order to ensure that rotas are adequately staffed and the hours rostered are safe. NHSE however felt this was not practical due to the number of rotas and consequent demand on the Guardian.
The BMA's position is that if two such review exercises take place within 12 months, the Guardian should recommend that formal consideration be given to removing trainees from the employer.

Financial penalties

The BMA has a clear, consistent position on financial penalities. History and evidence have shown financial penalities to be the only effective way of preventing unsafe and dangerous working hours for junior doctors. The removal of banding and compulsory monitoring puts junior doctors at significant risk of a return to dangerous working patterns. If this system is to be replaced, a robust mechanism must first be introduced that would disincentivise Trusts and hospitals from rostering doctors to work hours that are dangerous for them and their patients.

When it is found that a junior doctor has breached their rostered hours of work or worked beyond the contractual safety limits, a punitive rate of four times the prevailing hourly rate penalty must be applied for the extra hours worked.

Use of the financial penalty would ideally be completely avoided by only rostering junior doctors within safe working limits and ensuring that junior doctors do not work over their rostered hours. Similarly, if contractual break requirements are not achieved, junior doctors must be allowed extra break time to compensate for this.

The goverment proposes that the doctor be paid at the prevailing rate for work done beyond rostered hours. However the financial penalty would only be applied to breaches of the Working Time Regulations and the contractual limit of 72 hours worked in a seven-day period. This remains an area of significant disagreement.

2. Pay and unsocial hours

Cost neutrality

The BMA's financial modelling for a fit-for-purpose contract for junior doctors is based on a pay bill of £3.298 billion for 2016-17. This includes 'on costs' but excludes pay protection and increased pensionability, in line with the November 'firm offer' from NHSE and DH. The BMA recognises the government's commitment to a cost-neutral pay bill.

Pay structure

The BMA pay model aims to reduce significant gaps in nodal points that may disadvantage the 54 per cent of trainees who do not follow a linear route through training, including those making important contributions to UK life sciences and the NHS more widely by taking time to undertake medical and academic research. Our intention is also to ensure that the gender pay gap is not exacerbated by disadvantaging less-than-full-time trainees – 80 per cent of whom are currently women.

For this reason, the BMA has outlined a basic pay proposal with a higher starting basic salary. We have presented a scale for junior doctor pay, to reflect different competency-based stages in training. The pay structure reflects the level of responsibility, intensity and work done. The pay system proposed would be front-loaded, offering a flattened pay structure so that no doctor would lose out over the duration of their training.

All pay proposals must of course be fully modelled to understand and address their equality impacts before final agreement is reached.

London weighting

There has been no increase in this fixed financial amount since its inception in the 1980s. Given the increased cost of living, particularly in and around London, the BMA would like these negotiations include discussion about increasing this figure.

Plain time and unsocial hours

Junior doctors already routinely work 24 hours a day, seven days a week, including evenings, nights and weekends. These must be recognised as unsocial working hours and paid accordingly. The BMA has consistently made clear that patients should receive the same high quality of care every day of the week, but equally that this must not be achieved at the expense of the existing fair and reasonable arrangements for recognising the unsocial nature of evening and weekend working.

Ensuring that junior doctors are paid fairly for work they do in unsocial hours will go some way to addressing recruitment problems in specialties that work most intensely across 24 hours. This is crucial in order to safeguard the future workforce of the NHS.

The BMA recognises that high-intensity specialties work increased shift patterns over the weekend. This places a significant burden on the personal and family lives of doctors training in these specialties. The impact of weekend working on individual doctors must be limited and recognised financially in order to retain staff and prevent doctors being forced to leave the profession in favour of careers that promote more family-friendly practices.

The BMA has proposed a safe, fair and cost-neutral pay structure that meets the government's financial requirements while properly recognising plain and unsocial hours and those working the most onerous rotas.

Pay for all work done

Junior doctors should be paid for all the work they do, without their goodwill and professionalism being exploited through unpaid overtime. A clear mechanism is needed to ensure that junior doctors are paid at the appropriate rate when their shifts overrun or when they are called into work during non-resident on-call shifts.

Pay protection

The pay system must recognise the value of the experience that junior doctors gain over time. Deciding which area of medicine in which to specialise is a significant decision for any doctor. The NHS benefits if doctors are able to change their specialty should they consider that their skills are better suited to a different one – especially if there are staff shortages in their new choice, or if they would be likely to leave medicine for good if forced to stay in the wrong specialty

The pay of a doctor who retrains in a new specialty should be protected where they bring relevant experience from their previous training.

- Those doctors who choose to retrain in a shortage specialty should not see a drop in basic salary and should continue to progress up the pay scale.
- Those doctors who choose to retrain in a non-shortage specialty should undergo a review process to assess any transferable experience that may merit entering their new specialty at a higher pay level than a new entrant without that transferable experience.
- The new contract must include pay protection for academic trainees taking higher degrees.

Training in oral and maxillofacial surgery (OMFS) requires both a medical and dental degree, which can be undertaken in either order. This means that significant numbers of OMFS trainees will work for several years in the NHS, before stepping out to do their second degree and then returning as an F1 (or a first year OMFS Senior House Officer).

This means that, currently, trainees have to start at the base of the pay scale after their second degree, despite having several previous years' experience working in the NHS in a career grade – as their continuity of service is generally broken by taking several years out for the second degree required for their chosen specialty. Despite the two degrees being necessary to become an OMFS, trainees are, therefore, likely to be penalised for taking time out to do their second degree.

The new contract must recognise that oral and maxillofacial trainees are required to complete two degrees to qualify in this specialty, and their pay should be protected once they return from study to ensure trainees are not financially penalised for choosing this specialty.

Transitional pay protection

Transitional pay arrangements will be required to prevent any individuals suffering a financial detriment in the transition.

Flexible pay premia

The proposed move towards using pay premia to incentivise recruitment would mean that pay would vary according to the popularity of a specialty choice at any given time, rather than the length or intensity of work done. If pay premia are funded from within the current total amount available for junior doctors' pay, then they could only be used by cutting the pay of other trainees elsewhere.

The BMA's position is as follows:

- Any discretionary flexible pay premia offered for hard-to-recruit specialities must be funded from outside the current pay envelope.
- The new contract must include a jointly owned mechanism for the management and allocation of pay premia.
- Flexible pay premia should not be used as a mechanism to subsidise the shortcomings of NHSE's proposed salary structure for doctors working the most onerous shifts.

Fees

Junior doctors must be permitted to retain fees for any category 2 work completed.

Annual pay uplifts

The new contract must include a mechanism for annual cost of living uplifts to pay.

Non-resident on-call duty

Payment for non-resident on-call duty must recognise the commitment a trainee has to make to be available to work at very short notice for an extended period, compared with regular shift lengths. Trainees who are required to work non-resident on-call rota patterns should receive a supplement of 20% for frequencies greater than one in four days, 10 per cent for frequencies between one in four and one in eight days, and five per cent for frequencies less than one in eight days.

GP trainees

Both BMA and NHSE/DH proposals on pay must ensure pay parity between hospital and GP trainees. The work schedule for a trainee on a general practice training programme who is working in a practice setting should reflect the sessional split recommended in the 2012 document issued by the Committee of GP Education Directors (COGPED), *Guidance to a session for GP trainees and trainers*, as updated from time to time, or that in any successor document.

This sessional split should only apply to the basic (40 hour) week; any additional hours included in the work schedule should only include delivery of GP-led services and be set out according to the work and/or training required.

GP trainees are supernumerary in general practice and when undertaking out of hours work as part of their training. Work done as part of training outside of normal working hours, as set by the Royal College of General Practitioners (RCGP), should be incorporated into the work schedule. Trainees should receive adequate rest and breaks for shifts in line with contractual requirements. Where GP trainees carry out work outside of their contracted hours they will receive appropriate rest and/or financial compensation.

APPENDIX ONE

Education group, agreed summary of discussions as at 21/12/2015

The group of the BMA, NHSE and HEE agreed a summary of discussions over its meetings in December 2015. While talks have been constructive, there has as yet been no agreement by NHSE on what aspects could be contractualised.

Work schedules and educational safeguards/exception reporting

- We support a work scheduling process as a way of defining training opportunities as part of the duties of a post.
- This system will protect time for training.
- For missed educational opportunities, we support internal and external escalation mechanisms for 'exceptions' as appropriate.
- There should be prioritisation of exception report types. This would reflect their seriousness, impact, and frequency. This would involve variable flexible trigger points for escalation.
- There should be set timeframes for action following reports.
- As part of the determination of appropriate timescales, reports of important missed opportunities should be dealt with quickly, with an underlying principle that all issues should be addressed in a sufficiently timely manner that they can be resolved while the trainee is still in their post.
- This would need to be determined in advance of implementation of new contractual arrangements.
- The negotiating parties should consider the impact of schedule adjustments at the commencement of employment and upon the advance notice of salary before commencement, as well as on the schedules and salaries of fellow junior doctors.

Lead employers

- We agree this model has value when implemented well and relationships between organisations involved work effectively.
- Benefits of lead employer arrangements include: improving accuracy of pay; avoiding emergency tax codes; minimising repeated mandatory and statutory training; avoiding repeated employment checks; maintaining statutory continuity of service; enabling salary sacrifice to smooth junior doctors' educational costs across months or years of their programme; aligning trainees to an employer and instilling a stronger sense of identity.
- The underlying principles of simplicity and avoidance of duplication in employment matters are positive and, where lead employer arrangements are not in place, we would seek to apply these principles through alternative models, such as streamlining.
- Speciality-specific lead employers are an alternative option.
- Shared inductions and streamlining are positive initiatives and should be extended, irrespective of employment model.

Continuity of service

- We envisage no educational barrier to contractual arrangements for maintaining continuity of NHS service during out-of-programme activities.

Access to flexible training

- We will work to identify and remove educational barriers to and constraints upon access to flexible training, liaising with others including the GMC.
- We are committed to continuing work to overcome cultural barriers to flexible training.
- We will convene a group to take these issues forward. We commit that this will begin its work and report on progress by the end of February 2016.

Period of grace

- HEE will implement whatever arrangements are contractualised for a period of grace.

Workplace facilities
- We would find it helpful to have a clear national framework for educational facilities provision and their local delivery.
- If the contractual framework provides for other facilities beyond educational, HEE would find this useful.
- Educational exception reporting should also cover issues with educational facilities.

GP training
- We appreciate the rationale for needing a section of the contract about GP training.
- The content of this section would need to be agreed in the negotiating group.

Study leave
- Study leave should be incorporated into the work schedule, pre-planned and approved with variation based on junior doctors' educational, development and progression needs.
- In order to guide juniors and their educational supervisors, and mitigate the potential impact on other juniors, a standardisation mechanism such as an indicative numerical element should remain.
- The indicative element could be based on existing study leave entitlements.
- Study leave for flexible trainees should not be defined on a strictly pro rata basis, but should instead reflect their needs.
- The work schedule will also include employer mandatory and statutory training, which should not count as study leave.
- The notion of individual study budgets reflects the historic structure of employment as a junior doctor. We agree that leave and resources to support educational activities should be part of a managed educational programme and facilitate rolling of leave between posts and years.

Training costs
- We agree that there are genuine concerns about different provision across the country, including rising costs, inappropriate top-slicing, and a postcode lottery in available support.
- Greater centralisation of training provision and bulk purchasing would help address this.
- Where 'top-slicing' arrangements are used, they should be used to extend the provision available rather than reduce the total spend on training. They should also maximise availability of funding for expenses, travel, subsistence, and other costs of attending training courses.
- Salary sacrifice may provide employers with an efficient way of significantly helping junior doctors with their costs of training.
- We commit to taking forward discussion about the burden of large fixed training costs such as examination fees.
- This discussion will cover the appropriate use, structure, and extent of study leave budgets and their incorporation in work schedules.
- This would need to be determined in advance of implementation of new contractual arrangements. We will convene a group to take these issues forward.

Expenses
- We agree the importance of establishing minimum standards, allowing for geographic variations.
- We should broaden consideration of travel expenses beyond the current system of relocation and mileage, taking account of time and method of travel.
- One helpful way of achieving this would be to create a national framework allowing for local implementation, based on key underlying principles including ensuring safety.
- Local variation could take into account relevant aspects of individual work schedules.

Notice of leave
- Contractualising a reciprocal notice period would need to be agreed in the negotiations, and HEE will deliver on the outcomes of the contract.
- A key enabling factor is the notice of deployment; see topic below.

Provision of information

Code of practice

- We jointly commit to the current code of practice, and to improving and delivering on it as outlined below. We recognise that exceptional late-notice changes will always remain (e.g. as a consequence of ARCP), but should not prevent delivery of the commitment for the vast majority of junior doctors.
- HEE will make delivering this a performance metric. This means they will review performance against this on a monthly basis, and publish outcomes.
- The code of practice should be revised to accommodate the work schedule system and reflect the updated timeframes and notification arrangements.
- We will establish a joint mechanism to facilitate ongoing educational improvements.

Notice of deployment

- We agree an aim of achieving notice to employers of 12 weeks for at least 90 per cent of trainees by August 2016, and expect to achieve this by October 2016. This should facilitate the removal of fixed leave.
- HEE commit to this and will use their performance management systems to monitor it. This will improve the current expectation of eight to 12 weeks' notice.

Information for trainees

- Employers commit to providing roster information to trainees eight weeks in advance of starting a post. This should facilitate the removal of fixed leave.
- We support a standardised letter, with improved methods of pre-population to enable the deadline to be met.