Junior doctors' handbook on the 2016 contract

A guide to the new 2016 terms and conditions of service for doctors and dentists in training in England

September 2016
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1. Introduction

The Junior doctors’ handbook on the 2016 contract
This handbook is your guide to the main contractual issues that may arise in junior hospital doctors’ employment and on which you may need to seek advice. The guidance in this handbook covers junior doctors working under the new 2016 terms and conditions of service that became effective from 3 August 2016. During the transition period, many junior doctors will continue to work under the previous 2002 terms and conditions of service, so this handbook will not apply to them and they should continue to refer to the 2015 handbook. The 2016 contract only applies to junior doctors working in England, so similarly any junior doctors working in Scotland, Wales or Northern Ireland should continue to refer to the 2015 handbook.

The handbook has been produced to provide information to help junior doctors understand their terms and conditions of service and matters arising in the course of their employment. Every effort was made to check accuracy at the time of publication but there may have been later changes. Members should also check the BMA website for updates since the time of publication.

BMA members may seek advice on specific problems relating to the terms of their employment by contacting our team of advisers on 0300 123 1233 or support@bma.org.uk

The Association is happy to receive any comments on the handbook, or any suggestions on how to improve the services provided for junior doctor members. Comments should be sent to the junior doctors committee at info.jdc@bma.org.uk

The handbook can also be found on the BMA website:

September 2016
2. Training appointments and educational approval

**Summary**

This chapter covers the key approvals required before a post can be recognised for training. It explains which organisations hold responsibility for approving training programmes and posts, as well as the types of posts that may not count towards a CCT.

All training posts must have educational and dean’s approval and this should be clearly stated in advertisements. Junior doctors should be aware that non-approved or non-standard posts will not count towards a CCT (certificate of completion of training). Junior doctors who have any concerns about a post should always seek advice from their postgraduate dean. All specialty training and fixed-term training appointments must adhere to national person specifications, which are available on the Health Education England website (http://specialtytraining.hee.nhs.uk/).

NHS training posts must be of an acceptable standard and accord with NHS workforce agreements. The following key features must apply to all training posts:

- A post or programme must have educational approval and approval by the postgraduate dean or it cannot be designated a training post or programme.
- A post not in a recognised NHS training grade (e.g., ST level Trust post/clinical fellow) cannot be regarded as a recognised training placement or programme. So you cannot assume that experience in such non-training posts will count towards the completion of specialty or general practice training.
- Placements or programmes in NHS training grades for doctors and dentists can only be advertised if they have the valid educational and dean’s approval.
- All recruitment procedures should comply with equality and diversity policies.

Employers must seek permission from the postgraduate dean whenever it is proposed to advertise a training placement or programme. Before the advertisement can appear, the postgraduate dean must confirm that:

- There is valid educational approval.
- There is current postgraduate dean’s approval.

The following two elements must be met for a post to obtain the postgraduate dean’s approval:

- Posts must meet agreed standards on training, supervision, contractual terms, compliance with **contractual working hour limits**, accommodation and catering, and local human resources strategy.
- Where there is a national or specialty-specific target for the number of doctors or dentists to be trained, the dean’s approval must not be granted to placements that may cause these targets to be breached.

**GMC (General Medical Council) approval of experience**

If a doctor has been in an educationally approved post in the UK (e.g., LAT or FTSTA) they can enter specialty training at an appropriate point above ST1 and proceed to a CCT (certificate of completion of training). The national person specifications outline the experience requirements for each level. If their posts have offered experience but have not been educationally approved, they can still enter beyond ST1, but will need to join the Specialist Register by the Article 14 (CESR (Certificate of Eligibility for Specialist Registration)) route.

**Prospective approval of posts**

The GMC does not retrospectively approve non-training posts for doctors hoping to gain a CCT. As stated above, posts that have offered experience but have not been educationally approved can be used to further training, but will require the doctor to join the Specialist Register by the Article 14 (CESR) route. However, doctors may gain prospective approval of research or overseas posts, which will then count towards a CCT. This approval must be agreed by the GMC and the dean in advance. See [http://www.gmc-uk.org/education/approval_post_and_programme.asp](http://www.gmc-uk.org/education/approval_post_and_programme.asp)

For further information on OOP (Out of Programme Experience) see chapter 2. Educational and training approval from the GMC is also needed for those placements not funded by the postgraduate dean but by other bodies, e.g., universities, charitable institutions, or research bodies, non-NHS providers etc.

**Honorary appointments**

An honorary appointment gives a doctor formal status at an employer. It does not provide a salary or require formal work but can open opportunities to undertake paid work and access appropriate expenses. Employers offering honorary NHS

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Please note — at the time of printing, in England, specialty-level LATs or FTSTAs are in the process of being phased out.
appointments to doctors wishing to gain experience in order to pursue clinical specialist training must obtain the dean’s approval before the placement is advertised or the appointment confirmed.

**LASs (Locum Appointments for Service)**
Locum doctors and dentists should not be appointed to training grades where there is no substantive placement to be covered. Locum appointments (apart from Locum Appointments for Training – LATs) will not normally be recognised for training purposes. Applicants should be told before appointment that, although the substantive placement may attract the relevant approvals, a locum appointment should not be assumed to count towards a CCT. Advice about prospective approval of training for locum hospital placements should be sought from the GMC and the postgraduate dean.

**Non-standard grades**
Employers have agreed with the BMA that non-standard titles can be misleading and that they should not use them. Substantive standard training grade titles used in the terms and conditions of service for junior doctors that are open for appointment include: ST1 (specialty registrar), dental core trainee, F1 (foundation doctor year 1), F2 (foundation doctor year 2).

If you are applying for a non-standard grade it is important that you read the terms of the recruitment advertisement carefully and check whether the post you are considering applying for has educational approval.

**Responsibility for educational approval**

**F1 grade**
The learning objectives for this year are set by the GMC. In order to attain full registration with the GMC, doctors must achieve specific competences by the end of this year. The postgraduate dean normally undertakes responsibility for approving trainees’ competences.

**F2 grade, specialty training grades and fixed term specialty training appointments**
The GMC is required to recognise and approve placements and programmes for the foundation programme and for all specialty training leading to the award of a CCT. The GMC will take advice from the relevant medical royal college or faculty, which approves placements on its behalf. However, not all placements/programmes confirmed by the dean as having educational and postgraduate dean’s approval automatically lead to the award of a CCT, e.g., Locum Appointments for Training and Str(core training). For detailed information on specialty training please read *A guide to postgraduate training in the UK* also known as the *Gold Guide* – this is available for all years at [http://specialtytraining.hee.nhs.uk/the-gold-guide/](http://specialtytraining.hee.nhs.uk/the-gold-guide/)

**SpR (specialist registrar) grade**
Even though this grade is closed to new entrants, some trainees continue on SpR contracts. These are educationally approved in the same way as the specialty training grades. For detailed information on SpR training please read *A guide to specialist registrar training; NHS Executive 1998*, also known as the *Orange Guide* – [http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publications/policyandguidance/DH_4006614](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publications/policyandguidance/DH_4006614)

**Further information**
*Rough guide to the foundation programme*
[www.foundationprogramme.nhs.uk/pages/home/keydocs](http://www.foundationprogramme.nhs.uk/pages/home/keydocs)
*Foundation programme reference guide*
[www.foundationprogramme.nhs.uk/pages/home/keydocs](http://www.foundationprogramme.nhs.uk/pages/home/keydocs)

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2 Please note – at the time of writing, in England, specialty-level LATs are in the process of being phased out.
3. Learning and development

Summary
This chapter provides information on learning and development support, tips on choosing a specialty and career progression. Making a choice of which career path to pursue requires considerable thought. Personal choice needs to be aligned with aptitude, strengths and interests, as well as the extent of competition for, and the availability of, opportunities.

The BMA is committed to supporting doctors throughout their careers and provides a wide range of specialist non-clinical learning and development services. We recognise the importance of continued non-clinical training in helping doctors to advance their careers and to help with demonstrating further valuable learning for appraisal and revalidation.

As a BMA member, your access to these services currently ranges from free medical careers information and online guidance available 24/7, through to discounted career development workshops, free webinars and e-learning modules. This includes in person and online training, medical careers information, top tips and guides on how to choose a specialty, training recruitment processes and timelines, job vacancies and links to other careers sites.

Open career development workshops
These interactive workshops focus on issues specific to you as a junior doctor and are designed to give you the support and guidance you need to develop your true career potential.

Topics include:
- time management
- interview skills and CV review
- presenting skills for clinicians
- negotiating and influencing
- management essentials and many more.

Workshops are delivered by highly-qualified medical careers consultants and provide you with the extra skills you need to prepare you for a successful career in medicine. Visit the BMA website to view information about each programme.

Career development webinars
We deliver a range of webinars that provide real-time teaching delivered live to your computer from a careers expert on topics which are aligned to your training, such as:
- Assertiveness in the workplace
- Making the most of your appraisal
- Options for taking a year out
- Networking for professional development
- Preparing for your specialty application.

We recognise that while in person teaching is ideal, work and other commitments don't always allow for this. Webinars provide a flexible learning approach to careers development, no matter where you are or when you decide to watch.

e-learning module resources for junior doctors
The BMA in partnership with BMJ Learning have developed a series of non-clinical e-learning modules that offer insightful, practical guidance that puts you in control of your career. Unlike some other career resources, these e-learning modules see things from your perspective.

Modules in the series include:
- Maximising your portfolio
- Time Management for foundation doctors
- Effective handover for foundation doctors
- Building professional relationships
- Getting and giving useful feedback
- How to be successful with your application for specialty training
- How to take a career break and have a successful return to work.

Access these exclusive and valuable modules at learning.bmj.com/BMA
Free Sci59 online psychometric test
The BMA works in association with CenMEDIC provides members with free access to the Sci59 online psychometric test which is designed to provide a list of medical career choices that are impartial and based only on your personal characteristics. The output of Sci59 provides a rational view of the specialties that match your needs.

The questionnaire takes around 25 minutes to complete and feedback is almost instantaneous. Remember, the result acts as a guide for your consideration – it is not a replacement of formal career guidance.

To access the site or for further information please visit 
bma.org.uk/psychometric

One-to-one careers coaching
Individual career advice is available through a confidential one-to-one coaching service. Designed to meet your specific needs and provide practical solutions to complex career issues and challenges, impartial, independent advisers will provide expert, in-depth analysis at significantly discounted rates to BMA members. For further information please visit 
bma.org.uk/careercoaching

More career progression benefits from the BMA
BMA members are entitled to a wide range of benefits from the BMJ. Make sure you support your continued non-clinical learning and career progression needs with:
- free access to BMJ Learning an extensive range of CPD and postgraduate training modules
- discounted BMJ Masterclasses specialist one-day courses to keep you up to date with the latest evidence, new guidelines and best practice
- BMJ Portfolio to evidence your CPD
- free access to BMJ Careers, the UK’s leading resource of medical jobs
- free weekly print editions of The BMJ
- free online access at thebmj.com; and
- discounted subscriptions to Journals from BMJ (Excluding: BMJ Case Reports, Drug and Therapeutics Bulletin, Veterinary Record and In Practice).
4. Recruitment to specialty training – advice for applicants

**Summary**
Applications for specialty training are made to lead deaneries, LETBs or Royal Colleges. The specialty training website gives detail on person specifications and application processes.

All applications to specialty training programmes are managed through the online application portal 'Oriel': [www.oriel.nhs.uk](http://www.oriel.nhs.uk)

Recruitment is either organised locally by the deanery for a specific region or nation, or for some specialties recruitment is coordinated on a UK-wide basis and led by a specific deanery or royal college.

You should first check the relevant college, LETB or deanery website for information about training programmes and application processes. You should also ensure that you meet the criteria listed in the person specification for the training programme to which you will be applying.

You can apply to training programmes during the vacancy window by searching for vacancies on the relevant college, LETB or deanery website, NHS jobs online or on the Oriel website. You will be shortlisted for interview against the criteria listed in the person specification.

HEE (Health Education England) has produced guidance for applicants that includes dates of vacancy windows and its website also links to specific programme descriptors and competition ratios for each specialty.

Applications to the Foundation Programme also use the Oriel system.

If you are in doubt, please check the oriel website or the specialty training website ([http://specialtytraining.hee.nhs.uk/](http://specialtytraining.hee.nhs.uk/)) for up to date information on applying to specialty training programmes.

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**Further information**
Frequently asked questions on the BMA website [bma.org.uk/developing-your-career/specialty-training/applying-for-a-specialty-training-post](http://bma.org.uk/developing-your-career/specialty-training/applying-for-a-specialty-training-post)
Oriel [www.oriel.nhs.uk](http://www.oriel.nhs.uk)
HEE specialty training [www.specialtytraining.hee.nhs.uk](http://www.specialtytraining.hee.nhs.uk)
NHS Jobs [www.jobs.nhs.uk](http://www.jobs.nhs.uk)
UKFPO for Foundation Training [www.foundationprogramme.nhs.uk/pages/home](http://www.foundationprogramme.nhs.uk/pages/home)

**Recruitment to general practice**
The National Recruitment Office coordinates recruitment to general practice. More information is available on the National Recruitment Office website at [https://gprecruitment.hee.nhs.uk/](https://gprecruitment.hee.nhs.uk/)

**Code of Practice: Provision of information for postgraduate medical training**
The Code of Practice has been adopted across the UK. The Code lays out the agreed set of information that recruiting organisations and employers should provide to doctors in training at each stage of the recruitment process, including the first post and subsequent rotations. Under the Code, employers should share the following information well in advance:

- Contact details
- Location of work
- Hours and out-of-hours rota
- Basic pay and any supplementary pay
- Pension arrangements
- Leave rules and entitlement

Many junior doctors are still not receiving sufficient notice and in these cases you should first contact your prospective employer or recruiting organisation to address the problem. If this does not resolve the issue then contact the BMA. The BMA is also working to improve the content of the Code and its implementation at a national level.

More information about the Code - including timescales, links to the national versions, and updates as they occur - is

Recruitment to an Academic Clinical Fellowship/Clinical Lectureships
An overview of the academic training programmes across the UK, including links for further information, is available on the BMA website bma.org.uk/developing-your-career/specialty-training/academic-training

Top tips on applying for a specialty training post

- Read the programme descriptors carefully.
- Read the person specifications to ensure your skill set matches with the role you are applying for.
- Check you know which level you should apply for.
- Check the competition ratios for each specialty.
- Check you can back up your experience with sufficient evidence.
- Find out if your specialty is recruiting through either:
  - locally led by your deanery
  - coordinated on a UK-wide basis led by a deanery or royal college.
- Check the application deadlines (late applications will not be accepted under any circumstances).
- Find out if you have to submit an application online and how long this will take you.
- Start planning your applications early and download the application form and ensure you have all the information you need.
- Read the Specialty Recruitment Applicant Handbook on the specialty training website www.specialtytraining.hee.nhs.uk for help and advice on how to best present your skill set and experience in your application. For other nations, please check the relevant websites for further information.
5. Contracts of employment

Summary
This chapter covers model contracts of employment, individual contracts of employment, job descriptions and notice periods. It explains the different types of employer and provides some information on the circumstances where local variations can be made to national terms and conditions of service. It also includes a brief summary of the F1 shadowing period.

Each time you rotate to a new employer you should receive a contract. The only exception to this is if you are employed by a lead employer organisation, which holds all the contracts. If you have a lead employer this normally means you will have just one employer while rotating within that deanery/LETB area.

Within two months of starting with a new employer you should receive a written statement of particulars of employment. This will normally be a contract of employment and a job description. Further information is available in the Code of practice: Provision of Information for Postgraduate Training https://www.bma.org.uk/advice/employment/contracts/juniors-contracts/accepting-jobs/code-of-practice

If you haven’t received this contractual information contact our team of advisers on 0300 123 1233.

Once you have received your contractual information get it checked by the BMA before you sign, either by submitting an online form or use our FREEPOST: bma.org.uk/practical-support-at-work/contracts/contract-checking-service

Background to the 2016 contract
In 2012, the government asked the BMA to look into negotiating a new contract for junior doctors. Since then, periods of negotiation have taken place, culminating in agreement on a new contract in May 2016 by BMA negotiators. However this agreement was subject to acceptance by BMA members in a vote, and in a referendum of junior doctor members in England (and final and penultimate year medical students) the proposed contract was rejected by the majority of voters. The government proceeded to introduce the contract that was agreed upon in May, and it became effective on 3 August 2016.

There are a number of arrangements in place to transition existing junior doctors onto the new terms - this is a complex process. Chapter 11 outlines transitional pay protection arrangements, but there are a number of ways that exceptions to the new contract rules outlined in this handbook may be made for juniors transitioning from the old terms to the new, so you are advised to check with BMA employment advisors for individual advice and check the FAQs on our website:

bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations/new-contract-faqs

As at September 2016, the contract had still not yet been accepted by junior doctors. You are advised to check our website for the latest updates if anything relating to the content or implementation arrangements for the new contract have changed.

Further information

Model contracts of employment
One model contract is designed to be applicable to all junior doctors in the training grades in England. This is reproduced at Appendix I of this handbook. Doctors who carry out academic work should also refer to the medical academics section, chapter 23, for information on medical academic employment contracts. The model contract covers the specific terms of each employment contract and is subject to the TCS (Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016). Appendix II has an additional model contract, to be used for junior doctors who are transitioning from being employed under the 2002 terms and conditions of service to the new 2016 contract, who are eligible for transitional pay protection.

Individual contracts of employment
A contract of employment is an important legal document. Once signed, the contents are binding and it may be impossible to make changes. Contracts should follow the national models but some employers include clauses that
differ from those national agreements. These should be no less favourable than the model contract. If you are concerned that your contract falls below the minimum terms and conditions set out in the model, contact the BMA for advice.

**Honorary contracts**

An honorary contract is distinct from a substantive contract of employment. It gives a doctor formal status with an employer and can open opportunities to undertake paid work and access appropriate expenses, but does not provide a salary or regular employment. An honorary contract with an NHS employer might be held by a doctor who works primarily in an academic institution but remains clinically active. An honorary contract with an academic employer might be held by a doctor who works primarily within the NHS but who also undertakes academic research. This chapter discusses substantive contracts.

We offer members a free contract checking service and the JDC urges that junior doctors who are BMA members seek this professional advice from our team of advisers before signing a contract. Getting your contract checked can save you having to deal with problems in the future. If a contract does not conform to the national model, juniors should give written notice to the employer that they do not accept a non-standard contract and should not sign it without first seeking advice. You can call our team of advisers on 0300 123 1233 or go to our website for more information: bma.org.uk/practical-support-at-work/contracts/contract-checking-service

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**Further information**

BMA website: bma.org.uk/practical-support-at-work/contracts/juniors-contracts

Model contract: www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract/information-for-employers

**Job descriptions**

A job description should accompany the contract and forms part of the contractual relationship between the junior doctor and the employer. Ideally, the doctor should be given a copy of the job description on application for the post. The job description should provide an accurate picture of the post and define the hours (including details of the rota) and duties of the job. The JDC recommends that the rota, in particular, is provided by the employer a minimum of six weeks before the doctor is due to begin a placement.

Alterations to the job description should be by mutual agreement. Contact our team of advisers on 0300 123 1233 before signing, if in any doubt.

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**Further information**

BMA website: bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accepting-jobs/code-of-practice

**Notice periods**

The following minimum periods of notice should apply, (schedule 10 paragraph 5, Terms and Conditions of Service) unless there is an agreement between both parties that a different period should apply:

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<thead>
<tr>
<th>Category</th>
<th>Period</th>
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<tbody>
<tr>
<td>F1</td>
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<td>F2</td>
<td>1 month</td>
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<tr>
<td>Specialty registrar (fixed term)</td>
<td>1 month</td>
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<tr>
<td>Specialty registrar (core training)</td>
<td>1 month</td>
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<tr>
<td>GP specialty trainee</td>
<td>3 months</td>
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<tr>
<td>Specialty registrar (run through)</td>
<td>3 months</td>
</tr>
<tr>
<td>Specialty registrar (higher specialty training)</td>
<td>3 months</td>
</tr>
<tr>
<td>Specialist registrar</td>
<td>3 months</td>
</tr>
</tbody>
</table>

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**Employment documentation**

It is worth remembering to obtain the relevant documentation when starting work with a new employer. A staff transfer form, a P45, a GMC annual registration certificate, a recent payslip and proof of hepatitis B status would all, if readily available, help facilitate a smooth start in your early days in a new job.

A checklist is available on the BMA website covering all of the above, which serves as a useful reminder when rotating.
Junior doctors’ employers

Junior doctors’ contracts are made with and held by individual NHS employers, such as Trusts. This means that employers are distinct from the organisations ultimately responsible for junior doctors’ educational provision. Chapter 2 discusses how these bodies exercise their duties to ensure the educational value of training posts.

Foundation programme employers

The JDC recommends that doctors in the foundation programme are employed by one employer acting as a ‘host employer’ during the two-year programme. The host employer would usually be the employer where a trainee is based for the majority of their programme. The host employer would then second the foundation trainee to any other employers that form part of the programme. Even where this arrangement does not exist, foundation trainees will need to be seconded from their last employer to a GP practice when undertaking a GP placement.

Lead employers

It is open to employers to join together to agree an arrangement whereby one employer administers contracts on behalf of a group of employers. In such cases the ‘lead’ employer may hold all contracts and second junior doctors from that employer to others. Such arrangements should assist in better planning and organisation of training rotations, and the JDC strongly approves of them. Members offered contracts in which they will be seconded from one employer to another should seek advice from our team of advisers on 0300 123 1233 before signing the contract.

Variations to national agreements on contracts and terms of service

Although employers are asked to employ junior doctors on national terms and conditions of service, they have some flexibility to introduce variations to the national model contracts for specialist and specialty registrars. However, this flexibility should be only at the margins of terms and conditions of service, and usually involve additions or modifications to enhance rather than reduce existing rights. It is intended that juniors should hold a uniform contract throughout a rotational training programme, with only the employer’s identity changing as they move between posts in the rotation.

Any local variations to national agreements on contracts and terms of service must meet the following important conditions:

- they have been negotiated with local junior doctors’ representatives, and through the LNC (Local Negotiating Committee);*
- the postgraduate dean is satisfied that they will not adversely affect quality of training; and
- they are agreed by all the employers in the rotational training programme.

*For more information on LNCs, including how you can become involved, see the BMA website bma.org.uk/lnc

It is essential that junior doctors’ representatives are involved at all stages in any negotiations aimed at seeking variations to national agreements and that the above safeguards are met. Generally, discussions will be held at deanery level and proposals will need to be endorsed by each employer and its LNC. It is therefore crucial that the LNC has a junior doctor representative who is able to attend meetings.

Regional JDCs may have appointed negotiators who are taking the lead in any discussions at deanery level. Junior doctors should seek advice from our team of advisers on 0300 123 1233 if they are aware that changes are being considered without any junior doctor input.

Vacant posts

The terms of any job description can be reviewed in light of the level of service required where posts fall vacant. Proper consultation must, however, take place and the employer is required to consult those most closely involved with the posts, including the consultants and other junior doctors on the shift/rota and, so far as possible, the previous incumbent. Any changes can only be made as a result of these consultations, but the new incumbent may seek an immediate review if the revised allocation of duties is unrealistic. You can seek advice from our team of advisers on 0300 123 1233.
**F1 shadowing**

Shadowing is an arrangement where a prospective doctor observes an existing F1 (foundation doctor) undertaking the usual activities required of their role before taking over the role themselves. It helps forthcoming F1 doctors become more familiar with working practices and hospital systems, gain confidence and professional skills and helps to improve patient care. It can also provide an opportunity to develop working relationships with the clinical and educational supervisors they may work with in the future.

All new F1s across the UK should receive at least four days paid shadowing at the basic F1 salary rate (£26,614 annually) pro rata to the hours undertaken. The BMA believes that this should be calculated on the basis that the hours undertaken in a four day shadowing period (32 hours) are four fifths of the full hours (40 hours) for which an F1 doctor is paid in a week. If your new employer says they will not be paying you for shadowing, or if it is not calculated at this rate, please call the BMA on 0300 123 1233 or email support@bma.org.uk.

There are no nationally agreed contractual arrangements in England for F1s undertaking paid shadowing placements. JDC believes that the best approach is for a full employment contract to be used as this allows new F1s to engage fully in clinical activity whilst shadowing.

The new 2016 terms and conditions of service include a clause stating that the terms should not be used for the period of shadowing and that separate arrangements should be made (introduction, paragraph 3). A copy of the 2016 TCS with this clause removed can be used for this purpose for the F1 shadowing period.

Comprehensive information on shadowing is available on the BMA website.

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**Further information**


HEE guidance [https://www.nwpgmd.nhs.uk/sites/default/files/HEE20Shadowing20Guidance202014_0.pdf](https://www.nwpgmd.nhs.uk/sites/default/files/HEE20Shadowing20Guidance202014_0.pdf)

6. Salaries

Summary
This chapter provides information on salaries for junior doctors including information on: salary scales, the importance of checking payslips, starting salaries, incremental dates, counting of previous service and additional payments such as London weighting and private fees.

Junior doctors are paid on national pay scales which are set each year. The DDRB (Doctors and Dentists Review Body) receives evidence from the BMA, the UK Health Departments and NHS Employers. The DDRB then reports to the Secretary of State for Health and to the equivalent for Scotland, Wales and Northern Ireland with their recommendations on how to set the pay scales for the year. The report is later made public, with each government making the final decision on whether to implement it in each of the four nations. Any change is usually effective from 1 April each year.

If an announcement is made after the 1 April then any increase will be backdated to that date. The DDRB may recommend an increase to the pay scales but it may also recommend that pay should remain the same. Each of the health departments then has the ability to accept the recommendations of the DDRB or, as is sometimes the case, reduce what is recommended due to the availability of funding.

Further information

Check your payslip
You should always check your payslip when you change post, or change employer, as this is when most errors tend to occur. The key things to look for on your payslip are basic salary, superannuation, NI (National Insurance) number and your tax code. Your salary may change for a number of reasons:

Pay supplements – Your pay supplements remunerate you for additional work you undertake over your basic hours, on-call availability, weekend working and for antisocial hours such as night shifts, or a flexible pay premium where applicable. See below for further detail on these. They are also detailed fully in schedule 2 of the terms and conditions of service.

DDRB award – Each year the DDRB considers evidence from the BMA, the UK Health Departments and the employers, and then issues a report outlining its recommended pay award for the next 12 months. Although the DDRB report is published in the spring it takes time for new pay scales to be issued. Assuming there is a pay award for that year then you normally will not see it in your payslip until May. You will normally receive pay on the new scale one month, followed by arrears of pay for preceding months back to April in the following month. It cannot be guaranteed that the DDRB will recommend a pay increase every year but on those years that an increase in basic pay is recommended make sure you check your payslip carefully.

Other deductions – The main deductions are income tax and National Insurance contributions, as explained above, as well as student loan and pension contributions. However you may also have other deductions on your payslip – eg for a car parking permit, or childcare vouchers. These deductions can only be made by your employer with your consent. You should raise any queries regarding these direct with your employer (normally the payroll department).

There is detailed guidance on the BMA website which can help you check your payslip and details how pay changes and what to look out for, particularly when changing post: bma.org.uk/practical-support-at-work/contracts/juniors-contracts

Further information
BMA website bma.org.uk/practical-support-at-work/pay-fees-allowances/juniors-payslip-explained
Terms and conditions, schedule 2 paragraphs 4-17

Pay supplements
Under the 2016 terms and conditions of service pay is made up a number of elements. Basic pay, with values as set out in the pay circular, is for the average 40 hour working week (for full time trainees).
The pay scale is comprised of four nodal points, linked to the stage of training the junior doctor is working at, they are:
- FY1 - Nodal point 1
- FY2 - Nodal point 2
- CT1-2/ST1-2 - Nodal point 3
- CT3/ST3-8 - Nodal point 4

**Additional hours**

You can have up to 8 additional hours of work rostered into your work schedule, and these are paid in addition to the basic salary, at a rate of 1/40th of weekly whole-time equivalent for each additional hour worked.

**Weekend allowance**

The way weekends are paid is that instead of having certain time periods defined as meriting a pay enhancement, such as 'plain' versus 'premium' time, instead the pay for work done at the weekend is determined by the number of weekends that doctor has to work. As such there are two definitions of 'weekend', one for the purposes of pay and one for the purposes of working hour limits.

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

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 weekend in 2</td>
<td>10%</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 1 and greater or equal to 1 weekend in 4</td>
<td>7.5%</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 4 and greater or equal to 1 weekend in 5</td>
<td>6%</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 5 and greater or equal to 1 weekend in 7</td>
<td>4%</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 7 and greater or equal to 1 weekend in 8</td>
<td>3%</td>
</tr>
<tr>
<td>Less frequently than 1 weekend in 8</td>
<td>No allowance</td>
</tr>
</tbody>
</table>

A doctor working less than full time will also be entitled to be paid this allowance when working on a rota where the doctors working full time on that same rota are in receipt of such an allowance. The allowance paid to the doctor working less than full time will be paid pro rata, based on the proportion of the full time commitment to the weekend rota that has been agreed in the doctor’s work schedule. For example, a doctor making a 50 per cent contribution to the rota would be paid 50 per cent of the value of the availability allowance paid to a doctor making a full contribution to the rota.

**On-call availability allowance**

A doctor on an on-call rota who is required by the employer to be available to return to work or to give advice by telephone, but who is not normally expected to be working on site for the whole period, shall be paid an on-call availability allowance. The value of the allowance is 8% of full-time basic salary for the relevant grade, and will take the form of a cash sum that is paid for all on-call duty periods in the doctor’s work schedule.

Resident on-call is not generally a feature of the 2016 terms and conditions of service, and the definition of ‘on-call’ is restricted to non-resident on-call, not including more informal use of the term such as ‘holding the on-call bleep’ while working a normal shift at your place of work. All full shift work must be paid properly, and the availability allowance is only to be used to pay doctors for period of duty when they are not required to be at the workplace but can be called on to come to work or provide advice over the telephone.

For doctors employed on a less-than-full-time basis, in any grade, the value of the on-call availability allowance shall be paid pro rata, based on the proportion of full-time commitment to the rota that has been agreed in the doctor’s work schedule. For example, a doctor making a 50 per cent contribution to the rota would be paid 50 per cent of the value of the availability allowance paid to a doctor making a full contribution to the rota.
Payment for work undertaken whilst on-call
Doctors shall be paid for their average hours of work done while on-call, in addition to the 8% availability allowance for the whole duty.

The hours paid will be calculated prospectively across the rota cycle and the estimated average hours at each rate of pay will be set out in the work schedule. For the purposes of pay, these total estimates shall be converted into equal weekly amounts by dividing the total number of prospective hours at each rate by the number of weeks in the rota cycle.

The weekly amount will then be turned into an annual figure and the doctor shall be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked. If, across the rota cycle, the doctor works a greater number of hours than the prospective average estimate, the individual doctor will be paid in addition for these hours.

Hours that attract a pay enhancement
An enhancement of 37% of the hourly basic pay rate shall be paid on any hours worked between 21.00 and 07.00, on any day of the week.

Where a shift is worked which begins no earlier than 20.00 and no later than 23.59, and is at least 8 hours in duration, an enhancement of 37% of the hourly basic rate shall also be payable on all hours worked up to 10:00 on any day of the week.

This is in order to ensure that shifts which are ostensibly ‘night shifts’, are paid at the enhanced rate in full. Whereas any individual hours worked during the night period, as part of a shift which started earlier, receive the enhanced rate as well. Employers should not start night shifts slightly earlier, for example at 19:30, in order to avoid paying the enhanced rate for the whole shift. The contract explicitly refers (schedule 3 paragraph 6) to the need to ensure shifts with hours worked during the night period are rostered in the correct way - check the BMA’s rota design guidance, available online, if you need help with this.

The number of hours in the rota for which an enhancement is paid will be assessed across the length of the rota cycle (as set out in the work schedule), and converted into equal weekly amounts by dividing the total number of hours to be paid at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure and the doctor will be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked.

Flexible pay premia
These are annual pay supplements of varying amounts that are awarded to certain types of trainee. This can be for various reasons, for example to address current recruitment shortages in a particular specialty by making the specialty more financially attractive, or to address a pay disparity between one specialty and others. These are set out in Annex A of the 2016 terms and conditions of service, and they will be published annually with pay circulars to take into account any changes in recruitment levels, for example.

<table>
<thead>
<tr>
<th>Name of premia</th>
<th>Applicable training programme</th>
<th>Eligibility</th>
<th>Full time annual value</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice premium</td>
<td>General practice</td>
<td>Payable to ST1, ST2, ST3, ST4 during general practice placements only</td>
<td>£8,200</td>
</tr>
<tr>
<td>Hard to fill training programme</td>
<td>Emergency medicine</td>
<td>Payable to ST4 and above only</td>
<td>Dependent on length of programme, see below</td>
</tr>
<tr>
<td></td>
<td>Psychiatry</td>
<td>Payable to all grades above foundation training</td>
<td></td>
</tr>
<tr>
<td>Dual qualification - OMFS</td>
<td>Oral and maxillofacial surgery, as per paragraphs 39-41 of Schedule 2 of the TCS</td>
<td>Payable to ST3 and above only</td>
<td></td>
</tr>
<tr>
<td>Academia</td>
<td>As per paragraphs 33-38 of Schedule 2 of the TCS</td>
<td>Upon return to training following successful completion of higher degree</td>
<td>£4,000</td>
</tr>
<tr>
<td>Length of training programme*</td>
<td>Full time annual value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 years</td>
<td>£6,667</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 years</td>
<td>£5,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 years</td>
<td>£4,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 years</td>
<td>£3,334</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 years</td>
<td>£2,858</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 years</td>
<td>£2,500</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* This is the length of the eligible training programme as specified by the curriculum, it is not the number of years that any particular trainee has remaining on their eligible training programme. For example, trainees joining an eligible training programme part way through will be entitled to the annual value according to the length of the full training programme, not the length of the training programme that they have left to complete.

It is important to note that while the GP premium is designated separately to the hard to fill training programme premia, for the purposes of the 2016 terms and conditions of service general practice is designated as a hard to fill training programme also - see below on protection of salary on changing training path.

A doctor must have a national training number to be eligible for flexible pay premia. A doctor can receive more than one flexible pay premium where the eligibility criteria for more than one premium have been met. A doctor cannot be eligible for the same flexible pay premium twice.

Flexible pay premia will be fixed at the rate applicable at the point in time at which the doctor becomes eligible, and shall continue to be paid at that same rate for the remaining period in which the doctor is working in a post as part of the training programme that attracts the premium.

Flexible pay premia are additional to basic pay, and are not included for the purpose of calculating any other allowances or enhancements. Where flexible pay premia are payable, these will be paid to less-than-full-time trainees pro rata to their agreed proportion of full-time work.

For full details of eligibility for flexible pay premia see schedule 2 paragraphs 18-44 of the 2016 terms and conditions of service.

**Protection of salary on changing training path**

Where a doctor chooses to switch directly from one training programme (other than a Foundation programme) into a hard-to-fill training programme for the purpose of obtaining approved training, and as a result their salary is lower in the new appointment, they will be eligible to receive pay protection provided they have completed 6 months or more continuous service at the level of basic pay in the previous appointment and take up their appointment on the new programme within 12 months of leaving the original programme (such a time could be extended in the event that a doctor is disabled (for the purposes of the Equality Act 2010)).

Where a doctor, for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010), or to caring responsibilities, switches from one training programme (other than a Foundation programme) into another programme, including those that are not designated as ‘hard-to-fill’, they will also be eligible for pay protection as outlined above. Please note that the six-month continuous service requirement does not apply where reasons are directly or indirectly linked to a disability (for the purposes of the Equality Act 2010).

Such doctors as outlined above, will have pay protection calculated by adding together the basic salary for the new training programme and any related flexible pay premium applied to that programme, compared with the basic salary in the previous training programme (any flexible pay premium in the previous appointment will not be taken into consideration for this purpose). Where the total value of the new basic salary plus any related flexible pay premium is lower than the previous basic salary, the doctor will have their basic salary protected on a mark-time basis. The protection will consist of an additional pensionable amount at the value of the difference between the old basic salary and the combined total of the new basic salary and any related flexible pay premium.

**Protection of salary on re-entering training from career grade**

Where a doctor already employed in the NHS in a nationally recognised career grade (ie. an appointment on national terms and conditions of service other than those for doctors and dentists in training), choose to return to training in a hard-to-fill training programme, and as a result their basic pay would be lower than received in the previous career grade job, shall be eligible for pay protection. For the purposes of this, the composition of basic pay in the career grade job will exclude any pay
for additional hours/sessions, excellence awards or similar payments, on-call or other allowances, pay premia or any other supplementary payments.

To be eligible for the pay protection, the doctor must have at least 13 months continuous service in the same nationally recognised career grade prior to re-entering training and must move immediately into the hard-to-fill training programme.

Where a doctor already employed in a recognised career grade post, for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010) re-enters training into another programme, including those that are not designated as ‘hard-to-fill’, will also be eligible for pay protection as outlined above.

Such doctors as outlined above, will have pay protection calculated by comparing the basic salary received whilst employed in the previous career grade post, with the sum total of the nodal point applicable to the level they are re-entering training in the hard-to-fill training programme and any additional payments due in that role (including; pay for additional rostered hours, any enhanced rates for hours worked that attract enhancements, any on-call availability allowance, any weekend allowance, and any flexible pay premium).

Where the basic salary in the previous career grade post exceeds the sum of pay outlined in the new post upon re-entering training, the doctor will have their basic salary protected on a mark-time basis and will receive an amount to increase the total salary so that it equals the higher amount previously paid. The protected basic salary will not be taken into consideration in calculating pay for additional hours, hours at enhanced rates or any other amounts, these will continue to be based on the actual basic salary for the post in which the doctor is employed.

Further information
Terms and conditions, schedule 2 paragraphs 46-52

Overpayment or underpayment of salary
There may be occasions where salaries have either been over- or underpaid. In cases where overpayment has been established the BMA would expect there to be a negotiated repayment schedule, rather than repayment in a lump sum, to avoid any financial hardship. No monies should be deducted without consent and no interest should be charged on the monies owed. We would however expect that any underpayment be repaid at the earliest opportunity and in full.

In both situations, members are advised to contact our team of advisers on 0300 123 1233.

London weighting
Junior doctors should be paid London weighting if their hospital is within a specified area. There are two zones – a London zone and a fringe zone – and different rates apply to each. Members may obtain further information or clarification on whether their hospital is within a particular zone by contacting our team of advisers on 0300 123 1233. A reduced rate of London weighting is payable to resident staff who receive their accommodation free of charge or who are paying lodging charges. However, compulsorily resident doctors occupying free single accommodation who also maintain a separate home within reasonable daily travelling distance of the hospital should receive the full rate of London weighting.

Doctors on rotations moving from posts that do not attract London weighting to posts which do, or from posts attracting the fringe London weighting to posts attracting the inner London weighting, in their second or subsequent placement in a rotation, may exercise the option to receive the appropriate London weighting allowance in place of excess travelling expenses.

Changes to the work schedule affecting pay
Where pay is increased as a result of changes to the work schedule, pay will be altered from the date that the change is implemented. Other than in exceptional circumstances, such changes to pay will usually be prospective.

Where changes to the work schedule are required by the employer and total pay would be decreased as a result, the doctor’s total pay will be protected and so remain unchanged until the end of the particular placement covered by that work schedule. This protection will not extend to any subsequent placement, including a placement where the doctor returns at a later date to the same post.

Where changes to the work schedule are requested by the doctor and agreed by the employer, and total pay would be decreased as a result, the doctor’s total pay.
Pay in exceptional circumstances to secure patient safety

Because of unplanned circumstances, 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 their manager. This authorisation would be given before or during the period of extended working, or afterwards if this is not possible. If pre-authorisation is not possible, the doctor should submit an exception report as per schedule 5 of the 2016 terms and conditions of service, which their manager must address within 7 days, to allow for payment for the additional hours worked.

Such compensation should be by additional payment (at the basic pay rate described above, uplifted by any enhancement that may apply at the time that the unscheduled work takes place), or by time off in lieu, or by a combination of the two. Where safe working hours are threatened by such an extension of working hours, time off in lieu will be the preferred option. If the additional hours of work have caused a breach of rest requirements, the time off in lieu must be taken within 24 hours unless the doctor self declares as fit for work and the manager agrees, in which case it can be accrued. Time off in lieu arising from breaches of hours but not rest can be accrued. Accrued time off in lieu should normally be taken within three calendar months of accrual. Where time off in lieu cannot be taken, payment will be made in lieu, at the rate described above.

Where a manager does not authorise payment, the reason for the decision will be fed back to the doctor and copied to the guardian of safe working hours for review. Where such additional work takes place on a Saturday or a Sunday, any payment made will be at the prevailing locum rate, as set out in Annex A of the 2016 terms and conditions of service. Where a doctor is paid for additional hours worked while ‘acting down’ their pay will reflect their current nodal point and not the lower nodal point of the grade at which they are ‘acting down’.

Where such additional hours are in breach of the Working Time Regulations limit of a 48-hour average working week or of the absolute contractual maximum of 72 hours worked across any consecutive seven-day period set out in paragraph 8 of Schedule 3, or where the minimum rest requirement of 11 hours described in paragraph 20 of Schedule 3 has been reduced to fewer than eight hours, any hours above these 48- and 72-hour limits and/or which reduced the 11-hour rest period will attract a penalty rate as set out in Annex A of the 2016 terms and conditions of service.

Medical academic staff

Provided junior doctors have an honorary NHS contract in addition to their university contract, they should be eligible for the above provisions. Those with university contracts only may find their conditions vary according to each university.

Refer to the medical academics section, chapter 22, for more details, or see the BMA’s Medical academic handbook.

Private fees for junior doctors

Junior hospital doctors can earn fees for their services to private patients in some circumstances, and it is their responsibility to advise their employer of any regular commitments. Where junior doctors attend private patients outside their contracted hours they are entitled to receive payment, however they should make clear their trainee status on each occasion. In carrying out private work, junior doctors’ total hours of work should not exceed the contractual limits.

If the attendance is arranged privately, the fee is negotiated between doctor and patient, although junior doctors should be aware that medical insurers will usually only pay for consultant services and all such income is taxable.

If the work is required by the employer as part of its general arrangements for the treatment of private patients, payment is the responsibility of the employer under the normal contractual arrangements and no additional fees are payable.

Fee paying work

Junior doctors, like other hospital doctors, may charge a fee for certain types of medical work. However, such activities should normally be carried out in the time in which the doctor is not being paid by their employer. The employer may agree that fee-paying work can be undertaken in work hours provided that either the doctor remit the total value of the fee to employing organisation, or that doctor retains the fee and allows the employer to reclaim the time that the fee-paying work was undertaken from their basic salary, or the doctor agrees to carry out additional NHS work outside of their work schedule to make up that time at a later date.

If you have any problems with private or fee paying working, contact our team of advisers on 0300 123 1233.

Further information

Terms and conditions of service, schedule 7
Payment of annual salaries
The annual salaries of full-time employees will be apportioned as follows:
- for each calendar month: one-twelfth of the annual salary
- for each odd day: the monthly sum divided by the number of days in the particular month.

The annual salaries of less than full time doctors should be apportioned as above except in the months in which employment commences or terminates when they should be paid for the hours worked.

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

Locum pay
Where a doctor carries out additional work for the employer through a locum bank, such work will be paid at the rates set out for this purpose in Annex A of the 2016 terms and conditions of service.
7. Work Scheduling

Summary
This chapter looks at work scheduling and the processes for designing a work schedule. It also looks at rota planning and the rules for full shifts and on-call duty periods, setting out the necessary rest requirements and hourly limits that must be adhered to.

The pattern of work, the length of duty period, and the frequency of unsocial hours work undertaken by junior doctors are key features in deciding a doctor’s working arrangements. It is important to ensure that the correct working arrangement is adopted for the actual work involved and the amount of rest that can be taken during duty periods.

Junior doctors should always be involved when a rota pattern is drawn up, and educational supervisors must ensure that any working pattern provides adequate opportunity for accessing training. It is particularly important to remember that colleagues will be taking annual and study leave throughout the duration of the rota.

Principles and objectives of work scheduling
Employers must design work schedules that are safe for patients and doctors and ensure that they are adhered to. Normally, a work schedule will apply for the duration of a training placement and will identify the distribution of the doctor’s contracted hours.

The training and service commitments of junior doctors are interdependent, therefore work schedules should be designed to meet both the service delivery needs of the organisation and the educational and training needs of the doctor. When designing the work schedule, employers are expected to refer to jointly agreed national guidance on good rostering practice.

For doctors on integrated academic pathways, the academic components of the placement should be reflected in the work schedule in accordance with Follett principles. See Chapter 23 for more information for medical academics.

Developing a generic work schedule
A generic work schedule must be provided to a doctor before they start a placement. It should feature intended learning outcomes, scheduled duties, time for quality improvement and patient safety activities, periods of formal study, and the doctor’s contract hours.

Specifically, the generic work schedule should include:
- A description of the hours to be worked and any shift or on call arrangements.
- Clinical care and service duties, specific training, and work in or for other organisations (if applicable).
- Expected requirements to contribute to a duty roster and/or on-call rota (if a doctor has a service commitment to unscheduled, urgent or emergency care). This may include duties throughout the 24 hour day and seven day week, including work on statutory and public holidays, and an estimate of anticipated actual work during the on call period.
- For trainees working in a GP practice setting, the work schedule should reflect the 2012 COGPED guidance (or any successor document) on the session split during the average minimum 40-hour week.

Key criteria
- Standard full-time work schedule: Minimum of 40 hours and maximum of 48 hours per week. This is averaged over a reference period which is defined as the length of the rota cycle, length of the placement, or 26 weeks – whichever is shorter.
- Less-than-full-time work schedule: Maximum of 40 hours per week, averaged over the same reference period.
- To calculate average total hours, the average number of days leave to be taken by the doctor will be deducted from the rota, and the remaining hours will be divided by the remaining weeks in the cycle. An eight week cycle with six days leave deducted would therefore involve dividing the total remaining hours by 6.8 weeks.

Developing a personalised work schedule
The personalised work schedule should be agreed between the junior doctor and educational supervisor, in accordance with the Gold Guide and/or other relevant documents. The doctor and educational supervisor are jointly responsible for personalising the work schedule according to the doctor’s learning needs and opportunities within the post.
In some cases, employers may need to make changes to the work schedule in light of significant changes in facilities, resources or services. It’s expected that every effort should be made to anticipate and agree on such changes.
Maintaining the work schedule

- As a minimum, there should be an educational review and work schedule discussion at the start and finish of the placement.
- The personalised work schedule should be agreed at the first formal meeting between the doctor and the educational supervisor.
- The doctor and educational supervisor should regularly consider progress against agreed learning and service objectives.
- Work schedule discussions should take place to establish if any changes in support, resources, or planned service duties are needed.
- Discussions should take place if the employer or doctor consider that training opportunities, duties, responsibilities, accountability arrangements or objectives have changed or need to change significantly.
- If agreement is not reached regarding the work schedule, the doctor may request a work schedule review (schedule 5, Terms and Conditions of Service).

Planning a rota

Limits on working hours

The contractual limits on working hours and protected rest periods are vital for ensuring the safety of patients and junior doctors. In relation to this, employers must have a guardian of safe working hours, and this role is outlined in more detail in schedule 6 of the Terms and Conditions of Service and in chapter 8.

When planning a work schedule, it is imperative that employers and junior doctors take into account the contractual limits on working hours. There are also separate rest requirements for on-call periods.

Further information

TCS Schedule 3

Opting out of the WTR

A junior doctor may choose to voluntarily opt out of the WTR average weekly limit of 48 hours. If they do, all other limits set out in the WTR and TCS (including the maximum average of 56 hours per week and maximum of 72 hours over seven consecutive days) will still apply. This agreement to opt out is subject to prior agreement, and can apply to either a specified period or indefinitely.

Further information

TCS Schedule 3, paragraphs 38-42

On-call periods

An on-call period is one where a junior doctor is required by their employer to be available to return to work or give advice by telephone, but is not normally expected to be working on site for the whole period. A doctor carrying an ‘on call’ bleep whilst already present at their worksite would not be considered to be working an on-call period.

Work schedules should include an average amount of time for anticipated on-call work. This should include both clinical and non-clinical work undertaken either on or off site, such as telephone calls and travel time arising from these calls - excluding the first initial journey to work and the last journey home. Any time a doctor is not undertaking such work during the on-call period will not count as working time. Pay for work done while on-call will be based on the prospective average estimate of hours worked - if the work actually done while on-call goes above the prospective estimate on average, the additional hours of work will be paid, but for the purposes of the work schedule the hours are an estimate.

On-call patterns and the Working Time Regulations

The EWTD and the SiMAP and Jaeger rulings imposed limits on working hours and requirements for rest breaks. These limits on working hours have been incorporated into the 2016 terms and conditions of service for NHS doctors and dentists in training. With regards to on-call working, if a junior doctor is required by their employer to be resident in the workplace then the entire period of residence will count as working time for the purposes of the Working Time Regulations. This and other provisions surrounding safe working hours are embedded into the 2016 terms and conditions of service, meaning that they
would continue to apply if the Regulations were repealed. Therefore ‘on-call’ in the terms and conditions of service refers to non-resident on-call.

Further information
TCS Schedule 3 paragraph 36

Preventing shadow rotas
The 2016 terms and conditions of service include a clause prohibiting the use of ‘shadow’ rotas, when an additional doctor is rostered to do an on-call shift for what should be a full shift, in order to save money (the availability allowance for on-call duty is 8% of basic pay).

If a junior doctor is required to work a night shift or a shift on a weekend as part of a rota, the employer cannot roster a second doctor working that same rota to be available non-resident on call for the same night or weekend. The exception is if there is a clearly identified clinical reason agreed by the clinical director, and the work pattern is agreed by both the guardian as being safe and the DME as being educationally appropriate.

If a junior doctor is asked to work such a rota and feels that it is inappropriate, they should request a work schedule review.

Locum work
If a junior doctor intends to undertake hours of paid work as a locum in addition to the hours set out in the work schedule, they must first offer these additional hours to the service of the NHS via an NHS staff bank. The service offered should be commensurate with the doctor’s grade and competencies.

There is no obligation for juniors to do locum work, or to opt out of the Working Time Regulations to increase the spare hours they have for such work. However, if they do choose to do locum work, they must offer their hours to the service of the NHS first via the local NHS staff bank.

If the doctor offers hours of locum work to the staff bank but there is no suitable work available, they are then be released from the terms of schedule 3 paragraph 43 and given permission to find locum shifts elsewhere (for example, through an agency).

For work to be suitable it must be at the grade and competency level of the doctor – so if the only locum work available through the staff bank would involve the doctor acting down, they do not have to accept this and can be free to locum elsewhere.

For rates of payment, see Annex A in the 2016 terms and conditions of service.

Further information
TCS Schedule 4 paragraph 43
Annex A

How to plan a rota
- A workload study should be undertaken; this will also provide useful documentary evidence to justify a change in working practices.
- Junior doctors should be involved in designing the rota.
- Consultants should be involved and their support is crucial.
- Other affected staff groups should be involved (eg nurses, managers).
- It is essential to build in teaching sessions and handover time.
- Any shift should comply with the required rest periods.
- The planned shift should be piloted and then evaluated; often the final shift has to be redesigned several times.
8. Hours of work and EWTD

Summary
This chapter explains the contractual and legislative restrictions on the hours that junior doctors can work. It covers the limits on hours and the requirements for rest laid out in the junior doctors contract and in the European Working Time Directive (EWTD) and explains what to do if posts breach either of the regulations.

From 2016 there are two different protection frameworks in place to impose limits on working time and rest requirements for junior doctors. The 2016 terms and conditions of service feature a new comprehensive list of hours limits and rest requirements which match, and in many cases supersede, the statutory protections imposed by the EWTD (European Working Time Directive). The EWTD is a European Union initiative, which is known as the WTR (Working Time Regulations) in British law. However there are in some cases different rules in the contract for those who have chosen to ‘opt out’ of the EWTD, so it is important to understand the law as well as the contractual rules. If the EWTD legislation was to be changed or revoked, the working protections in the contract would continue to apply.

EWTD
Background and history
The EWTD, which came into force in the UK on 1 October 1998 for consultants and other career grade hospital doctors, originally excluded junior doctors. Agreement was later reached to extend the directive to doctors in training, and it has applied in full to juniors since August 2009.

EWTD provisions
The Directive was designed to protect the health and safety of workers by restricting the number of hours an individual can work and by imposing minimum rest requirements for all workers. It imposes a limit on doctors’ working hours of 48 per week on average, calculated over a maximum period of six months. The requirements for taking rest breaks are set out below.

EWTD rest requirements
The rest requirements are as follows:
- a minimum of 11 hours’ continuous rest in every 24-hour period
- a minimum rest break of 20 continuous minutes after every six hours worked
- a minimum period of 24 hours’ continuous rest in each seven-day period (or 48 hours in a 14-day period)
- a minimum of 28 days or 5.6 weeks paid annual leave
- a maximum of eight hours’ work in each 24 hours for night workers.*

* A night worker is someone who works at least three hours of their daily working time during night time. Junior doctors are unlikely to be classified as night workers. However, this should not be assumed and where there is any doubt each case should be considered on an individual basis.

Opting out of the hours limit
The EWTD is enshrined in UK legislation and is therefore not optional for employees in the UK. However, an individual junior doctor can voluntarily sign a waiver and ‘opt out’ of the limit on working hours if they wish. This does not opt them out of the rest requirements. The JDC would urge caution where anyone is considering opting out of the hours limit. As a result of the additional contractual limits on working time (see ‘New Deal’ section later in this chapter for further information), junior doctors can only opt out to work a maximum of 56 hours in any case.

Employers must not pressurise workers to sign an opt out, and they must continue to keep accurate records of the working hours of all doctors, including those who have opted out. Further guidance for junior doctors on opting out is available on the BMA website.

Medical academic doctors
Junior academic doctors with a substantive NHS contract should be covered by the working time directive where they undertake academic work on a day release basis. They have the same obligation to provide continuity of care for patients as their junior doctor colleagues.

The BMA believes that all time spent working either in the NHS or at the university (aggregated) should count towards the weekly hours limit and rest requirements. However, members should be aware that universities have been resistant to the local application of the EWTD for academic work.
**EWTD definition of working time**
The way in which working time is defined under the Directive has had important implications for junior doctors’ working arrangements in the UK. Two important European Court of Justice rulings (the ‘SiMAP’ and ‘Jaeger’ cases) have meant that currently working time includes all time spent at the place of work and available to the employer. This includes periods when the doctor is not actually working, for example resting during resident on-call periods.

**Further information**
See [bma.org.uk/ewtd](http://bma.org.uk/ewtd) for extensive guidance

**The junior doctors contract**
The 2016 terms and conditions of service for junior doctors includes a range of contractual limits on working hours and also rest requirements which match, or in many cases go beyond, the legal limits as prescribed in the EWTD. Many of the principles are similar, for example the maximum number of hours worked per week which is averaged out across a certain period, so sometimes the terms of the contract and the EWTD apply simultaneously. However where the contract includes requirements or restrictions that are not part of the EWTD, or go beyond the minimum in the EWTD, the contract takes precedent and the more favourable rules will apply.

**Enforcement of rules**
It is vital for doctor and patient safety that trainees do not work beyond the rostered hours agreed in their work schedule and breach the safe working limits enshrined in the contract. The terms and conditions of service include mechanisms to prevent this, and where this is not possible - to compensate doctors with rest and, where necessary, pay to address the breach. These are set out in chapter 7 (work scheduling) and chapter 9 (exception reporting, work schedule reviews, and the Guardian of Safe Working).

**Working hours**

**General limits**
- Normally a minimum of 11 hours continuous rest between shifts. Breaches of this rest are subject to TOIL which must be within 24 hours. If this rest period is reduced to less than eight hours due to service needs, the doctor will be paid for the additional hours worked at a penalty rate (schedule 2 paragraph 68, Terms and Conditions of Service), and will not be expected to work more than five hours the following day. Their pay will not be deducted for the resulting time off.
- A maximum of eight shifts on consecutive days. After the eighth shift, a minimum of 48 hours rest must be rostered.
- No doctor should be rostered to work more than 1 in 2 weekends. The exception is for F2 doctors where, for one placement (ordinarily emergency medicine), the restriction is on any shift that starts at the weekend.

**Maximum hourly limits**
- A maximum of 48 hours on average of work per week
- A maximum of 72 hours of work in any period of seven consecutive days
- A maximum shift of 13 hours (for on-call periods the maximum is 24 hours)

**Consecutive shifts**
- A maximum of five ‘long shifts’ (a long shift is one lasting longer than 10 hours) on consecutive days. A minimum of 48 hours rest must be rostered immediately following the fifth long shift.
- A maximum of four long shifts finishing after 23:00. A minimum of 48 hours rest must be rostered immediately following the fourth long shift.
- A maximum of four long shifts where at least three hours of work fall between 23:00 and 6:00 on consecutive days. There must be a minimum of 46 hours rest after the fourth shift. If only three such shifts are rostered, then there must be a minimum of 46 hours rest after the third shift.

**Breaks**
A junior doctor must receive at least one 30-minute paid break for any shift lasting over five hours, and a second 30-minute paid break for any shift lasting over nine hours. These breaks should be taken separately, and if they are combined into one
then the break should take place towards the middle of the shift. Breaks should not be taken in the first hour of the shift, or at the end of a shift.

**On-call periods**

An on-call period is one where a junior doctor is required by their employer to be available to return to work or give advice by telephone, but is not normally expected to be working on site for the whole period. A doctor carrying an ‘on call’ bleep whilst already present at their worksite would not be considered to be working an on-call period.

Work schedules should include an average amount of time for anticipated on-call work. This should include both clinical and non-clinical work undertaken either on or off site, such as telephone calls and travel time arising from these calls. Any time a doctor is not undertaking such work during the on-call period will not count as working time.

**Planning an on-call period**

On-call periods can only be worked consecutively at the weekend when two (beginning on Saturday and Sunday respectively) are permitted. Longer runs (up to a maximum of seven consecutive days) can be agreed locally, provided that this doesn’t breach any other limits on working hours or rest.

**Rest requirements**

A junior doctor should get eight hours rest per 24 hour period, at least five of which should be continuous between 22:00 and 7:00. If this is not possible, then rostered work the day after the on-call period cannot exceed five hours.

If a doctor’s overnight rest during the on-call period is significantly disrupted so as to breach these expected rest requirements, the doctor must inform their employer as soon as possible. Arrangements for the doctor to take appropriate rest must be made as a result.

If, as a result of actual hours worked during the on-call period, a doctor’s rest is significantly disrupted so as to breach these expected rest requirements, the default assumption is that it may be unsafe for them to work. In this case, the doctor must inform the employer that they will not be attending work except to ensure the safe handover of patients. This will not result in any detriment to their pay, and arrangements for dealing with this must be agreed locally.

**Hourly limits**

- The maximum length of an individual on-call period is 24 hours
- A maximum of three on-call periods can take place in seven consecutive days (unless otherwise agreed locally)
- The day following an on-call period (or following the last on-call period if more than one is rostered consecutively) must not be rostered to last longer than 10 hours.

**Low intensity on-call**

Low intensity duty is one where a junior doctor’s on-call duty at the weekend contains three or less hours of work per day, and three or less episodes of work per day. Under this working pattern, a maximum of 12 days can be rostered consecutively.

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**Further information**

TCS Schedule 3

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**Tips for designing a compliant rota**

While formal enforcement processes are available (see chapter 9), the following could also be considered in any effort to resolve problems with non-compliant rotas:

**Total hours**

It might be possible to reduce hours by redistributing workload.

**Frequency of out-of-hours work**

The first step should be to identify what work is being done out of hours.

In both problem areas, the following might assist:

**Bleep policies**

- For example, filtering of calls by other practitioners, eg senior ward nurse; additional channelling through juniors on full shift; no juniors to be bleeped during organised training session.

**Organisational changes**
- Bringing more work back into daylight hours, eg emergency theatre lists, emergency admissions unit.
- Encouraging moves towards a consultant-delivered service. For example, evening ward rounds by consultants on-call can resolve many acute problems which might otherwise disturb juniors at night. Consultants working in an identified admissions unit can provide an instant focus for clinical input.
- Avoiding duplication of tasks, eg multiple clerking of patients by different grades.
- Use of bed bureau to locate beds.

**Skill mix initiatives**

- Ensuring adequate staffing levels in support services, both daytime and out of hours.
- Sharing of tasks with other suitably trained staff, eg nurse practitioners.
- Working to identify which tasks can be appropriately delivered by other staff. Possible examples include administration of IV drugs, carrying out requested investigations (bloods, ECGs, arranging X-rays etc), and catheterisation. There must also be mechanisms in place to ensure that, in the event of staffing pressures, these jobs do not default back to juniors.

**Reorganisation**

- Increasing cross-cover of working patterns where appropriate so that, for example, doctors on a night shift may be able to relieve on-call doctors' workload.
- More team working.
- Possible merging of services between smaller units.
- Introduction of the ‘Hospital at Night’ model.

**New working patterns**

- When all the above have been implemented, and as long as there is an appropriate number of doctors on the rota to facilitate a working pattern change, some alternative form of working pattern may be investigated.

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**Further information**

*A guide to the implications of the EWTD for doctors in training*, Department of Health (2009)

9. Exception reporting, work schedule reviews, and the Guardian of Safe Working

Summary
This chapter explains some of the key safeguards in the contract, designed to protect junior doctors from excessive working hours and to provide means of redress when working limits are repeatedly breached. It will cover the new process of exception reporting, requirements around reviewing work schedules, as well as explaining the role and powers of the Guardians of Safe Working. If used effectively, these three provisions will ensure that junior doctors are able to maintain safe and sustainable working patterns.

Exception reporting
Junior doctors’ work is often varied and requires a certain amount of flexibility. However, if an individual finds that the work they are actually doing differs greatly from what is set out in their job plan – either because it is significantly different or regularly varies from what has been agreed – they should raise this with their employer as soon as possible so that immediate steps can be taken to address the issue. If concerns about individual working patterns cannot be resolved in discussions, these ‘exceptions’ can be raised with the employer via an exception report.

Your employer should explain to you when you start in your post what the process is for exception reporting in your place of work. The contract specifies it must allow for a technological method of submission and response, and many trusts may use a mobile phone app for this. The form will require your details (name, specialty, grade), the name of your educational supervisor, details about the variation, and an outline of the steps taken to address the issue before escalation. This report will then be sent to your educational supervisor who will decide how the issue can best be resolved. When the concerns relate to training issues, such as lack of support or resources, then the report will be copied to the Director of Medical Education (DME); where the concerns relate to safe working, such as for total number or pattern of hours worked, the report should be copied to the Guardian of Safe Working (see below).

The educational supervisor will discuss with the junior doctor what action is required to address the concerns highlighted. They will then send a formal electronic response, setting out an agreed outcome of the exception report. The DME and/or Guardian will review the outcome and, if necessary, make further recommendations.

Breaches, fines and immediate safety concerns
When the guardian is reviewing all safe working exception reports that have been copied to them by junior doctors, they will have to make a decision about whether a breach has occurred which will incur a financial penalty. This centres around the safeguards set out in Schedule 3 of the Terms and Conditions of Service, and applies to:

- Breaches to the 48-hour average working week (across the reference period agreed at work scheduling)
- Breaches to the maximum 72-hour limit in any seven days
- Reductions from the minimum 11 hours’ rest requirement between shifts to fewer than eight hours

Where the guardian determines that the concerns raised in the exception report are valid and correct, the junior doctors affected will be paid for the additional hours at penalty rates (Schedule 2, paragraph 68 – see table below). The guardian will also be responsible for levying a fine against the department employing that doctor for the additional hours worked.

<table>
<thead>
<tr>
<th>Basic rate</th>
<th>Total hourly value (£)</th>
<th>Hourly penalty rate (£), paid to the doctor</th>
<th>Hourly fine (£), paid to the Guardian of Safe Working Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The total value of the fine is four times the basic hourly rate</td>
<td>x1.5 of the basic hourly locum rate</td>
<td>The total hourly value minus the hourly penalty rate paid to the doctor</td>
</tr>
<tr>
<td>Enhanced (night) rate</td>
<td>The total value of the fine is four times the enhanced hourly rate</td>
<td>x1.5 of the enhanced hourly locum rate</td>
<td>The total hourly value minus the hourly penalty rate paid to the doctor</td>
</tr>
</tbody>
</table>

Additionally, in instances where breaks have been missed on at least 25% of occasions across a four week reference period, the guardian will levy a fine at twice the relevant hourly rate for the time in which that break was not taken.

It has been agreed that the money raised through fines must be used specifically to benefit the education, training and working environment of trainees. The guardian will be responsible for collaborating with the relevant Junior Doctors Forum (or a local equivalent) to decide how funds raised through fines levied should be disbursed to benefit junior doctors. However, it is important to note that these funds cannot be used to supplement any facilities or resources that the employer should be expected to provide anyway. In order to ensure that doctors can place their trust in this system, details of expenditures will be included in an annual report, which will be open, accessible and subject to audit.
While we expect these processes to improve safety over time, there will be occasions where an exception report highlights an immediate and substantive risk to the safety of patients and/or individual doctors. In such instances it will of course be necessary for more urgent steps to be taken. Where these concerns exist, they should be raised straight away in a conversation with the relevant senior clinician responsible for the service, rather than with the guardian. This conversation should be followed up with an electronic exception report to the educational supervisor within 24 hours. The responsible clinician who receives the report must comply with one of the following actions, set out in detail in Schedule 5, paragraph 17 of the 2016 terms and conditions of service:

- grant immediate time off from an individual’s agreed work schedule
- ensure immediate provision of individual support
- require an immediate work schedule review be undertaken by the educational supervisor.

**Work schedule reviews**

One of the guardian’s most important functions is to ensure that no further breaches occur. As such, in addition to the other processes, they are likely to require that a work schedule review take place to address outstanding issues that might otherwise lead to further breaches in the future.

While a guardian or educational supervisor is able to require a work schedule review, they can also be requested by an individual doctor or their manager.

The process of work schedule reviews is as follows:

- **Written request for work schedule review submitted**
- **Education supervisor engages with doctor within seven working days**
- **Conversation results in one or more of the following outcomes:**
  - No change to work schedule required
  - Prospective changes made to the work
  - Compensation or TOIL awarded
  - Organisational review required

Organisational changes, such as a review of ward round timings, may take longer to be enacted. However, temporary alternative arrangements, including amendments to pay, may be necessary. Whatever the outcome of the conversation, this will be communicated to the affected doctor in writing.

**Further work reviews**

If a junior doctor is unhappy with the outcome of the conversation, they are entitled to request a level 2 work review within 14 days of being notified of the decision. This request would need to outline areas of disagreement and the outcome that the individual is seeking.

A level 2 work review involves a meeting with their educational supervisor, a service representative, and a nominee of the director of postgraduate medical education (where the request pertains to training concerns) or of the guardian (where the request pertains to concerns about safe working). At the meeting, the previous review and its outcomes will be considered. The level 2 review will then either uphold the previous decision or will result in one or more of the four previous work review outcomes.

There is a final stage of appeal that can be requested within 14 days of being notified of the level 2 work review decision. This review will be a formal hearing, held in accordance with the final stage of the employer’s local grievance procedure, before a panel including the Director of Medical Education (or a deputy). Where the appeal concerns a decision made by the guardian of safe working hours, a representative of the BMA will need to be involved in the panel. The decision of this panel will be final.
Guardian of safe working
The Guardian’s role within a trust is to provide assurance, both to staff and employers, that junior doctors are working in compliance with the safe hours requirements set out in the contract, and to make recommendations for how these issues can be quickly and appropriately addressed. An employer or host organisation must appoint a guardian - it is not an option to not recruit one. The guardian will be a senior appointment and will not hold any other managerial role with the employer.

As set out in Schedule 6, para 10 of the 2016 terms and conditions of service, the Guardian’s duties are to:
- Act as the champion of safe working hours
- Provide assurance that rostering is safe and compliant with the restrictions set out in Schedules 3, 4 and 5
- Receive copies of exception reports relating to safe working, allowing them to monitor compliance
- Escalate concerns about working hours breaches with executive directors, where a resolution has not been found at department level
- Intervene in urgent situations to mitigate identified risks to junior doctors or patients
- Require work schedule reviews where safe working hours are regularly breached
- To levy and distribute financial penalties for safe hours breaches
- To liaise with the local Junior Doctors Forum to determine the disbursement of fines

The guardian will also be responsible for producing quarterly reports to the Board of the employing trust which will include data on rota gaps and details of any escalated issues which have not been addressed.

The appointment process
The guardian will be appointed by a panel of four, made up of the trust medical director, HR director and two junior doctor representatives. We encourage junior doctors to take up offers to be involved with the guardian’s appointment in their trust, to ensure that the person appointed has the confidence of junior doctors and is able to carry out this important role in a truly independent way.

The panel must reach consensus on its appointment – so if the junior doctor representatives don’t share the decision taken by others on the panel, they cannot proceed without their agreement. It is a contractual requirement that 50% of the panel be made up of junior doctors and that consensus be reached.

Despite the seniority of others on the panel, junior doctors have an equal right to be on the panel and their opinion counts equally. If the junior doctors on the panel are unhappy with the candidates, they should not feel pressurised to appoint, and the position should be re-advertised.

We would advise junior doctors to identify the director within the trust that the guardian will be reporting to, and meet with them to discuss the role and their expectations.

Guardians for trainees in non-hospital settings
No trainee should be denied access to a guardian of safe working, regardless of their specialty or the location of their working. There are specific provisions within the contract to ensure that individuals in all non-hospital work settings will also be linked with a guardian.

For those who work under a lead/host employer arrangement, the guardian role will be established by the host employers under provisions agreed between the two employers. For GP trainees, however, the lead employer will be responsible for employing a guardian who is familiar with the issues faced by GPs working in practice settings. If there are no lead/host employer arrangements, and a practice employs a GP trainee directly, they will then be expected to appoint an independent guardian themselves.

There is never an excuse for employers to deny a trainee access to a guardian. Smaller employing organisations, such as GP practices, will still be expected to make arrangements. Where the employer has fewer than 10 trainees, they can club together with other employers to appoint a guardian, or they can contract a neighbouring NHS Trust to take on this role for their trainees.
10. Indemnity

Summary
It is essential for all doctors to ensure they have sufficient indemnity. This chapter provides a summary of the different types of indemnity and what is covered by these.

Medical indemnity
Since 1990 the NHS has had financial responsibility for negligence attributable to medical and dental staff of the hospital and community health services. Although it is not a contractual requirement for NHS employed doctors to hold indemnity insurance, such as that provided by the defence bodies, some work which does not fall strictly within the terms of the doctor’s NHS contract is not covered by the NHS indemnity scheme and there may be occasions where there is a dispute about liability between the doctor and the employer.

Health service indemnity schemes in place across the UK provide support for clinical negligence claims, but not for disciplinary issues, or referrals to the General Medical Council, whereas the medical defence organisations do provide this level of support.

The BMA therefore advises all doctors to hold membership of a defence body or provide themselves with other personal indemnity insurance.

Defence body indemnity works on the basis that the claim is covered as long as the cover was in place when the incident occurred, rather than when the claim is made. With insurance, cover is provided whilst the policy is in place and/or for a defined period after.

NHS indemnity
Further details of what is and is not covered by NHS indemnity are given below.

Work covered
- work which falls strictly under the doctor’s contract with their employer (this includes where junior doctors work in independent hospitals as part of their NHS training, as a requirement under their NHS contract)
- foundation work in general practice
- family planning in hospitals
- hospital locum work (including through a locum agency)
- clinical trials authorised under the Medicines Act 1968 or subordinate legislation
- care of private patients in NHS hospitals where it is part of the junior’s contract
- private practice carried out by junior clinical academic staff on the same basis as above
- work in a hospice if the doctor is seconded from a contract with an NHS employer
- work in a prison if part of the doctor’s NHS contract.

Work not covered
- category 2 work, for example completing cremation certificates
- defence of medical staff in GMC disciplinary hearings
- stopping at a roadside accident, or other ‘good Samaritan’ acts
- GP locum work
- GP registrars working in general practice in England
- clinical trials not covered under legislation
- work for other agencies on a contractual basis or for voluntary or charitable bodies
- work overseas
- work where a crime has been alleged.

Junior hospital doctors need separate cover if they undertake any category 2 work, which includes completing cremation certificates, examinations and/or reports on patients for courts, insurance companies, Department for Work and Pensions etc and making court appearances. For more information on category 2 fees see chapter 6. Private practice or work in independent hospitals which is not covered above also requires separate insurance.

Junior doctors who are required either by their employer or by their consultant to perform work which takes them over the hours limits set down in the contract and EWTD, would be covered by NHS indemnity and defence organisation cover.

Changing defence organisation
Doctors who are thinking of changing defence organisation should consider the wider implications of such a transfer, for example which organisation will provide cover for past events.
EWTD and medical indemnity

Medical Defence Organisations have not changed the cover they provide in light of the full implementation of EWTD. They have assured the BMA that doctors are not required to inform them if they opt out of the EWTD unless their working hours alter significantly, their responsibility levels increase, or non-NHS indemnified work is undertaken. The medical defence organisations note that it remains the responsibility of the individual to ensure that they are fit for work and that they continue to abide by Good Medical Practice.

Further information regarding EWTD and indemnity is available on the BMA website at bma.org.uk/ewtd

Junior doctors and data protection

Junior doctors who make personal manual or electronic records of patient data, for example for training logbook purposes, should be aware of the provisions of the Data Protection Act 1998. If patient data are recorded on, for example, personal computers, and that data can identify a patient, then the data must be held subject to the provisions of the Data Protection Act. This would require the doctor to be registered for this purpose. Further information on the Act can be found on the Information Commissioner's website at https://ico.org.uk/

The Information Commissioner enforces and oversees the Data Protection Act 1998, and has a range of duties including the promotion of good information handling and the encouragement of codes of practice for data controllers, that is, anyone who decides how and why personal data (information about identifiable, living individuals) are processed.

The BMA advises junior doctors not to record data that identifies a patient, for example a patient’s name, though data which can be matched to a patient only through use of a hospital record system or separate second data set is lawful on an unregistered computer. For example, a hospital number can only identify a patient if cross-referred with the hospital records system.

Further information
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
www.themdu.com

The Medical Protection Society
Medical Protection Society,
33 Cavendish Square, London
W1G 0PS
www.medicalprotection.org/uk/
Tel: 020 7399 1300
info@mps.org.uk
11. Transition arrangements

Summary
The 2016 terms and conditions of service became effective on 3 August 2016. The contract is being introduced with a phased implementation, due to complete by October 2017. During this period and up until 2022 there are temporary arrangements in place to allow current junior doctors to transition to the new contract, including pay protection. This is set out in temporary schedule 14 'Transition arrangements' of the terms and conditions.

Timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016</td>
<td>Appoint guardians of safe working hours</td>
</tr>
<tr>
<td>26 July 2016</td>
<td>Guardian of safe working hours conference, London</td>
</tr>
<tr>
<td>3 August 2016</td>
<td>Contract is live</td>
</tr>
<tr>
<td>October 2016</td>
<td>Transition to the new terms and conditions of service (TCS) for:</td>
</tr>
<tr>
<td></td>
<td>− Obstetrics ST3 and above</td>
</tr>
<tr>
<td>November - December 2016</td>
<td>Transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>− F1 doctors taking up next appointments</td>
</tr>
<tr>
<td></td>
<td>− F2 doctors taking up next appointment and sharing rotas with F1 doctors</td>
</tr>
<tr>
<td>February - April 2017</td>
<td>Transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>− Psychiatry trainees taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>− Pathology trainees (lab based) (all grades)</td>
</tr>
<tr>
<td></td>
<td>− Paediatrics trainees taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>− Surgical trainees (all disciplines) taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>− F2 doctors and GP trainees (ST1/2) taking up next appointments and sharing rotas with any of the above</td>
</tr>
<tr>
<td>August - October 2017</td>
<td>− All remaining trainees taking up next appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>− All new starters (all grades)</td>
</tr>
</tbody>
</table>

The above does not include trainees employed on long-term lead employer arrangements (other than those who joined such arrangements on a single placement contract in August 2016, or those whose contracts have a clause allowing them to be varied in this way); these trainees will remain on the 2002 terms and conditions of service until they finish training and/or their current contracts expire.

There will be some parts of the country where rotation dates do not coincide precisely with the above timetable. In such cases, trainees will move to the new terms and the next rotation date following their scheduled transition date, by October 2017 at the latest.

F2 doctors are not identified explicitly in the phased implementation plan. F2 doctors frequently share rotas with other trainees in their early years of specialty training or with F1 doctors, and can expect to be offered the 2016 contract at the same time as the doctors on the rota they are moving into. Employers will need to adapt rotas to ensure that working patterns meet the new safer working rules before the 2016 contract is used for any doctors working on that rota.

For example, NHS Employers anticipate that F2 doctors who are due to enter psychiatry, public health, pathology or paediatric placements from February to April 2017 will be moved onto the new contract terms at the same time as colleagues training in those specialties if they share the same rota. Employment contracts based on the 2002 New Deal TCS
will need to be provided only up to the date upon which each doctor is due to move onto the 2016 TCS except where a longer contract of employment is already in place.

Pay protection arrangements
The new contractual arrangements include an initial period of pay protection for some existing doctors. Schedule 14 of the terms and conditions of service deals with the arrangements which are aimed at ensuring no current junior doctor receives a pay cut as a result of the new contract. The arrangements are complex, so if you are unsure how this may affect you we would encourage you to use the BMA's interactive pay protection tool available on our website.

The principle is that junior doctors employed on the 2002 terms and conditions will have their pay protected to ensure they do not see any drop in pay as a result of the introduction of the new contract. Given that transition to the new contract takes place from October 2016, this includes new F1s, who will start on the 2002 TCS in August 2016 before moving to the new one once it starts being used later in the year.

Eligibility categories
There are two categories for pay protection - one covering doctors in Foundation, core, GP and the initial stages of run-through training programmes, the other covering those already in higher training programmes and the later stages of run-through training (ST3 and above). The first category will have their pay protected against a 'cash floor', based on the basic salary the doctor was earning on the day before they transitioned to the new contract and the banding for the rota they were working the day before transition, based on the value of that banding supplement as at 31 October 2015.

The cash floor is calculated once and your pay cannot drop below this point, but it will not be calculated again. Your pay is protected against the cash floor until such time as your pay on the new contract would be greater, at which point pay protection stops and you are just paid under the new contract as normal.

The second category, doctors already at ST3 or above on a run-through training programme on 2 August 2016 above, will have their pay protected by continuing to be paid under the old pay system, including increments and banding (but not band 3). For the purposes of their pay only, the old definitions of 'plain' and 'premium' time will apply. The 2016 terms and conditions include detailed instructions as to how the old pay system will work with the new contractual terms, including how these doctors can make use of the new exception reporting system under the guardian of safe working. If you qualify for section 2 protection and earn less under the old contract pay system than you would under the new contract, you still get paid under the old contract i.e. the lower amount.

Arrangements for those training LTFT, on OOP or absent at the time of transition
There are various provisions to ensure fairness in the calculation of the cash floor and the length of protection. Those taking time out of training for maternity leave, for example, will have this time out disregarded for the purposes of their four years of continuous employment. LTFT trainees will also have their coverage extended pro rata - so someone working on an 80% basis would have their four year period extended by a year. Doctors who are out of training for maternity leave, for example, or on an approved out of programme (OOP), at the time they would transition to the new contract, will have their pay protected at the incremental pay point that they might otherwise have reached had they not been absent.

Arrangements for those not currently in training
If you are not currently in a training programme – for example, if you are currently a medical student, a career grade doctor planning on returning to training – you will not qualify for protection if starting training or returning after 3 August 2016, even if you have been in training before.

The pay protection covers new F1 doctors in August and doctors in training on 2 August who either remain in that programme or progress directly to their next one. If for example you take a break between core and higher specialty programmes or between foundation and specialty training, you aren’t eligible.

There are some exceptions.
- A doctor who has accepted a place in a training programme in a 2015 recruitment round, or earlier, and has agreed with Health Education England to defer the entry date at that time will qualify for pay protection when entering that programme on the agreed date.
- A doctor who has accepted a place on a training programme during a 2016 recruitment round (prior to 30 June) and has agreed with HEE a deferral of the start date will qualify for pay protection when entering that programme on the agreed date.
- A doctor who has accepted an appointment to start a period of research or organised leadership programme (eg the FMLM scheme) prior to 31 March 2016 without having secured a place on a GP or specialty training programme, and who would otherwise qualify for pay protection on return to training under the 2016 terms and conditions of
service. To be eligible for pay protection in this circumstance, the doctor must enter a nationally recognised specialty training programme at the first available opportunity, in line with the national specialty training recruitment timetable, following the successful completion of that academic or leadership work. This provision will only be extended to those who have made the decision to take up such academic or leadership programme activity prior to 31 March 2016. Doctors should be asked to provide evidence of the date upon which they accepted this academic or leadership work to prove their eligibility for pay protection.

This is a complex area and we recommend you read schedule 14 in full along with the detailed guidance available on the BMA website.

Further information
Interactive pay protection tool bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations/pay-and-transition
Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Annex B - Transitional banding questionnaire for Schedule 14
FAQs on transition to the 2016 terms and conditions bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations/new-contract-faqs
12. LTFT (less than full-time) training (previously known as flexible training)

Summary
This chapter explains what LTFT training is, the eligibility criteria for working LTFT, the application process, appealing decisions, the types of post available, and how to find out more.

Less than full time training allows doctors and dentists to work part time in posts that are fully recognised for training. It covers any arrangement with reduced working hours. All those in training are able to apply for LTFT training.

There are many reasons such as domestic commitments, disability or ill health or the undertaking of a particular activity outside of medicine, which may mean you wish to train less than full time. Your training programme and some elements of your contract of employment will be determined to reflect your individual circumstances and should reflect the formal guidelines referred to below. Access to LTFT training will be dependent on individual circumstances and the availability of LTFT places in your training location. However, the BMA is working with training authorities to improve access to flexible working opportunities including LTFT training.

The BMA has produced a comprehensive online guide (https://www.bma.org.uk/advice/career/applying-for-training/flexible-training) as a single resource to answer your questions relating to LTFT training. It takes you through the basic principles, explains your rights and responsibilities, and what you can expect from your employer and training organisation (LETB or deanery). It also provides examples and experiences from doctors who have trained LTFT themselves. It aims to ensure you know how to apply, what it is like to train less than full time, possible problems you might run into, how to deal with them, as well as what support is available to you.

If you feel that working and training less than full time is right for you, the BMA will support you wherever possible. We suggest you read the full guidance, which will reflect changes as they occur. If you need information quickly, have an application that you need advice about, or are a less than full time trainee with questions, get in touch with an adviser through https://www.bma.org.uk/contact-bma

The rest of this chapter outlines the basics of the current arrangements,

Criteria
To aid the prioritisation of those wishing to apply, deaneries or LETBs are advised to review applications based on 'well founded individual reasons', which are divided into two categories. The categories are not exhaustive and applications may be considered for other reasons, however, this will be dependent on the particular situation and the needs of the specialty in which the doctor is training or applying to train. All LTFT training requests should be treated positively.

Category 1
- Disability or ill health (this may include IVF programmes)
- Responsibility for caring (irrespective of gender) for children
- Responsibility for caring for an ill or disabled partner, relative or dependent
- Category 1 applicants are treated as 'priority' applicants.

Category 2
- Unique opportunities for personal professional development, such as training for national or international sporting events, or short term extraordinary responsibility (eg a national committee)
- Religious commitment (eg involving training for a particular religious role which requires a specific amount of time commitment)
- Non-medical professional development
- Category 2 applicants are treated on their individual merits.

Application process
To make the application process run as smoothly as possible there are a number of things that you need to consider in advance of your application.

- Determine how you fit into the categories and where possible and/or appropriate gather as much supporting evidence for your circumstances.
- Speak to other colleagues who work LTFT and ask them about their experiences (even if you are about to move deaneries).
- Find out how many hours they are contracted to work per week.
- Find out how they agreed their training programme to incorporate the full range of training opportunities available to full-time trainees? Perhaps they have worked one half of the week for six months and the other half for another six months.
- Find out what the full-time trainees do each week, eg proportion spent covering ward work, clinics, theatre, emergencies etc. Remember to include time for audit/protected teaching time/ research etc.
- If you are applying through open competition and it is your first time applying for a LTFT training post, it may be hard for you to get all this information. Familiarise yourself with similar information in your current workplace so you know what you should be looking for when you discuss your programme in your new role.
- Seek advice on eligibility from your associate postgraduate dean with a responsibility for LTFT training as to your eligibility. Find out who to contact by looking on your deanery website. If you are told by your deanery that there are no spaces available, you should still request to receive any information they can send you and you should still submit your application.

Contact our team of advisers for assistance through https://www.bma.org.uk/contact-bma. There are a number of steps to the application process and it can take up to three months. If you wish to train LTFT in a post, it is recommended that you start this process as soon as possible. The steps to take when applying are as follows.

1. Seek advice on eligibility from your associate postgraduate dean with a responsibility for LTFT training as to your eligibility. Find out who to contact by looking on your LETB/deanery website.
2. If you are not already working within the specialty or grade that you wish to train LTFT in you should apply through competitive entry to a full time post. If you are already in a full-time training post and wish to train LTFT within that same post you will not have to reapply for training.
3. Once your application for LTFT training has been accepted you need to agree your training programme with your LETB/deanery.
4. The Regional Specialty Education Committee or Training Programme Director will then obtain approval of the training programme on behalf of the dean and royal college.
5. Finally funding approval will be given by the deanery and the employer.

When applying for a training post, be reassured that it is not part of an appointment committee’s job to consider whether a candidate wishes to train LTFT on taking up a post or in the future and candidates do not need to state in their application that they wish to train in this way.

However, it is suggested that potential applicants discuss with the postgraduate deanery their intention to train LTFT at the earliest opportunity.

If your application to train LTFT is refused, you have the right to appeal this decision. You can also use this process if you are refused access to LTFT training, ie you are told you are not eligible to apply.

The application process is outlined in fuller detail within our LTFT guide bma.org.uk/advice/career/applying-for-training/flexible-training/application-process

**Appeals**

The appeals process should only be required on rare occasions as discussions with your LETB/deanery before applying should help inform you of whether you are eligible for LTFT training. Before starting the full appeals process you must first attempt to resolve issues informally by discussing your concerns with your deanery.

You are allowed and encouraged to have a representative in these discussions and the BMA will provide support for members throughout the whole of the pre-appeals and appeals process. If the matter is resolved informally, this must be confirmed in writing. If not, then you are entitled to progress with the full appeals process.

Appeals are heard by an appeals panel who consider your application, your concerns and reasons for appeal in addition to the deanery's case. Then appeals panel will then make a final decision regarding your access to LTFT training.

In order to register your appeal you should follow these steps:
- submit your appeal in writing using the 'notification of appeal' form which is available from your LETB’s/deanery’s associate postgraduate dean with responsibility for LTFT training
- send a copy of the notification of appeal form to your postgraduate dean within 30 working days of the decision about which you are appealing
- send a copy of your notification of appeal form to the LTFT training administrator at your LETB/deanery.

For more information about appeals, see the section in our LTFT guide bma.org.uk/advice/career/applying-for-training/flexible-training/appeals-process

**Types of LTFT training post**

Deaneries in principle offer different ways of incorporating LTFT training into rotas. There are three ways in which doctors can train LTFT; slot-sharing, supernumerary posts and job sharing. However, access to these different post types is variable.
Slot share
A training placement can be divided between two trainees, so that all duties of the full-time post are covered by two trainees. In a slot share two LTFT trainees are employed and paid as individuals (often for 60% or more) and work together. The two trainees share an educational post but not a contract and may overlap sessions.

Job-share
In job-share arrangements it is usual for two trainees to share a full-time salary, work half the hours and receive 50 per cent of the training opportunities.

Supernumerary post
Supernumerary posts can be offered when LTFT trainees cannot be placed in a slot-share because there is not a suitable partner or where LTFT training is needed at short notice. Supernumerary posts are additional to a normal complement of trainees and increasingly are only offered for those who require LTFT at short notice. Many deaneries no longer offer supernumerary posts as a standard form of training.

Information about postgraduate training is available from your local postgraduate dean’s office. Usually one associate dean has a designated responsibility for LTFT training in the region.

Pensions for LTFT trainees
It should be noted that any less than full-time working will have pension implications. For more information, please see chapter 18.

Further information
BMA guidance on LTFT training: https://www.bma.org.uk/advice/career/applying-for-training/flexible-training
SpRs should refer to ‘A guide to specialist registrar training’ (the Orange Book) //webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4006614
STRs should refer to ‘A reference guide for postgraduate specialty training in the UK’ (the Gold Guide) http://specialtytraining.hee.nhs.uk/the-gold-guide/
13. Locum work in the NHS

Summary
This chapter provides information on locum work in the NHS and explains the terms and conditions of service for locum doctors directly employed by the NHS. There are a number of issues to think about when considering working as a locum such as how this work relates to the EWTD, pay, and other terms and conditions of service such as annual leave, sick leave and notice periods.

Junior doctors employed on a locum basis in the NHS are subject to the terms and conditions of service for hospital medical and dental staff, unless they are employed directly by a locum agency. It is not possible to give advice on the terms which agencies may offer, as these vary between agencies. It should be noted that locum posts do not usually attract recognition for training except in certain circumstances. The situation should be ascertained before accepting a post.

Locum cover
Employers are obliged to obtain a locum to cover a junior doctor’s annual and/or study leave. Locum cover must be organised to cover sick leave and maternity leave, except in emergencies as explained below. Employers should first try to arrange an external locum. Where this is not possible, and junior doctors agree to cover for colleagues as an internal locum and this cover takes place outside of their contracted hours, they should receive either an equivalent off-duty period in lieu or be paid according to the national locum rates set out in the Pay and Conditions Circular (M&D) 2/2016.

You will be expected to be flexible and to cooperate with reasonable requests to cover for your colleagues’ absences where you are competent to do so, and where it is safe and practicable for you to do so.

Responsibility for arranging locum cover
It is the responsibility of the junior doctor to bring to the attention of the employer the need for locum cover. However, it is the responsibility of the employer to engage the locum.

Cover in emergencies
Your employer should not ask you to cover for absent colleagues on a long-term basis. However, there are specific circumstances where you may legitimately be asked to cover the ‘occasional brief absence of colleagues’ (as well as in exceptional emergency scenarios) and that ‘sick colleagues will normally be covered only for short periods of absence’, and we interpret this short period to be 48 hours in length. This would not apply to foreseeable short- or long-term rota gaps.

Such emergency cover should be recognised with either compensatory time off in lieu or with pay.

Lastly, academic trainees can be a special case as they may have additional commitments within the university or department and these should be protected and respected. This could also be the case with doctors with multiple employers.

If your situation is not covered here or you need more information, please contact our team of advisers on 0300 123 1233 for advice.

Further information
Terms and conditions of service, Schedule 1, para 3

Spare professional capacity and first refusal
No doctor should be rostered to work for more than a maximum average of 48 hours per week (or up to 56 hours per week if the doctor has opted out of the WTR). This means junior doctors will have an average 8 additional hours in the week during which they could work but would not be scheduled to work by their main employer.

There is now a contractual requirement for junior doctors to give first refusal on these additional hours to the service of the NHS via an NHS staff bank. This limited to work commensurate with the grade and competencies of the doctor rather than work at a lower grade than the doctor currently employed to work at.

Where a doctor intends to undertake hours of paid work as a locum, additional to the hours set out in their work schedule, they must initially offer such additional hours of work exclusively to the service of the NHS via an NHS staff bank.
The employer can, but is not obliged to, offer the doctor the opportunity to carry out additional activity up to a maximum average of 48 hours per week (or up to 56 hours per week if the doctor has opted out of the WTR).

Rates of payment for such work are set out in section 6 of the Pay and Conditions Circular (M&D) 2/2016.

The employer will agree with the LNC local processes for the doctor to inform an NHS staff bank of their intention to carry out such work.

Only after the employer has declined the doctor's offer to work additional hours as a locum should the doctor enter into any agreement to carry out any additional work for any other employer, whether directly or indirectly (for example through an agency or limited company).

Please note up to 40 hours of work per week are pensionable in the NHS.

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**Further information**
Terms and conditions of service, Schedule 2, para 73 & Schedule 3, paragraphs 43-44 40-42

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**External locums**
External locums engaged through an agency are paid according to the rate negotiated by the agency; employers are allowed to negotiate locally the best arrangements for their particular circumstances.

The rate is appropriate to the grade of the doctor being covered (not the locum's own grade).

**Internal locums**
Junior doctors employed on an internal locum basis in the NHS are subject to the Terms and Conditions of service for hospital medical and dental staff.

Under internal locum arrangements, employers pay junior doctors providing locum cover at locum rates set out in the Pay and Conditions Circular (M&D) 2/2016 for the whole time they are on duty, provided that such work is undertaken when the doctor would otherwise have been off duty.

**Part-time locums**
A junior doctor engaged as a locum for less than 40 standard hours per week without a regular appointment is paid on the same basis as internal or external locums above.

**Locum pay**
The national locum rate is set out in section 4 of the Pay and Conditions Circular (M&D) 2/2016.

**LATs (locum appointments for training)**
Junior doctors in LATs are excluded from the pay arrangement detailed above. Doctors in LAT posts are paid at the incremental point to which they are entitled because of previous experience, not the mid-point.

**Other terms and conditions of service**
Locums are entitled to the same terms and conditions of service as regular appointments except in the following areas:

**Notice periods**
Locums are not entitled to the minimum periods of notice for regular appointments. An employer is required by statute to give a minimum of one week's notice to terminate the employment of a locum who has been employed for at least four weeks.

**Annual leave**
Junior doctors acting as locums are entitled to 27 days leave (rising to 32 days after five years’ completed NHS service) 'Continuous locum service' means service as a locum in the employment of one or more employer uninterrupted by the tenure of a regular appointment or by more than two weeks during which the junior doctor was not employed in the hospital service.

Wherever possible, leave should be taken during the occupancy of the post. If this is not possible, leave may be carried
forward to the next succeeding appointment, or payment in lieu of leave earned and not taken may be made. In practice, the latter is more common.

**Sick leave**

Although the sick leave provisions of the terms and conditions of service apply to locums, a locum contract cannot be extended to cover sickness that continues after the contract has expired. For the purpose of sickness absence allowances, a doctor’s previous contracted NHS locum service shall be recognised, subject to a minimum of three months’ continuous NHS locum service.

**Travelling expenses**

Where a locum travels between their place of residence and their hospital, travelling expenses are paid in respect of any distance by which the journey exceeds 10 miles each way. Where a locum takes up temporary accommodation at or near the hospital, the initial and final journeys are paid.

**The specialist registrar and specialty registrar grades**

When vacancies arise in the specialist and specialty registrar grades, two types of appointment can be made:

- a locum appointment covering the service element of the post only (LAS)
- a locum appointment which not only covers the service element but which provides a training opportunity (LAT).


Advice is available to members from our team of advisers on 0300 123 1233.
14. Study and professional leave

Summary
This chapter covers junior doctors' entitlements to time off and expenses for study leave and explains what can be done if problems are encountered.

Study leave is leave that allows time, inside or outside of the workplace, for formal learning that meets the requirements of the curriculum and personalised training objectives. This includes but is not restricted to participation in:
- study (linked to a course or programme)
- research
- teaching
- taking examinations
- attending conferences for educational benefit
- rostered training events
- regional educational events (where the time is protected).

Attendance at statutory and mandatory training (including any local departmental training) is no longer counted as study leave. This means that juniors will no longer have to use their study leave to attend obligatory training.

Professional leave is leave in relation to professional work.

Funding for study leave ensures that doctors continue to be paid for the time spent absent from their place of work. With prior agreement, reasonable expenses incurred by the trainee for approved study leave should also be reimbursed by the deanery.

Study leave and reimbursement of related expenses will be granted at the discretion of the LETB or Local Education Provider (in England) or deanery.

Entitlement
Study leave up to the limits described below will normally be granted flexibly and tailored to individual needs, in accordance with the requirements of the curriculum.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Days per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundation Doctor Year 1</td>
<td>15 days</td>
</tr>
<tr>
<td>All other doctors in training</td>
<td>30 days</td>
</tr>
</tbody>
</table>

A doctor on a contract of employment of less than 12 months' duration is entitled to study leave on a pro rata basis.

Study leave for Foundation Year 1 doctors will take the form of a regular scheduled teaching/training session (or similar arrangement) as agreed locally.

Study leave for doctors at Foundation Year 2 and above will include periods of regular scheduled teaching/training sessions, and may also, with approval from the educational supervisor and service manager, include undertaking an approved external course and / or periods of sitting (or preparing for) an examination for a higher qualification where it is a requirement of the curriculum.

The Gold Guide states that:
1. trainees must be made aware of how to apply for study leave and be guided as to what courses would be appropriate and what funding is available
2. trainees must be able to take study leave up to the maximum permitted in their terms and conditions of service
3. the process for applying for study leave must be fair and transparent, and information about a deanery-level appeals process must be readily available.

Less than full-time trainees
Less than full-time trainees are eligible for study leave; if the LTFT doctor is required to undertake a specific training course required by the curriculum, which exceeds the pro rata entitlement to study / professional leave, the employer will make arrangements for additional study leave to be taken, provided that this can be done while ensuring safe delivery of services.

Medical academic doctors
Study, sabbatical and other leave are determined by the substantive employer, and will be agreed in consultation with the
NHS where there may be an impact on clinical services.

Applications
The administration of how you can access the funding and time off for study leave varies between LETBs/deaneries. When starting a training programme, junior doctors should check the deanery’s policy on study leave Regional postgraduate deans have overall responsibility for managing study leave budgets.

However, in most regions budgets have been devolved to clinical tutors or the appropriate NHS employer. Applications are usually required to be submitted locally before the leave is taken and all expenses that are likely to be incurred should be indicated on the application. The study leave application will normally require the approval of the junior doctor’s consultant or clinical director.

It is not the responsibility of the junior doctor to find or arrange any locum cover during the study leave period. Junior doctors should contact the human resources department to find out the procedure for applying for study leave in their hospital.

Expenses
Doctors may be entitled to reimbursement of reasonable study leave expenses, in accordance with local policy, which must meet the minimum standards for provision set out in the Learning and Development Agreement (or any successor document) between the employer / host organisation and HEE.

However, there are circumstances where this could be unreasonable, for example, where expenses are met wholly or partly by a sponsoring body or where a doctor holds a contract with more than one employer.

In deciding what are ‘reasonable expenses’ employers have been told by the Department of Health that ‘it would not, in our view, be reasonable for an authority to pre-determine a given level of expenses which it was prepared to approve in connection with applications for study leave’. In other words, when employers grant study leave, they must grant pay and expenses.

Where study leave expenses are granted, the full rates of travel and subsistence set by the General Whitley Council (an early set of terms and conditions for NHS staff that is sometimes still referred to on certain issues) should be paid. Examination fees are not paid.

Some deaneries/LETBs also put a limit on the study leave budget allowed for each junior. For the reasons stated in the above paragraph, the JDC regards this as inappropriate.

Further information
General Whitley Council (GWC) handbook

Professional leave for overseas conferences
Employers may at their discretion grant professional or study leave outside the UK with or without pay and with or without expenses or with any proportion thereof.

Accommodating time off for study leave
All requests for study leave will be properly considered by the employer. Any grant of study leave will be subject to the need to maintain NHS Services (and, where the doctor is on an integrated academic pathway, academic responsibilities) and must be authorised by the employer.

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

Requests for study leave in excess of the limits above should be considered fairly where circumstances indicate such requests to be reasonable, and may be granted by the employer provided that the needs of service delivery can be safely met.

Study or professional leave must be used for the purpose for which it was granted. Safeguards on hours and rest as set out in
Schedule 3 of the 2016 terms and conditions of service will continue to apply.

The BMA strongly advises junior doctors to get involved with rota planning. As study leave will normally be agreed a minimum of four to six weeks in advance, it should be able to be incorporated into the rota. If study leave is not granted because of rota shortages or poor rota design, this should be raised with the clinical tutor, director of medical education or the guardian.

Appeals
If study leave is refused or granted without pay or expenses, junior doctors can take the following steps.

i. Appeal to the regional study leave committee (if one exists). This is a regional committee, on which junior doctors are represented, whose job it is ‘to ensure consistent and uniform practices and to decide appeals’. If there is no study leave committee in your region you should contact your postgraduate dean. Further details of the local study leave policy may be also obtained from the postgraduate dean. It is important that junior doctors do appeal because referral of refused applications will not otherwise occur.

ii. If study leave is granted but without pay and/or expenses, the matter may be pursued through the small claims court as long as the claim is under £5,000. Hearings are usually in private and less formal than proceedings in higher courts. However, it is possible for a case to be referred, by the registrar hearing the case, to the full County court. Costs may then be payable.

iii. Employer’s grievance procedure. In cases where pre-determined policies are being arbitrarily imposed, it may be worth appealing to the employer under the grievance procedure.

BMA members should seek advice from our team of advisers on 0300 123 1233 before embarking on an appeal.

Study leave for GP trainees
The GP trainees subcommittee of the GPC has agreed policy on study leave for GP registrars. The guidance note Study leave for GP registrars is available on the BMA website bma.org.uk/practical-support-at-work/contracts/leave/leave-gp-trainees

Further information
The entitlement to study and professional leave is in schedule 9 paragraphs 29 - 39 in the 2016 terms and conditions of service. More information on study leave can be found in the following resources:

Rough guide to foundation programme – for all foundation year 1 and foundation year 2 trainees.
www.foundationprogramme.nhs.uk/pages/home/keydocs

‘A reference guide for postgraduate specialty training in the UK or the Gold Guide – All specialty trainees or StRs (including general practice trainees, those in core training, LTFT training and trainees in academic programmes) should refer to the Gold Guide. http://specialtytraining.hee.nhs.uk/the-gold-guide/

‘The guide to specialist training or the Orange Book – SpRs (specialist registrars), SpTs (Specialist Trainees in Public Health Medicine) and GPRs (General Practice Registrars), whose training programme started before August 2007, should refer to the Orange Book.


UK Foundation Programme Office Guidance on specialty tasters for foundation trainees
www.foundationprogramme.nhs.uk/pages/home/keydocs
15. Annual leave

Summary
This chapter explains the basic annual leave entitlements for junior doctors and how to calculate annual leave entitlements. The chapter also details public holiday entitlements and what to do if you become sick while on annual leave.

Basic entitlement
Annual leave will now be stated in days, rather than weeks. The annual leave entitlement for a full-time doctor is as follows, based on a standard working week of five days:

On first appointment to the NHS: 27 days
After five years’ completed NHS service: 32 days.

Please note these leave entitlements include the two extra-statutory days previously available in England under the 2002 Terms and Conditions of Service.

Where the doctor's contract or placement is for less than 12 months, the leave entitlement is pro rata to the length of the contract or placement.

Annual leave for LTFT trainees will be pro-rata.

Principles
It is in the interest of doctors' health and wellbeing and the continued safety of patients in their care, that they take their full annual leave entitlement. The employer and the doctor must make every effort to work together to ensure that the doctor is able to take the full annual leave entitlement.

The employer should, where possible, respond positively to all leave requests, and should normally agree reasonable requests.

Employers must allow annual leave to be taken for life-changing events, for example a doctor’s wedding day, provided that the doctor has given a minimum six weeks’ notice to the employer.

Further information
Terms and conditions of service, Schedule 9 paragraphs 1-22
GWC handbook sections 1 and 2:

Payment for annual leave
Pay is calculated on the basis of what the doctor would have received had the doctor been at work, based on the doctor’s work schedule and on any reference period that may be applied locally.

Purchase of additional annual leave
Where the employer offers a local scheme for the purchase of additional annual leave, a doctor will be permitted to seek participation in such a scheme, subject to any training requirements. The impact of any additional leave must be considered by HEE (local office) and agreed on behalf of the postgraduate dean. Any such agreed additional annual leave can only apply to the placement with that specific employer.

Daytime work cover
Some departments engage locums for daytime work, some expect juniors of the same grade to cover, some expect juniors of different grades on the same firm to cover, and some have ‘floating’ juniors. Whichever method is used, junior doctors should ensure that they do not feel exploited or overworked by their colleagues’ absence. If this is the case, members should consult our team of advisers on 0300 123 1233.

Leave year
The annual leave year runs from the start date of the doctor’s appointment.
**Untaken leave**

In cases where exceptional circumstances or service demands have prevented a doctor from taking the full leave allowance, up to five days of leave per annum (pro rata for contracts or placements of less than 12 months’ duration or for doctors who work less than full time), may be carried forward to the next post or placement with the same employer. This must be with the agreement of the relevant department, in line with the employer's local policy.

With the agreement of the employer and in line with local policy, payment in lieu can be made for up to five days' annual leave (pro rata as appropriate) which could not be taken before a move to a new employer. In general it is more beneficial to take the leave than to be paid in lieu, since payment in lieu for a day's leave is normally made at only 1/31 of a month's salary.

**Transferring leave from post to post**

Carry over of leave from one post to another is often contentious, and should be agreed in advance with the new employer. The previous employer is responsible for notifying the next employer about the outstanding leave, although it is prudent to check that this has been done.

**Notification of leave**

A doctor shall normally provide a minimum six weeks’ notice of annual leave to be approved in accordance with local policies and procedures. If, due to circumstances beyond the doctor’s control, a reasonable request is made for leave outside the minimum six weeks’ notice period, then the employer will fairly consider this while paying due regard to service requirements.

**Fixed leave**

In exceptional circumstances where agreement on planning leave is not possible despite the best reasonable efforts of the doctor and the employer, some leave may need to be allocated to ensure that all doctors are able to take their full leave entitlement while maintaining safe coverage of services. However, leave should not be fixed into a working pattern for this or any other reason without agreement.

**Sickness during annual leave**

If a junior doctor falls sick during annual leave and produces a statement to that effect at the time, (eg a self-certificate) the junior doctor should be regarded as being on sick leave from the date of the statement. Where the first statement is a self-certificate, that statement should cover the first and any subsequent days up to and including the seventh day of sickness. Medical statements should be submitted to cover the eighth and subsequent calendar days of sickness where appropriate. Further annual leave should be suspended from the date of the first statement.

**Public holidays**

Full-time junior doctors are entitled to eight paid public holidays each year as follows: New Year’s Day, Good Friday, Easter Monday, May Day, Spring Bank Holiday, Late Summer Holiday, Christmas Day and 26 December. This is in additional to annual leave entitlement.

A doctor working LTFT is entitled to paid public holidays at a rate no less than pro rata to the number of public holidays for a full-time doctor, rounded up to the nearest half day. Public holiday entitlement for LTFT doctors shall be added to annual leave entitlement, and any public holidays shall be taken from the combined allowance for annual leave and public holidays.

**Working on public holidays**

If a junior doctor is required to be present in the hospital (or other place of work) at any time (from 00.01 to 23.59) on a public holiday, or who is rostered to be on call on a public holiday, they will be entitled to a standard working day off in lieu. If it is not feasible to take these days in lieu, then pay in lieu can be given.

**Further information**

GWC handbook sections 1 and 2  
Terms and conditions of service, paragraphs 23-28

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**Public holidays and zero hour days**

Where a doctor’s working pattern includes scheduled rest days (sometimes known as zero hours’ days) and such a day falls on a public holiday, then the doctor will be given a day off in lieu of the public holiday.
**Annual leave for locums**

Information on annual leave for locums is available in the ‘locums’ section of the handbook (see chapter 13).
16. Maternity, paternity and shared parental leave

**Summary**

This chapter provides a summary of the eligibility criteria for maternity and paternity leave and provides details of how they are calculated. Information is also provided on maternity pay and the contractual and training rights when on maternity leave.

Following the birth of a child, the rights to paternity leave and pay give eligible employees the right to take paid leave. There is a NHS scheme and a statutory scheme. New legislation regarding shared parental leave allows both parents to take leave concurrently or sequentially.

**Eligibility**

An employee working full time or part time will be entitled to paid and unpaid maternity leave under the NHS contractual maternity pay scheme if:

- she has 12 months’ continuous service with one or more NHS employers at the beginning of the 11th week before the EWC (expected week of childbirth)
- she notifies her employer in writing before the end of the 15th week before the expected date of childbirth (or if this is not possible, as soon as is reasonably practicable thereafter) of her intention to take maternity leave and of the date she wishes to start her maternity leave; and
- that she intends to return to work with the same or another NHS employer for a minimum period of three months after her maternity leave has ended and provides a MATB1 form from her midwife or GP giving the expected date of childbirth.

For doctors on visas, consideration needs to be given as to the timing of maternity leave and the implications this may have on visa status. The visa rules do allow for maternity leave but there are certain requirements that need to be met. If you are a BMA member you can contact the BMA Immigration Advice Service for more information.

**Changing the maternity leave start date**

If the employee subsequently wants to change the date from which she wishes her leave to start she should notify her employer at least 28 days beforehand (or, if this is not possible, as soon as is reasonably practicable beforehand).

**Confirming maternity leave and pay**

Following discussion with the employee, the employer should confirm in writing:

- the employee’s paid and unpaid leave entitlements under this agreement (or statutory entitlements if the employee does not qualify under this agreement)
- unless an earlier return date has been given by the employee, her expected return date based on her 52 weeks’ paid and unpaid leave entitlement under this agreement; and
- the length of any period of accrued annual leave and accrued leave for public holidays which it has been agreed may be taken following the end of the formal maternity leave period
- the need for the employee to give at least 28 days’ notice if she wishes to return to work before the expected return date.

**Keeping in touch**

Before going on leave, the employer and the employee should also discuss and agree any voluntary arrangements for keeping in touch during the employee’s maternity leave including:

- any voluntary arrangements that the employee may find helpful to help her keep in touch with developments at work and, nearer the time of her return, to help facilitate her return to work
- keeping the employer informed of any developments that may affect her intended date of return.

**Keeping in touch (KIT) days**

KIT days have been introduced to help make it easier for employees when it is time to return to work after a period of maternity leave. KIT days may be used for training or other activities that enable the employee to keep in touch with the workplace. However, they are not compulsory and any such work must be by agreement and neither the employer nor the employee can insist upon them. An employee may work for up to a maximum of 10 KIT days, excluding the first two weeks of compulsory maternity leave immediately after the birth of the baby, without bringing her maternity leave to an end. Any days of work will not extend the maternity leave period, but will be paid at the employee’s basic daily rate for the hours worked, less appropriate maternity leave payments.
Paid maternity leave

Amount of pay
Where an employee intends to return to work the amount of contractual maternity pay receivable is as follows:

− for the first eight weeks of absence, the employee will receive full pay, less any SMP (statutory maternity pay) or MA (maternity allowance) (including any dependants allowances) receivable
− for the next 18 weeks, the employee will receive half of full pay plus any SMP or MA (including any dependants allowances) receivable providing the total receivable does not exceed full pay
− for the next 13 weeks, the employee will receive any SMP or MA that they are entitled to under the statutory scheme.

By prior agreement with the employer this entitlement may be paid in a different way, for example a combination of full pay and half pay or a fixed amount spread equally over the maternity leave period.

Calculation of maternity pay
Full pay will be calculated using the average weekly earnings rules used for calculating SMP entitlements, subject to the following qualifications.

In the event of a pay award or nodal pay point advancement being implemented before the paid maternity leave period begins, the maternity pay should be calculated as though the pay award or nodal pay point advancement had effect throughout the entire SMP calculation period. If a pay award was agreed retrospectively, the maternity pay should be recalculated on the same basis.

In the event of a pay award being implemented during the paid maternity leave period, the maternity pay due from the date of the pay award should be increased accordingly. If a pay award was agreed retrospectively, the maternity pay should be recalculated on the same basis.

In the case of an employee on unpaid sick absence or on sick absence attracting half pay during the whole or part of the period used for calculating average weekly earnings in accordance with the earnings rules for SMP purposes, average weekly earnings for the period of sick absence shall be calculated on the basis of notional full sick pay.

In the event that upon return from an approved period of time out of programme, the continuity of service provisions mean an employee is eligible for maternity leave and pay but the reference period for calculating maternity pay would mean the resulting value of contractual maternity pay would be nil, the level of pay will be calculated from their last paid employment in a training post held immediately prior to going out of programme.

Unpaid contractual maternity leave
Employees will also be entitled to a further 13 weeks’ unpaid leave, bringing the total leave to 52 weeks.

Commencement and duration of leave
An employee may begin her maternity leave at any time between the 11th week before the expected week of childbirth and the expected week of childbirth provided she gives the required notice.

Sickness prior to childbirth
If an employee is off work ill, or becomes ill, with a pregnancy-related illness during the last four weeks before the expected week of childbirth, maternity leave will normally commence at the beginning of the fourth week before the expected week of childbirth or the beginning of the next week after the employee last worked whichever is the later. Absence prior to the last four weeks before the expected week of childbirth, supported by a medical statement of incapacity for work, or a self-certificate, shall be treated as sick leave in accordance with normal sick leave provisions. Where sickness absence is unrelated to pregnancy the normal sickness provisions will apply up until the date notified for the start of maternity leave.

Odd days of pregnancy-related illness during this period may be disregarded if the employee wishes to continue working until the maternity leave start date previously notified to the employer.

Pre-term birth
Where an employee’s baby is born prematurely the employee will be entitled to the same amount of maternity leave and pay as if her baby was born at full term.

Where an employee’s baby is born before the 11th week before the expected week of childbirth, and the employee has worked during the actual week of childbirth, maternity leave will start on the first day of the employee’s absence.
Where an employee’s baby is born before the 11th week before the expected week of childbirth, and the employee has been absent from work on certified sickness absence during the actual week of childbirth, maternity leave will start the day after the day of the birth.

Where an employee’s baby is born before the 11th week before the expected week of childbirth and the baby is in hospital the employee may split her maternity leave entitlement, taking a minimum period of two weeks’ leave immediately after childbirth and the rest of her leave following her baby’s discharge from hospital.

Still birth
Where an employee’s baby is stillborn after the 24th week of pregnancy the employee will be entitled to the same amount of maternity leave and pay as if the baby was not stillborn.

Miscarriage
Where an employee has a miscarriage before the 25th week of pregnancy normal sick leave provisions will apply as necessary.

Health and safety of employees pre- and post-birth
Where an employee is pregnant, has recently given birth or is breastfeeding, the employer should carry out a risk assessment of her working conditions. If it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties the employer should provide suitable alternative work for which the employee will receive her normal rate of pay. Where it is not reasonably practicable to offer suitable alternative work the employee should be suspended on full pay.

These provisions also apply to an employee who is breastfeeding if it is found that her normal duties would prevent her from successfully breastfeeding her child.

Return to work
An employee who intends to return to work at the end of her full maternity leave will not be required to give any further notification to the employer, although if she wishes to return early she must give at least 28 days’ notice.

An employee has the right to return to her job under her original contract and on no less favourable terms and conditions.

Returning on flexible working arrangements
If at the end of maternity leave the employee wishes to return to work on different hours the NHS employer has a duty to facilitate this wherever possible, with the employee returning to work on different hours in the same job. If this is not possible the employer must provide written, objectively justifiable reasons for this and the employee should return to their original contractor to a post at the same grade and work of a similar nature and status to that which they held prior to their maternity absence.

If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period this will not affect the employee’s right to return to her job under her original contract at the end of the agreed period.

Sickness following the end of maternity leave
In the event of illness following the date the employee was due to return to work normal sick leave provisions will apply as necessary.

Failure to return to work
If an employee who has notified her employer of her intention to return to work for the same or a different NHS employer in accordance with the regulations fails to do so within 15 months of the beginning of her maternity leave she will be liable to refund the whole of her maternity pay, less any SMP, received. If there is no right of return to be exercised because the contract would have ended if pregnancy and childbirth had not occurred the repayment provisions set out above will not apply. In cases where the employer considers that to enforce this provision would cause undue hardship or distress the employer will have the discretion to waive their rights to recovery.

Employees not returning to NHS employment
An employee who satisfies the required eligibility conditions but who does not intend to return to work with the same or another NHS employer for a minimum period of three months after her maternity leave is ended, will be entitled to pay equivalent to SMP, which is paid at 90 per cent of her average weekly earnings for the first six weeks of her maternity leave and to a flat rate sum for the following 33 weeks.
Employees with less than 12 months’ continuous service
If an employee does not satisfy the eligibility conditions for contractual maternity pay she may still be entitled to SMP. SMP will be paid regardless of whether she satisfies the eligibility conditions above. If her earnings are too low for her to qualify for SMP, or she does not qualify for another reason, she should be advised to claim MA from her local Job Centre Plus or social security office.

Fixed-term contracts or training contracts
Employees subject to fixed-term or training contracts which expire after the 11th week before the expected week of childbirth, and who satisfy the required conditions, shall have their contracts extended so as to allow them to receive the 52 weeks, which includes paid contractual and statutory maternity leave and the remaining 13 weeks of unpaid maternity leave. Absence on maternity leave (paid and unpaid) up to 52 weeks before a further NHS appointment shall not constitute a break in service.

Employees on fixed-term contracts who do not meet the 12 months’ continuous service condition set out above may still be entitled to SMP.

Rotational training contracts
Where an employee is on a planned rotation of appointments with one or more NHS employers as part of an agreed programme of training, she shall have the right to return to work in the same post or in the next planned post irrespective of whether the contract would otherwise have ended if pregnancy and childbirth had not occurred. In such circumstances the employee’s contract will be extended to enable the doctor to complete the agreed programme of training.

Contractual rights
During maternity leave (both paid and unpaid) an employee retains all of her contractual rights except remuneration.

Salary advancement
Maternity leave, whether paid or unpaid, will not be considered in the criteria for advancement to a higher nodal pay point and will result in a delay in the time taken to progress between pay points.

Accrual of annual leave and public holidays
Annual leave will accrue during maternity leave, whether paid or unpaid. Where the amount of accrued annual leave would exceed normal carry over provisions, it may be mutually beneficial to both the employer and employee for the employee to take annual leave before and/or after the formal (paid and unpaid) maternity leave period. The amount of annual leave to be taken in this way, or carried over, should be discussed and agreed between the employee and the employer.

Public holidays will also accrue during maternity leave.

Pensions
Pension rights and contributions shall be dealt with in accordance with the provisions of the NHS Superannuation Regulations.

Ante-natal care
Pregnant employees have the right to paid time off for ante-natal care. Ante-natal care may include relaxation and parentcraft classes as well as appointments for ante-natal care.

Post-natal care and breastfeeding mothers
Women who have recently given birth should have the right to paid time off for post-natal care. Employers are required to undertake a risk assessment and to provide breastfeeding women with suitable private rest facilities, and should consider requests for flexible working arrangements to support breastfeeding women at work.

Continuous service
For the purposes of calculating whether the employee meets the 12 months’ continuous service with one or more NHS employers qualification set out above, the following provisions shall apply:

- NHS employers includes health authorities, NHS Boards, NHS Trusts, primary care organisations and the Northern Ireland Health Service
- a break in service of three months or less will be disregarded (though not count as service).

The following breaks in service will also be disregarded (though not count as service):
- employment under the terms of an honorary contract
– employment as a locum with a GP (general practitioner) for a period not exceeding 12 months
– a period of up to 12 months spent abroad as part of a definite programme of postgraduate training on the advice of the postgraduate dean or college or faculty adviser in the specialty concerned
– a period of voluntary service overseas with a recognised international relief organisation for a period of 12 months which may exceptionally be extended for 12 months at the discretion of the employer which recruits the employee on her return
– absence on an employment break scheme in accordance with the provisions of the hospital terms and conditions of service
– absence on maternity leave (paid or unpaid) as provided for above.

If your break in service is not covered by the list above but spans a period approved as an OOPE (Out of Programme Experience for Clinical Experience), it may also be possible to have it disregarded. If you are in this situation, contact the BMA for advice.

Employment as a trainee with a general medical practitioner in accordance with the provisions of the Trainee Practitioner Scheme shall similarly be disregarded and will count as service.

Employers have the discretion to count other previous NHS service or service with other employers, and to extend the periods specified above.

University or honorary contracts
Doctors holding university and NHS honorary contracts will be subject to the maternity leave scheme that is in operation at their place of employment. A university contract, with or without an NHS honorary contract, does not count as continuous service under the NHS maternity scheme. However, where an employee has a university contract with an NHS honorary contract this period of employment will not constitute a break in service although it cannot be counted towards service for the purposes of further maternity leave.

Further information
Further guidance on maternity leave and pay, including the NHS Employers guide for junior doctors, can be found on the BMA website bma.org.uk/workingparents

Unfair dismissal
Regardless of length of service or hours of work it is unlawful for an employer to dismiss an employee or to select her for redundancy, solely or mainly because she is pregnant or has given birth, or for any other reason connected with her pregnancy or childbirth.

If you feel that you are being denied your employment rights contact our team of advisers on 0300 123 1233 in the first instance. They will assess your circumstances and where necessary arrange for local representation.

Defence body subscriptions
Doctors who take maternity leave should contact their defence body as special beneficial arrangements should apply.
Paternity leave

NHS scheme
The scheme applies equally to biological and adoptive fathers, nominated carers and same-sex partners.

Eligibility
Employees must have 12 months’ continuous service with one or more NHS employers at the beginning of the week in which the baby is due in order to qualify for the NHS paternity leave scheme. More favourable local arrangements may be agreed with staff representatives and/or may be already in place.

Benefits
There will be an entitlement to two weeks’ occupational paternity leave at full pay (less any statutory paternity pay receivable) per birth. SPP should only be deducted if the employee is eligible to receive it (see below).

Full pay will be calculated on the basis of the average weekly earnings rules used for calculating occupational maternity pay entitlements. Only one period of occupational paternity pay is ordinarily available when there is a multiple birth. However, NHS organisations have scope for agreeing more favourable arrangements where they consider it necessary or further periods of unpaid leave.

Local arrangements should specify the period during which leave can be taken and whether it must be taken in a continuous block or may be split up over a specific period.

An employee must give his or her employer a completed form SC3 ‘Becoming a parent’ at least 28 days before they want leave to start. The employer should accept later notification if there is good reason.

Paternity leave
Reasonable paid time off to attend ante-natal classes will also be given.

Those with insufficient NHS service to qualify for the occupational scheme will still be entitled to 2 weeks unpaid maternity support leave and may qualify for the statutory scheme.

Statutory scheme

Eligibility
Employees must satisfy the following conditions in order to qualify for paternity leave. They must:

- have or expect to have responsibility for the child’s upbringing
- be the biological father of the child and/or the husband or partner of the mother
- have worked continuously for the same employer for 26 weeks ending with the 15th week before the baby is due, or employed up to and including the week your wife, partner or civil partner was matched with a child for adoption.
- must be earning an average of the lower earnings limit a week (before tax).

Employers can ask their employees to provide a self-certificate form SC3 (becoming a parent) as evidence that they meet these eligibility conditions.

Length of paternity leave
Eligible employees can chooses to take either one week or two consecutive weeks of paternity leave (not odd days). They can choose to start their leave:

- from the date of the child’s birth (whether this is earlier or later than expected); or
- from a chosen number of days or weeks after the date of the child’s birth (whether this is earlier or later than expected); or
- from a chosen date later than the first day of the week in which the baby is expected to be born.

Leave can start on any day of the week on or following the child’s birth but must be completed within 56 days of the actual date of birth of child; or if the child is born early, within the period of the actual date of birth up to 56 days after the expected week of birth.

Only one period of leave is available to employees irrespective of whether more than one child is born as the result of the same pregnancy.

Statutory paternity pay
During their paternity leave, most employees are entitled to statutory paternity pay (SPP) from their employers.
SPP is paid by employers for either one or two consecutive weeks as the employee has chosen. The rate of SPP is the same as the standard rate of SMP.

**Notice of intention to take statutory paternity leave**
Employees must inform their employers of their intention to take paternity leave by the end of the 15th week before the baby is expected, unless this is not reasonably practicable. They must tell their employers:
- the expected week the baby is due
- whether they wish to take one or two weeks' leave
- when they want their leave to start.

Employees can change their mind about the date on which they want their leave to start providing they tell their employer at least 28 days in advance (unless this is not reasonably practicable). Employees must tell their employers the date that they expect any payments of SPP to start at least 28 days in advance, unless this is not reasonably practicable.

**Self-certificate**
Employees must give their employers a completed self-certificate as evidence of their entitlement to SPP. A model self-certificate for employers and employees to use is available on the BIS website. Employers can also request a completed self-certificate as evidence of entitlement to paternity leave. The self-certificate must include a declaration that the employee meets certain eligibility conditions and provide the information specified above as part of the notice requirements.

By providing a completed self-certificate, employees will be able to satisfy both the notice and evidence conditions for paternity leave and pay. Employers will not be expected to carry out any further checks.

**Contractual benefits**
Employees are entitled to the benefit of their normal terms and conditions of employment, except for terms relating to wages or salary (unless their contract of employment provides otherwise), throughout their paternity leave. However, most employees will be entitled to SPP for this period. If the employee has a contractual right to paternity leave as well as the statutory right, he may take advantage of whichever is the more favourable. Any paternity pay to which he has a contractual right reduces the amount of SPP to which he is entitled.

**Return to work after paternity leave**
Employees are entitled to return to the same job following paternity leave.

**Protection from detriment and dismissal**
Employees are protected from suffering unfair treatment or dismissal for taking, or seeking to take paternity leave.

Employees who believe that they have been treated unfairly can complain to an employment tribunal.

**Employers recovery of payments**
Employers can recover the amount of SPP they pay out in the same way as they can claim back SMP. Employers can claim back 92 per cent of the payments they make, with those eligible for small employers relief able to claim back 100 per cent plus an additional amount in compensation for the employers portion of national insurance contributions paid on SPP.

Additional paternity leave and pay is no longer be available for babies born after 5 April 2015. This has been replaced by shared parental leave (see below).

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**Further information**
Further guidance on paternity leave can be found on the BMA website: bma.org.uk/practical-support-at-work/working-parents/thinking-of-having-a-baby/paternity-leave

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**Shared parental leave**
In April 2015 the UK government introduced new legislation governing SPL (shared parental leave). This legislation allows SPL for two people who share care of a child (parent, husband, wife, civil partner, joint adopter or partner of the parent if they live with the parent and child) and allows them to share any untaken maternity leave (two weeks maternity leave is required after the birth) up to a maximum of 50 weeks. SPL can only be taken between the birth and first birthday (or the date of adoption and one year later). An overlap of maternity leave and SPL (of the other partner) is permitted but only if 8 weeks’ notice of the end of maternity leave has been provided.
There are a number of eligibility criteria which can be viewed on the Department of Health webpage (www.gov.uk/shared-parental-leave-and-pay/overview).

SPL can be taken at different times or overlapped with the partner but the total combined leave cannot exceed the duration of any remaining maternity leave. Both parents are able to work 20 days each during SPL.

Statutory SPL pay is at the same rate as maternity pay.

**Further information**
Further guidance on shared parental leave can be found at:
www.gov.uk/shared-parental-leave-and-pay/overview
www.bma.org.uk/advice/work-life-support/working-parents/shared-parental-leave
17. Sick leave

Summary
This chapter provides details on sick leave allowances, including the scale of the allowance, the calculation of allowances, notification of sickness and statutory sick pay.

Further information
Terms and conditions of service, schedule 9 paragraphs 40-60
NHS terms and conditions of service handbook (amendment number 35) 2015, section 14 & 22

Scale of allowance
Junior doctors absent from duty owing to illness, injury or other disability receive the following sick leave allowances.

<table>
<thead>
<tr>
<th>Duration of Service</th>
<th>Allowance</th>
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<tbody>
<tr>
<td>During the first year of service</td>
<td>one month’s full pay and two months’ half pay</td>
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<tr>
<td>During the second year of service</td>
<td>two months’ full pay and two months’ half pay</td>
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<tr>
<td>During the third year of service</td>
<td>four months’ full pay and four months’ half pay</td>
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<tr>
<td>During the fourth and fifth years of service</td>
<td>five months’ full pay and five months’ half pay</td>
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<tr>
<td>After completing five years of service</td>
<td>six months’ full pay and six months’ half pay</td>
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</tbody>
</table>

Full pay will include regularly paid enhancements, allowances, premia and London weighting based on the previous three months at work or any other reference period that may be locally agreed.

Employers can extend these allowances in exceptional cases. Because these periods are relatively short, junior doctors should also seek independent financial advice on income protection.

Calculation of allowances
The amount of sick leave allowance and the period for which it is to be paid are worked out by taking the junior doctor’s sick leave entitlement as on the first day of sickness and subtracting the total sick leave taken in the 12 months prior to the current absence. When calculating total periods of absence, days taken as unpaid sick leave are not counted towards the final figure. Specific conditions apply to absence due to injury, disease or other health conditions resultant through the discharge of duties in employment, and injury resulting from a violent crime. For the purposes of calculation of the allowance, 26 working days are equivalent to ‘one month’.

Previous qualifying service
All previous NHS service, (including continuous NHS locum service exceeding 3 months), university, local authority or civil service employment without any break of more than 12 months, is aggregated for sick leave purposes. There are several exceptional circumstances in which a break of more than 12 months does not mean a break in previous qualifying service.

Where a junior doctor has broken their regular service in order to go overseas on a rotational appointment forming part of their recognised training programme, or on an out of programme appointment for clinical training (OOPT), clinical experience (OOPE) or research (OOPR), their previous NHS or other approved service should be taken fully into account in assessing entitlement to sick leave allowance, provided that:

− the employer considers that there has been no unreasonable delay between the training abroad or out of programme appointment ending and the commencement of the subsequent NHS post.

Limitation of allowance when insurance or other benefit is payable
Sickness allowance, when added to sickness benefit, severe disablement allowance, invalidity benefit, statutory sick pay, compensation payments or other social benefits receivable, may not exceed the junior doctor’s normal salary for the period and the occupational sick leave allowance is restricted accordingly.

Notification of sickness
A junior doctor who is incapable of working because of illness should immediately notify their employer under the circumstances specified by the employer. If the sickness absence continues beyond the third calendar day, the doctor must
submit a statement of the nature of the illness within the first seven calendar days of absence. Further statements must be submitted to cover any absence extending beyond the first seven calendar days. They should take the form of medical certificates completed by a doctor other than the sick doctor. Exceptionally, the employer may require statements to be submitted at more frequent intervals.

A junior doctor admitted to hospital must submit a doctor’s statement on entry and on discharge in substitution for periodical statements. However, if the period of absence is less than seven calendar days, only a self-certificate is required.

‘Fit notes’ have now replaced sickness certificates. If you have any concerns about your sick leave or payment during this period, contact our team of advisers on 0300 123 1233.

**Injury sustained on duty**

It is important to note that a period of absence due to injury that is sustained by junior doctors in the actual discharge of their duties, and is not their own fault, is not recorded for the purpose of the scheme. It is essential that all such injuries are recorded at the first opportunity in the accident book or other mechanism for recording adverse incidents that may be in place.

**Termination of employment**

When a junior doctor is receiving the sick leave allowance at the time of expiry of their contract in a regular appointment, the allowance continues to be paid during the illness, ie after the contract would have been terminated, subject to the maximum entitlements set out in the ‘Scale of allowances’ section. This is an important provision of the sick pay arrangements, which is often overlooked by employers.

**Accident due to sport or negligence**

Sickness allowance is not paid in a case of accident due to active participation in sport as a profession or in a case in which contributory negligence is proved, unless the employer decides otherwise.

**Recovering damages from a third party**

A junior doctor who is absent as a result of an accident is not entitled to an allowance if damages are recoverable from a third party, but the employer may advance to the junior doctor a sum not exceeding the sickness allowance which would have been payable, subject to the junior doctor undertaking to refund any damages received.

Where a refund is made in full, the period of absence does not count against the sick leave entitlement. These provisions do not apply to compensation awarded by the Criminal Injuries Compensation Authority.

**Medical examination**

The employer may at any time require a junior doctor who is unable to perform their duties as a result of illness to submit to an examination by a doctor nominated by the employer.

**Forfeiture of rights**

If it is reported to the employer that a junior doctor has failed to observe the conditions of this scheme or has been guilty of conduct prejudicial to their recovery, and the employer is satisfied that there is substance in the report, the payment of the allowance can be suspended until the employer has made a decision. Before making a decision, the employer must advise the doctor of the terms of the report and provide an opportunity for the doctor to submit their observations and appear or be represented at a hearing.

**SSP (statutory sick pay)**

SSP is paid by the employer to employees. The sick pay paid by an employer will usually include both SSP and occupational sick pay entitlements. Where a doctor is entitled to occupational sick pay allowance equivalent to half pay and to SSP, the occupational sick pay allowance is increased by an amount equivalent to the amount of SSP due, except that the sum of the occupational sick pay allowance and SSP payable should not exceed the doctor’s normal pay for the period.

**Medical academic doctors**

For trainees employed by higher education institutions the policies concerning sickness absence (including any qualifying period of service that may apply) are determined by the university employer who should be informed immediately according to local arrangements.

**Carrying over annual leave as a result of sickness related absence**

Doctors unable to take their statutory annual leave allowance as a result of sickness related absence are permitted to carry over the remaining leave to a subsequent leave year where employment is continuous. The leave must be used within 18 months from the end of the leave year from which it was carried over. Where the doctor changes employer before taking this
entitlement, the leave will be compensated through pay. This provision only applies to leave within the statutory entitlement. any additional allowance exceeding this will lapse if it is not taken within the leave year in which it accrues.

Further information
18. **NHS pension scheme**

**Summary**
This chapter provides an overview of the new NHSPS (NHS Pension Scheme) which was introduced on 1 April 2015. Most junior doctors will join this new scheme (unless they had membership of either the 1995 or 2008 sections of the NHS pension scheme previously and were within 13.5 years of the section’s relevant normal pension age as at 1 April 2012) and all new employees will enter the new scheme automatically unless they opt-out.

On 1 April 2015 the new NHSPS (NHS Pension Scheme) was introduced for all new employees, and all current employees more than 13.5 years from normal pension age. All new employees will be automatically enrolled into the scheme on commencement of employment.

The scheme provides career average revalued earnings meaning that each year 1/54 (equivalent to 1.85%) of the pensionable earnings accrue towards the pension. It is necessary to have in place a mechanism for revaluing previous years’ earnings so that they do not lose value. Each year’s accrual is revalued by the Consumer Prices Index plus 1.5%. The total of all the annual pension accrual amounts are added together at retirement to calculate the final pension.

**Example**
If you earn £75,000 in pensionable income this year and the CPI rate is 3% your pension accrual for this year would be 1/54 x £75,000 = £1,389 and this accrual would be increased by the revaluation rate (CPI 3% + 1.5%) to £1,452.

Every year the total of the previous years’ pension accrual will be increased by the relevant rate for that year.

Comprehensive information is available on the NHS Business Services Authority website, including how the 2015 pension scheme will affect you, how it is different to the existing scheme and information about opting-out.

[www.nhsbsa.nhs.uk/Pensions/4017.aspx](http://www.nhsbsa.nhs.uk/Pensions/4017.aspx)

The following will be pensionable in the NHS Pension Scheme:
- all hours worked up to 40 hours per week on average and paid at the basic pay rate
- London weighting
- pay protection amounts as described in Schedule 2 paragraphs 46-50.

If you have not been able to find the answer you need on our web site, you can contact the BMA’s pensions department if you need further help. Write to:

Pensions Department, BMA House, Tavistock Square, London, WC1H 9JP

Tel: 020 7383 6138 or 020 7383 6166
Fax: 020 7383 6484
Email: pensions@bma.org.uk

[www.bma.org.uk](http://www.bma.org.uk/pensions)
19. Travelling and other expenses

Summary
This chapter covers the expenses that junior doctors are entitled to claim in respect of travel on NHS business. It explains the NHS lease car system and the reimbursement rates for subsistence when doctors are away from home on NHS business.

References are made throughout this section to paragraphs in the NHS Terms and Conditions of Service Handbook.

Junior doctors who are required to travel on NHS business are entitled to receive certain mileage allowances or may be offered a lease car. The circumstances under which juniors may receive mileage allowances are set out in Schedule 11 of the Terms and Conditions of Service and the NHS Terms and Conditions of Service Handbook. The following is a brief summary of the provisions:

Junior doctors working in the NHS who are required by their employer to travel on official business receive mileage allowances for the following journeys:

- principal hospital to any destination on official business
- home to principal hospital, when the junior doctor is called out in an emergency
- home to principal hospital in certain other circumstances when there is a subsequent official journey
- home to any destination other than the principal hospital, on official business, subject to certain conditions.

The mileage payable for such journeys is usually subject to a maximum allowance. Schedule 11, paragraph 15 of the terms and conditions of service sets out the entitlement in detail.

Further information
TCS Schedule 11
NHS Terms and Conditions of Service Handbook, Section 17

Rates of mileage allowances
Junior doctors who use their own car on NHS business are entitled to reimbursement at the appropriate rates shown in Table 7, Section 17 of the NHS Terms and Conditions of Service Handbook.

This rate will be reviewed each year soon after the new AA guides to motoring costs are published, normally in April or May. You should therefore check the NHS Terms and Conditions of Service Handbook to ensure your reimbursement rate is up to date.

Insurance
Junior doctors who use their own car on NHS business should ensure that the car is insured for business use.

Reserve rate of reimbursement
The reserve rate of reimbursement set out in Table 7 above will apply if a junior doctor uses their own vehicle for business purposes in the following situations:

- If the doctor uses their own vehicle when suitable public transport (eg rail or bus) would be appropriate, subject to a maximum of the public transport cost which would have been incurred and the rules on eligible miles in paragraph 15 of the 2016 terms and conditions of service and Table 8 in Section 17 of the NHS Terms and Conditions of Service Handbook.
- When a doctor is required to return to work on any day and thereby incurs additional travel to work expenses.
- If a doctor unreasonably declines the employer’s offer of a lease vehicle. In this situation, reasonableness should be determined by a joint agreement between the employer and doctor as to whether a lease vehicle is appropriate, and the timeframe for which the new arrangements will apply. All the relevant circumstances of the doctor and employer will be considered, including the doctor’s personal need for a particular type of car and the employer’s need to provide a cost effective option.
For the agreed principles underlying local lease vehicle policies, see Annex M of the NHS Terms and Conditions of Service Handbook.

If an employee uses public transport for business purposes, the cost of bus fares and standard rail fares should be reimbursed.

In all other circumstances, the standard rates apply.

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### Further information
TCS Schedule 11 para 17
NHS Terms and Conditions of Service Handbook, Section 17 & Annex M

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### Carriage of official passengers
A junior doctor carrying passengers who are employed by an NHS employer on NHS business, is entitled to receive a passenger allowance, at the rate outlined in Table 7 in the NHS Terms and Conditions of Service Handbook.

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### Further information
TCS Schedule 11 para 16
NHS Terms and Conditions of Service Handbook, Section 17

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### Garage expenses, tolls and ferries
Garage and parking expenses, and charges for tolls and ferries, will be reimbursed to junior doctors using their cars on official business on the production of receipts, whenever these are available. Overnight garaging or parking charges will only be reimbursed if the junior doctor is entitled to night subsistence allowance. This does not include reimbursement of parking charges incurred as a result of attendance at the doctor’s principle place of work.

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### Further information
TCS Schedule 11 para 22

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### Pedal cycles
Official journeys undertaken by pedal cycle attract expenses at 20 pence per eligible mile.

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### Further information
NHS Terms and Conditions of Service Handbook, Section 17

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### The Crown/lease car scheme
A Crown or lease car is any vehicle owned or contract-hired by an employer. The Crown/lease car scheme was introduced for hospital doctors in 1990. Although the outline of the scheme has been agreed nationally and is applicable to all employers, it is operated locally and may vary considerably between employers.
Eligibility
The default position is that junior doctors will use their own vehicles for travel in the performance of their duties, except where the employer has made a specific alternative provision. Use of a lease vehicle should be considered whenever it is expected that the business miles travelled in a year will exceed 3,500 miles.

Junior doctors are not automatically entitled to a lease car, but may be offered one if the use of a vehicle is essential to the job. The details of written lease vehicle policies are for local partnerships to design and agree.

Types of car
If a junior doctor chooses a vehicle not on the employer’s list of approved vehicles, any excess costs compared with the use of the approved vehicle are met by the individual junior doctor.

The arrangements for reimbursing junior doctors the costs of using the vehicle on NHS business must be made clear to the doctor. If the doctor is reimbursed fuel costs at a rate per mile, this rate must be reviewed regularly to ensure that it takes into account fluctuations on fuel prices.

Implications of declining a lease car
A junior doctor may be asked to have a lease car by an employer as it is more economical for them to provide a car rather than reimburse travelling expenses at standard rate. If the junior doctor unreasonably declines the request, they will be reimbursed at a reserve rate set out in Table 7 above.

Taxation
As far as HM Revenue & Customs is concerned, private use of Crown/lease cars constitutes a tax benefit and their treatment is therefore the same as a company car given to any employee. Junior doctors interested in Crown/lease cars should be aware that the scheme will only be economically advantageous to some individuals, depending on variables such as private and business mileage, size of car, and the tax position. They are therefore advised to proceed with caution. BMA members should seek advice from our team of advisers on 0300 123 1233 and/or their accountant.

Further information
TCS Schedule 11 paragraphs 8 & 17
NHS Terms and Conditions of Service Handbook, Annex M

Subsistence allowances
Subsistence allowances are payable in addition to travelling and other expenses when junior doctors are required to be away from their home. For example, they can claim in relation to periods of approved study leave, or in connection with removal expenses during a search for suitable permanent accommodation in a new area, subject to the terms of the employer’s removal expenses policy.

The following allowances are currently payable:

Night subsistence – commercial accommodation
When a junior doctor stays overnight in a hotel or other commercial accommodation with the agreement of the employer, the overnight costs will be reimbursed as follows:
- the actual receipted cost of bed and breakfast up to a normal maximum limit of £55; plus
- a meal allowance of £20 to cover the cost of main evening meal and one other daytime meal.

In exceptional circumstances where the maximum limit is exceeded (eg the choice of hotel was not within the claimant’s control or cheaper hotels were fully booked), additional assistance may be granted at the discretion of the employer.

Night subsistence – non-commercial accommodation
Where a junior doctor stays for short overnight periods with friends or relatives, a flat rate of £25 is payable. This includes an allowance for meals. No receipts are required.

Junior doctors staying in accommodation provided by the employer or host organisation are entitled to an allowance to cover meals which are not provided free of charge up to £20.
Where accommodation and meals are provided without charge, an incidental expenses allowance of £4.20 is payable. All payments of this allowance are subject to the deduction of income tax and NI through the payroll system.

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

**Short-term temporary absence travel costs**
Travel costs between the hotel and temporary place of work are reimbursed on an actual costs basis.

**Day meal allowances**
A meal allowance is payable when a junior doctor is absent from home and more than five miles from headquarters, by the shortest practical route, on the business of the employer. The rates are as follows:

- lunch allowance – £5 (more than five hours away from base including the lunchtime between 12 noon and 2pm)
- evening meal allowance – £15 (more than 10 hours away from base, returning after 7pm).

The above allowances are not paid where meals are provided free at the temporary place of work.

A day meal allowance is only paid when a junior doctor spends more on a meal/meals than would have been spent at the junior doctor’s headquarters. A junior doctor is required to certify accordingly on each occasion for which a day meal allowance is claimed, but a receipt is not required.

Junior doctors may qualify for both lunch and evening meal allowance in some circumstances. There will be occasions where, due to the time of departure, it will be necessary to take a meal but the conditions relating to the time absent from the base are not met. This, and any other exception to the rules, may be met at the discretion of the employer.

**Late night duties expenses**
A junior doctor may also receive in addition to a day meal allowance, an evening meal allowance of £3.25. This is paid at the discretion of the employer and is subject to income tax and NI contributions.

**Receipts**
The subsistence rates above are payable in full when junior doctors are away from home on official business. There is no requirement under the NHS Terms and Conditions of Service Handbook that staff should produce supporting vouchers/receipts, except in the case of claims for very long absence allowance, overnight bed and breakfast costs, train meal allowances or for abnormally high expenses. However, local policies (which do exist) may require receipts, and the position should be checked before claiming.

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**Further information**
TCS Schedule 11, paragraphs 35-42
NHS Terms and Conditions of Service Handbook, Annex N

**Telephone and postage expenses**
Any expenditure incurred by doctors on postage or telephone calls in the service of their employer is reimbursed by the employer, subject to evidence of expenditure.

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**Further information**
TCS Schedule 11, para 44
20. Removal expenses

Summary
This chapter covers the expenses that junior doctors are entitled to claim when moving to satisfy training needs, including the reimbursement of removal expenses, legal costs and other services.

The scheme for reimbursement of removal expenses gives employers discretion on the scope and level of removal expenses that they may reimburse. However, training grade doctors remain entitled to reimbursement of their removal or excess daily travelling expenses, and employers have been asked to take particular account of the circumstances of those who have to move frequently to satisfy their training needs, so that they are not disadvantaged by these moves.

Before accepting an appointment, doctors who would have to move to take up that appointment should contact the new employer as early as possible to check their eligibility for removal expenses. There is no national policy for the provision of removal expenses for clinical academics by university employers. This is very important because of the discretion which has been given to employers to determine eligibility.

It should be made clear that employers must reimburse removal expenses for junior doctors who are required to relocate in the interests of the service or to satisfy their training requirements.

As much information as possible should be obtained from the human resources department before accepting a post. Negotiation of removal or travel expenses should take place before the post is accepted, and confirmation of any agreement should be obtained in writing.

Junior doctors may find that their employer has negotiated a removal expenses agreement covering all staff. The BMA has issued guidance to its LNCs on negotiating such a package. Nevertheless, individual doctors may now have to play a greater role in negotiating their own expenses. In addition, some regions have established removal expenses policies covering all employers in the region and this will often include setting a limit on claims, usually of about £8,000 (above which any relocation payments become taxable).

Further information
TCS Schedule 11

Rotational appointments
Doctors who have to move during a rotational training appointment can choose to travel the greater distance between their home and their place of work on a daily basis instead of moving house. The mileage that may be paid under these circumstances is the difference between the mileage from home to their designated base place of work and the mileage from home to the new place of work, as set out in Schedule 11 paragraph 33 of the terms and conditions of service. In most cases the base place of work is where the majority of time and/or work is spent.

Further information
TCS Schedule 11, paragraphs 32-34

LTFT training
LTFT trainees should negotiate reimbursement of removal expenses directly with their new employer. The terms and conditions of service do not preclude full reimbursement to those moving into LTFT training, however if members experience difficulties with receiving reimbursement or would like advice on how best to approach their employers they should contact our team of advisers on 0300 123 1233.

GP trainees
Doctors who are on a GP training programme and who move from a hospital placement to a GP practice placement, or who move from one GP practice placement to another, and out of necessity change their accommodation are entitled to removal expenses.

Honorary contract holders
A doctor moving from a post with a university, the MRC (Medical Research Council) or the Wellcome Trust where they held an honorary NHS contract will probably be eligible to receive removal expenses on return to the NHS.
Doctors moving from the NHS to MRC or university appointments will receive whatever removal expenses are payable by the MRC or individual university. Universities do not always pay removal expenses though it may be available if discussed in advance of agreeing a contract.

Please refer to the Medical academic handbook for further information.

**Responsibility for payment**
The doctor's new employer is responsible for the payment of expenses.

**Agreement to remain in service**
As a condition of receiving removal expenses, employers may require some groups of doctors to sign an undertaking that they will not leave the service of that employer within two years unless the circumstances justify the release of the doctor from this undertaking. If this is broken, the doctor may be required to refund all or part of the expenses.

Doctors in training should be wary of signing a contract containing an agreement to remain in service as it is often the case that they will leave the employer’s service within two years for training reasons. Our team of advisers on 0300 123 1233 can advise on the best course of action if this occurs.

**Further information**
TCS Schedule 11, paragraphs 25-31

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**Level of expenses payable**
Under the terms and conditions of service employers should, prior to the post being accepted and in agreement with the employee, determine the scope and level of financial assistance to be provided. The provision of removal expenses will form part of the contract of employment. Employers have been asked to ensure equity between different categories of staff, and should take into account both their own interests and the needs of prospective employees. The employer must also ‘clearly indicate the aspects of removal costs that will be reimbursed, and, where applicable, the upper limit of payment in all usual circumstances’.

This implies that there may be considerable variation in expenses offered according to factors such as area, ease of recruitment in a particular specialty etc. Employers must, however, also take the following into account when considering the level of expenses:
- all the individual’s circumstances
- the need to re-house dependents
- comparability of old and new accommodation.

Doctors will need to be aware that expenses offered may vary, although expenses should be based on costs actually incurred. There should be a clearly set out appeals procedure to cover cases of disagreement.

**Legal and other services**
Employers are given discretion to establish, in negotiation with the employee, the procedure to be followed and costs to be reimbursed where an employer has entered into an agreement with solicitors or other agencies to provide house purchase, conveyancing or removal services at preferential cost.

The BMA is opposed to the concept of employers imposing their choice of legal or other services on an employee. Doctors who wish to choose their own solicitor etc should establish at an early stage whether this is acceptable, and should note that if they use their own solicitor, the employer may impose an upper limit on reimbursable expenses based on their own agency’s charges.

**Tax**
Removal expenses can be paid tax-free up to a ‘qualifying limit’, which is revised from time to time. Currently, the limit stands at £8,000. Further information can be obtained from our team of advisers on 0300 123 1233 and from our website: bma.org.uk/advice/employment/pay/removal-expenses/tax-on-removal-expenses. Your local tax office will also be able to help. Also be aware that to get tax relief your expenses must be incurred, or the benefits provided, before the end of the tax year following the one in which you start your new job (a tax year runs from 6 April one year to 5 April the next).

**Further information**
Finance Act, 1993, section 76, schedule 3
21. Accommodation and catering

Summary
This chapter covers entitlements to accommodation, overnight accommodation when on-call and working full-shift rota patterns, accommodation standards and catering provisions.

If a doctor's duties require them to be resident then the employer is required to provide accommodation. In addition, if a doctor, for good reason, cannot obtain suitable accommodation and whose recruitment and retention would otherwise prove difficult the employer may provide accommodation.

There is no longer a statutory requirement in the UK for preregistration doctors (first year foundation doctors [F1s]) to be resident, which in turn means that hospital accommodation no longer needs to be provided without charge to F1s in England.

Overnight accommodation when on-call
No charge should be made for on-call accommodation for junior doctors who are required to work overnight in the hospital on a resident on-call working pattern. This is detailed in Schedule 12 paragraph 12 of the terms and conditions of service.

If a doctor is rostered to work on a non-resident on-call working pattern and the doctor elects voluntarily to be resident during the on-call duty period, then they are not eligible for free accommodation.

If a doctor is working a full-shift pattern but is not required by condition of appointment to be statutorily or compulsory resident at the hospital then they are not eligible for free accommodation.

Accommodation for doctors on full shifts
Even with the EWTD provisions and new contractual limits on hours in place, a junior doctor could still be working 5 consecutive days consisting of 13-hour shifts. In addition to this, travel time to and from work following a 13-hour shift results in severely depleted opportunity to sleep, potentially exacerbated by lengthy journeys for doctors in rotations that cover large geographical areas.

A substantial body of research has been carried out into the negative effects of working long hours. If a junior doctor feels unable to travel home following a long late shift due to tiredness, they should inform their employer. The employer should then provide an appropriate rest facility where the doctor can sleep. If this is not possible, the employer must ensure that there are alternative arrangements in place for the doctor's safe travel home. In this situation, the hours where the doctor is resting in hospital will not count as working time.

A judgement in the ECJ (European Court of Justice), known as the Jaeger judgement, ruled on the way in which on-call work should be regarded. It notes the specific case of removal of accommodation during duty periods and permit of sleep while on duty on the hospital site. The JDC recognises that accommodation facilities are frequently unfavourable to restful sleep and also that with cross-cover arrangements within a full-shift arrangement there is less likelihood of sleep being possible while on duty.

This opinion, as well as confirming the position in SiMAP, goes further by suggesting that a bed provided to a doctor on duty to enable him to rest from time to time contributes to protecting his health and to ensuring that he is able to attend properly to patients. More details on the Jaeger judgement can be found in the EWTD section of this handbook.

If a junior doctor rostered to work a non-resident on-call pattern who is required to return to work during the night considers it unsafe to undertake the return journey home due to tiredness, the employer should provide an appropriate rest facility if requested. If this is not possible, the employer must make sure alternative arrangements are in place for the doctor's safe travel home. In this situation, the hours where the doctor is resting in hospital will not count as working time.

Further information
Terms and conditions of service Schedule 12, paragraphs 9-12
BMA joint position statement on on-call rooms bma.org.uk/employmentandcontracts/pay/accommodation/jntposstmtsleep.jsp
**Accommodation between duty periods**

In circumstances where intervals between duty periods make it unreasonable for the junior doctor to travel to their home or usual residence, for example between shift duties hospital employers do have a duty of care to ensure the safety of their employees and as best practice should offer to provide free accommodation.

For those doctors who feel unable to travel home following a night shift due to tiredness, an appropriate rest facility should be made available in order for the doctor to sleep. If this is not possible, the employer must ensure that there are alternative arrangements in place for the doctor’s safe travel home. In this situation, the hours where the doctor is resting in hospital will not count as working time.

Many hospital employers only provide a rest room with a chair or a recliner. This should not be considered adequate when there is a requirement for proper rest.

**Tenancy agreements**

The NHSE (NHS Executive) issued model tenancy and license agreements, to be used according to circumstances. Essentially, these are classified as:

- an assured tenancy agreement
- an assured shorthold tenancy agreement
- a license agreement.

A license agreement offers no security of tenure and merely licenses the occupation of the premises. An assured tenancy is the most common form of agreement between private landlords and their tenants. It cannot be used for properties that are not let as separate dwellings or are the individual’s only or main home. Junior doctors are therefore most likely to be offered assured shorthold tenancies.

An assured shorthold tenancy offers the landlord a guaranteed right to repossess the property at the end of the agreed period of the tenancy. The first assured shorthold tenancy must not be for less than six months and at least two months’ notice is required to bring it to an end. A model fixed-term tenancy agreement, which was agreed with the NHSE is available from our team of advisers on 0300 123 1233.

Rents under this type of tenancy should not be increased during the term of the tenancy, though they are exclusive of service charges, which may be added on (see below).

**Service charges**

Employers usually arrange for the installation of a meter for each unit of accommodation to assess the consumption of gas and electricity. The charge is laid down by the gas or electricity company and paid directly by the individual. In some cases, where meters are not installed, the employer may include these charges in the accommodation charge. Employers are also required to add to the assessed rent a sum equivalent to the cost of any services such as central heating, which they provide, though this must reflect a reasonable level of consumption and take account of the difficulty usually encountered by individual residents in controlling their own heating.

Employers may also add a sum to cover the cost of ‘furniture and fittings’ based on the gross value of the furniture when new.

**Standards of accommodation**

**Catering**

Junior doctors required to work during the overnight period must be able to access both hot and cold food and drink. If restaurant facilities are closed, there should be a range of foods available from vending machines or other means. Employers should make reasonable efforts to cater for various dietary requirements.

If catering facilities are limited, organisations should identify local establishments that can provide food during the night. They may also wish to provide facilities for preparation and storage of food brought by junior doctors.

Junior doctors rostered to work a night shift must have access to a space for taking meals and other rest breaks. This should be an area away from patients where possible.

**Guidance on hospital accommodation and catering**

The JDC has produced guidance on hospital accommodation and catering based on HSC 2000/036 ‘Living and working conditions for hospital doctors in training’. A copy of the guidance is available via the BMA website. In addition a toolkit is available on the BMA website for doctors in England to check the standard of their hospital accommodation.
**Further information**
BMA guidance and standards for living and working conditions for hospital doctors in training:
bma.org.uk/practical-support-at-work/contracts/juniors-contracts/accommodation/accommodation-full
22. OOP (Out of Programme) experiences

Summary
This chapter explains the different types of OOP options, application details and how to return to training.

The purpose of time spent OOP is to allow trainees to take up opportunities that their training programme would otherwise prevent. Depending on the activity, time spent OOP may or may not contribute towards the CCT (Completion of Training Certificate) as the nature of the activity will determine for how long a training programme should be extended.

Different types of OOP

- **OOPT** (Out of Programme Experience for Training) which has approval from the GMC and will contribute towards obtaining your CCT.
- **OOPE** (Out of Programme Experience for Clinical Experience) which has not received approval from GMC for contribution towards a trainee's CCT.
- **OOPR** (Out of Programme Experience for Research) (including a registerable higher degree) can be up to three years.
- **OOPC** (Out of Programme Experience for a career break (eg to work in industry, or for ill-health reasons)).

**OOP and CCT**
An OOP will only count towards CCT if it is undertaken as an OOPT. In this instance, approval will be provided in advance from the GMC.

**Application details**
Application processes vary depending on the deanery/LETB and therefore it is recommended you check the specific deanery/LETB website for guidance specific to the region.

If OOPT is being undertaken, the deanery/LETB will apply for approval to the GMC. The GMC is the only body which can give, amend or withdraw training approval for any OOP intended to lead to the award of CCT.

Full details of the approval process are on the GMC website at [http://www.gmc-uk.org/doctors/seeking_approval.asp](http://www.gmc-uk.org/doctors/seeking_approval.asp)

The GMC will not accept applications for OOP directly from the trainees or the respective colleges.

**Application timeframes**
The deanery/LETB will normally want trainees to have been in their current training programme for at least a year before they can apply for time OOP. Deferring the start of a training programme is slightly different, and deans will not normally agree to deferment except on statutory grounds like maternity, or for time to complete a higher degree - however, more flexible deferment may be available for those with an offer for GP training.

**Duration of OOP**
This will depend on the nature of the project/task being undertaken. There will need to be a declaration of the return date in the application to the deanery/LETB. The Gold Guide states that an OOP will normally be up to one year, but exceptionally can be up to two years. However, for longer periods and with OOPR, discussions should take place with the deanery/LETB at the time of making an application. The deanery/LETB will then be able to confirm if the trainee will retain their NTN number.

**Returning to training**
It is important to adhere to guidelines set by the deanery/LETB to ensure that the training post is still available once the OOP has finished, in particular to the specifications imposed by your deanery and GMC with regards to the nature of your work undertaken OOP and your obligations to keep the deanery/LETB up to date (including for ARCP/RITA purposes) during the time OOP. Ensure adequate notice of the intention to return to work and provide at least six months’ notice of the intended return to work.

**Application refusal**
If the application for time OOP is refused or the GMC will not approve time OOP for contribution towards CCT the following course of action is recommended. Write to the deanery/LETB to request written confirmation of the reasons the application for OOP was refused and written confirmation of the amendments to the application that would satisfy their criteria for an OOP request.
Upon receipt of the letter from your deanery/LETB, find out if it is possible to amend the application for time OOP to fulfil the criteria set. If you have any problems, contact our advisers on 0300 123 1233 or at support@bma.org.uk

**Further information**


The BMA website has further information available at:
- bma.org.uk/advice/career/applying-for-training/out-of-programme
- bma.org.uk/developing-your-career/career-progression/broaden-your-horizons/how-to-apply/trainee-doctor/reasons-for-oop

**Thinking of working abroad?**

The BMA international department has published guidance on working abroad and working in the EEA, which is available on the BMA website [https://www.bma.org.uk/advice/career/going-abroad/working-abroad](https://www.bma.org.uk/advice/career/going-abroad/working-abroad).

This guidance includes information about what to think about before you go, deciding where to go and how to apply.

The BMA also has guidance on its website about working in developing countries ([https://www.bma.org.uk/advice/career/going-abroad/volunteering-abroad](https://www.bma.org.uk/advice/career/going-abroad/volunteering-abroad)). This guidance aims to support doctors at all stages in their careers, from trainees, specialty doctors and associate specialists, to consultants and GPs, in successfully taking time out from working as a doctor in the NHS to gaining professional experience in developing countries. It also aims to support deans and employers in the NHS to understand how best to support doctors as part of the wider workforce.

The BMA international department also works with BMA regional services to provide advice to individual members on integrating overseas work with an NHS career, including specific issues such as registration and immigration procedures and working for agencies as well as steps to take before leaving and returning to the NHS to help avoid problems.

For further information please contact the BMA international department at info.international@bma.org.uk
23. Medical academic doctors

Summary
This chapter provides more information about routes into academic medicine. It also outlines what you might expect to encounter in the medical academic workplace, including information on contracts and pay.

What is academic medicine?
According to the Academy of Medical Royal Colleges: ‘Academic medicine is the work undertaken by clinicians with responsibilities to both their University and their NHS Hospital Trust. They usually combine service delivery with research, teaching and/or administration.’

In practice, doctors undertaking this role are usually employed by medical schools within universities, although also, but less commonly, employed by universities with postgraduate medical centres or without medical schools. They usually have honorary contracts with local NHS organisations and undertake a limited number of fixed clinical sessions, while the main focus of their work is on teaching and research. Those doctors also with clinical commitments are known as clinical academics and are on a pay scale equivalent to that in the NHS.

Training opportunities in academic medicine
The ‘Integrated Academic Training Pathway’ clearly defines the key entry points into the specialty area of academic medicine and outlines a transparent career structure where progression is identifiable from the outset. Starting at foundation level—which gives trainees a taster of academic medicine—and progressing through two specialty phases, the Pathway is intended to be the dominant career route for medical academics. Of the training opportunities offered, the majority will be research-focused with fewer concentrating on training for educationalists.

It is important to note that, although defined as the principal career pathway into academic medicine, it is not the only route and opportunities are available to enter the academic career structure at different stages of a clinician’s career, even as a consultant.

The BMA would argue that the Follett Review Principles should apply even from FY1 level. ACFs in England should, therefore, hold honorary university contracts, and the BMA advises that an honorary contract may also be useful for juniors on academic foundation programmes. These, however, are by no means automatically forthcoming.

Follett Review Principles
All medically qualified academic staff working for both the NHS and a higher education institution should be employed subject to the principles recommended by Professor Sir Brian Follett in September 2001 in his Review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties. The recommendations are broadly accepted by both sectors and are known as the Follett Review Principles. The key principle is for NHS and university organisations involved in medical education and research to work together jointly to integrate the separate responsibilities. For more details, see the BMA’s Medical Academic Handbook.

Academic foundation programmes (AFPs)
Academic foundation programmes (AFPs) offer a unique training opportunity for those interested in a career in academic medicine. The programme is delivered in the foundation year 2 (FY2) either as an academic rotation or integrated throughout the entire year. Under the scheme trainees receive a comprehensive introduction to academic medicine as part of their foundation programme. They will be employed by the NHS and paid under the same terms and conditions as apply to other foundation trainees. There are currently around 450 AFPs and they are offered by all foundation schools across the UK.

For further information see the Rough guide to the academic foundation programme (UKFPO):

Academic clinical fellowships (ACFs)
The ACF is the first phase of specialist academic training in England and usually leads to the attainment of a higher degree by means of a competitive peer-reviewed research fellowship or educational training programme. General clinical training and practice will still form the majority of the responsibilities of those on the fellowships, with 25 per cent of a trainee’s time protected for sessions aimed at developing the necessary academic skills required to develop ideas for and prepare applications to more substantive clinical fellowships or funding to do a higher degree. A maximum of three years (four years for a GP) is allowed to secure a research/teaching fellowship—although it is expected that one may be secured in less time—with a further three years for the completion of the higher degree. Part-time opportunities of a longer duration may also be available.

Royal College of Physicians of London, 2004
Successful applicants to an ACF will be employed by the NHS under the national terms and conditions agreed for junior doctors. They are classed as trainee members of the National Institute for Health Research (NIHR) faculty. ACFs should also have honorary academic contracts in order to have ease of access to HEI facilities and some further training. To help ensure that the best candidates are attracted to ACF posts, the recruitment round for national specialty training currently takes place before the general recruitment process.

However, posts do not necessarily have to be made available each year, and to allow a greater degree of flexibility for both deaneries and trainees the recruitment process may take place at any point within the year in which the post was allocated. Prospective applicants are therefore advised to contact the relevant deanery in the first instance to check for availability and the specific application timetable.

A list of deaneries with ACF programmes and allocated posts is available through the National Institute for Health Research (NIHR) Trainees Coordinating Centre website, along with the contact details for further enquiries. The MMC website and local deaneries provide more detailed information.

Success in obtaining a research training fellowship or a place on an educational programme which leads to a higher degree is usually seen as the end of the ACF period. At this point trainees, with the agreement of their postgraduate dean, will take time out of their clinical programme to complete the MD, PhD or equivalent higher degree.

**Clinical lectureships (CLs)**

CL posts are the second phase of specialist academic training in England and are designed to enable trainees to complete clinical training in conjunction with postdoctoral research or higher educational training. Clinical lecturers will be employed primarily by the higher education institution in which they hold a post. As the clinical academic timetable split will be half-half, a clinical lecturer should also have an honorary contract with the NHS to cover their clinical duties. A separate contract may be needed to cover out-of-hours work.

The CL phase lasts up to four years and a trainee’s continued academic career development will be the responsibility of the organisation in which they are based. The programme enables the trainee to undertake a substantial piece of postdoctoral research or educationalist project and leads to the attainment of a Certificate of Completion of Training (CCT) and the end of clinical training. Clinical lecturers are also classed as trainee members of the NIHR faculty.

**Other routes**

Although the three training programmes are seen as the dominant pathway for a career in academic medicine, there is flexibility, with other entry points and routes into the career framework. Other academic training posts that are not funded from the NIHR are also available. For more information, see the Medical Academic Handbook.

**Academic and clinical progression**

The progress of all trainees who undertake postgraduate specialty training is formally assessed through the Annual Review of Competence Progression (ARCP) which reviews evidence both for a trainee’s progression and the appropriateness of their clinical and academic training programmes. Full details regarding the monitoring of clinical progress and the roles and responsibilities of both trainee and supervisor are set out in the MMC’s ‘Reference guide for postgraduate specialty training in the UK’, known as the Gold Guide. Academic progress is assessed by the academic supervisor across three generic domains – generic and applied research skills, research governance and communication/education.

**Supervisors**

For all research projects, but particularly PhDs, the role of the supervisor is critical. Hence, the choice of supervisor is key. They will be a senior member of the academic community and you should ensure that the two of you are compatible with the right balance between supporting your creativity and having a practical eye on delivering the work on time. A checklist of what can be expected from a supervisor can be found on page 164 of the Medical Academic Handbook.

**Mentoring**

Given the long duration of academic training and its coupling with higher specialist training, early career medical academics particularly need support in developing a career. Mentoring schemes should be as flexible as possible and should allow either party to seek an alternative partner should they feel the mentoring relationship is not working. The Academy of Medical Sciences (www.acmedsci.ac.uk) has established a mentoring scheme for senior academic trainees and the local deanery may also be able to offer support in identifying a mentor.

**Role of postgraduate deaneries**

The BMA fully expect postgraduate deaneries to be involved in ensuring the clinical element of training accords with national standards. The deanery office can be approached for advice and we would urge trainees to establish a good relationship with clinical and education supervisors early on.
Terms and conditions
All institutions should provide information about their human resource policies to prospective employees. Terms and conditions of medical academic contracts may differ from NHS contracts. Look out for the details regarding pension schemes, annual leave and maternity leave. If you are in doubt, contact the BMA to have your contract checked before signing. The extent to which terms and conditions vary from NHS contracts depends on the grade of doctor, whether the doctor undertakes clinical work and, because HEIs are incorporated under individual statutes which govern their operations, the university employing the academic. MASC has produced detailed information about the human resource policies at many HEIs that employ medical academics in the BMA’s University employment good practice guide and the Medical Academic Handbook.

bma.org.uk/advice/employment/contracts/academics- contracts/guide-to-university-employers

Doctors working primarily in the NHS who also undertake research and/or education at a higher education institution should hold a substantive contract of employment with an NHS employer. They should also hold an honorary academic contract that outlines the rights and responsibilities of both the employee and the employer in respect of the academic work carried out. The honorary contract will also provide trainees with ready access to the university library and other facilities.

Intellectual property
Both employers will have rules about intellectual property, which are normally agreed between the university and the employer. Whatever rules apply must be made explicit to the clinical academic trainee, in all cases.

Pay
Junior academics employed by higher education institutions should have pay parity with their NHS colleagues. They should be paid equivalent to a specialty trainee, with pay banding for work above 40 hours per week and in out-of-hours time.

Clinical academics below the level of consultant are paid on a clinical lecturer and senior clinical lecturer/reader scales, which draws on the pay scale for specialist registrars working in the NHS. For more experienced trainees, it may be more appropriate to use the UCEA salary scale below the level of consultant as it contains a number of additional points on the scale.

Medically qualified academics who do not undertake clinical work will be subject entirely to the terms and conditions of the HEIs. This includes junior doctors who have secured grant funding for research (including from the MRC or the Wellcome Trust) but who hold a contract of employment with an academic institution. Junior doctors taking time out of a training programme to complete a period of research will be paid according to university pay scales or in accordance with grant funding. See the Medical Academic Handbook for more details or contact the BMA for further advice (0300 123 123 3).

Moving between sectors
NHS doctors planning to move into the academic sector should note that an honorary contract with an NHS Trust/health board should be offered jointly with the contract with the substantive university employer. Retaining an honorary contract while working in a university provides for some important employment protections, especially if the doctor intends to return to the NHS. The BMA recommends that all those working in the higher education sector, especially junior doctors undertaking a period of research OOP, hold honorary contracts with the NHS where possible.

A+B contracts
Some medical academics are employed on ‘A+B contracts’. They are either employed:

- jointly on a full-time basis. Doctors are employed on a full-time basis either by the NHS with sessions subsumed to the university and work done in these sessions directed by the university; or employed on a full-time basis by the university and sessions subsumed to the NHS and work done in these sessions directed by the NHS; or
- on a part-time basis with both a medical and dental school or MRC and an NHS organisation (in which case the consultant will be treated as part time by both the university and the NHS employer).

Short-term or fixed-term contracts
Medical academics can sometimes be offered short-term or fixed-term contracts by higher education institutions. Doctors who are employed on short-term contracts (or more accurately, fixed-term contracts) are in a relatively more vulnerable position but they do have certain rights under the law. These are enshrined in the Fixed-Term Employees (Prevention of Less Favourable Treatment) Regulations, 2002.

Under the Regulations, fixed-term employees cannot be treated less favourably than comparable permanent employees unless the different treatment can be objectively justified. If fixed-term employees believe that their rights under these Regulations have been infringed, they should contact the BMA.
Redundancy
For medical academics employed by a university terms and conditions are determined by the type of contract they have. Universities are independent employers and will have their own policies dealing with the possibility of redundancy in relation to all staff. You will have the same statutory entitlements as any other worker but your contractual entitlement may differ from those with contracts with another employer or with the NHS.
24. Overseas doctors and international medical graduates

Summary
The UK immigration system is a points based system. The points based system is not enacted through legislation so the UK Government can, and does, change the system on a regular basis. The Points Based System consists of five tiers. Tiers 2 and 4 are most relevant to doctors or prospective medical students from outside the European Economic Area (EEA) who wish to come to the UK.

As the rules change frequently it is important to check the BMA website for the most up-to-date information at: bma.org.uk/immigration

The process for doctors graduating in the UK
The immigration route for overseas medical graduates on the Foundation Programme is:
- a new Tier 4 visa is needed to take up a Foundation Programme post
- at the end of the Foundation Programme, the doctor needs to ‘switch’ to a Tier 2 (General) visa to take up a core specialty training post

Members should always check with the BMA immigration advice service before switching visas or changing training pathway, to make sure they meet all the requirements and to ensure they make the best choices for their route through training. The Service can advise any member who is a doctor subject to the immigration rules whether they are a graduate of a UK university, already working in the UK or looking to move to the UK. It is important to seek advice when considering taking any time out of training as this can have an impact on visas and future eligibility for re-entering training.

BMA immigration advice service
To help BMA members who are subject to the Immigration Rules, the international and immigration division provides an immigration advice service. Our immigration advisers are authorised by the Office of the Immigration Services Commissioner (OISC), to give members basic immigration advice. This includes:
- applications for leave to enter or remain in the UK which are within the immigration rules
- diagnosis of the member’s need for specific immigration advice
- provision of one-off advice.

The BMA immigration advice service can be contacted on 020 7383 6133 or email info.international@bma.org.uk

Further information
BMA Website: bma.org.uk/immigration
The UK Visa and Immigration website: https://www.gov.uk/government/organisations/uk-visas-and-immigration
25. Revalidation

Summary
Revalidation is the process for doctors to assure the General Medical Council (GMC) that they are up to date and fit to practice. The implementation of revalidation began at the end of 2012 and all doctors who wish to retain their licence to practise are now legally required to be revalidated every five years.

Background
Various schemes for revalidation of doctors’ fitness to practise have been considered over many years and in this time a number of models for revalidation have been proposed. Revalidation was on the verge of being implemented in 2005 but was thrown off course by the Shipman Inquiry. The current system builds on the recommendations from former chief medical officer for England Professor Sir Liam Donaldson in his 2006 report ‘Good Doctors, Safer Patients’. A more comprehensive overview on the background to revalidation can be found on the BMA’s website bma.org.uk/practical-support-at-work/revalidation/revalidation-background

What is revalidation?
Revalidation is the process for doctors to positively affirm to the GMC (General Medical Council) that they are up to date and fit to practice. It applies to all licensed doctors in the UK working in the NHS and the private sector and all branches of practice. Only doctors who have GMC registration with a licence to practise are legally required to revalidate. Doctors who hold registration without a licence to practise are not required to do so. Further information on licensing for doctors can be found on the GMC website.

The process
Doctors with a licence to practise must revalidate, usually every five years. Revalidation is based on an evaluation of a doctor’s practice in the workplace and doctors participate in an annual appraisal process. The appraisal is based on the GMC’s Good medical practice. Doctors also need to collect and reflect on a range of supporting information about their practice (including evidence of continuing professional development and feedback from patients), to be discussed at their appraisal. Doctors are supported through the process of revalidation by the organisation in which they work – a ‘designated body’.

These organisations have a statutory duty to provide the doctors connected to them with a regular appraisal and to help them with their revalidation. Designated bodies have a ‘responsible officer’ who, every five years, make a recommendation to the GMC that a doctor is up to date and fit to practise.

More information about the process is available on the GMC’s website: www.gmc-uk.org/doctors/revalidation.asp

As a doctor in foundation or specialty training, you will revalidate in a similar way to other licensed doctors. Your ‘responsible officer’ will make a recommendation to us that you are up to date, fit to practise and should be revalidated. The GMC has specific guidance for doctors in training: www.gmc-uk.org/doctors/revalidation/12383.asp

For junior doctors in training posts, the processes of assessment and the ARCP/RITA cycle will provide the evidence that is required to demonstrate this. It should be noted that failure to progress to the next stage of training does not mean that the doctor is not fit to practise at the level at which they are currently working; it means they are not ready to progress yet.

BMA’s seven principles on revalidation
The BMA believes that revalidation must be based on the following set of principles:

1. There must be a clear mechanism for dealing with conflicts of interest with responsible officers, including an appeals process with an independent scrutineer.
2. Remediation must be fully funded to ensure equality across branches of practice.
3. Medical royal college standards for revalidation must be equitable, fair and proportionate.
4. Knowledge tests should form no part in assessing fitness to practise, whether as part of the GMC’s generic standards for relicensing or in college standards for recertification; any multisource feedback system must be validated.
5. The introduction of revalidation must be cost-effective and not put undue strain on the NHS.
6. Pilots must run independently and be fully evaluated, with the results published and fed into subsequent pilot stages.
7. There must be equality of opportunity to revalidate.

* All doctors need a licence in order to practise medicine in the UK, in addition to GMC registration.
Further information
The BMA webpages provide updates on revalidation at bma.org.uk/revalidation

The GMC website www.gmc-uk.org/doctors/revalidation.asp

GMC Online, a secure area of the GMC website designed to make administration easier for doctors www.gmc-uk.org/doctors/information_for_doctors/gmc_online.asp
26. **Raising concerns and whistleblowing**

**Summary**
Doctors working in the NHS face many, sometimes conflicting, challenges on a daily basis. This is part of daily working life but in some circumstances you may find you have serious concerns about what is happening around you and feel that patient care may be under threat.

**What is whistleblowing?**
This is the term used to describe raising concerns in the workplace. If you are a worker and you report a type of wrongdoing — usually something you’ve seen at work but not always — and the disclosure of this wrongdoing is in the public interest, you are protected by law. You mustn’t be treated unfairly or lose your job because you ‘blow the whistle’ on wrongdoing that could affect the general public. All employers should have a formal policy for raising concerns, which will usually be known as the whistleblowing policy, and you should familiarise yourself with the local policy at an early stage when tackling a concern you have.

Doctors have a professional duty, under *Good medical practice*, to raise concerns. Concerns in the workplace can vary in nature but they will all have one common factor: ensuring patient safety. It is important to remember that raising a concern is different from raising a personal complaint or grievance. The Public Interest Disclosure Act 1998 gives statutory protection to employees who disclose information reasonably and responsibly in the public interest and who are victimised or dismissed as a result.

**Raising concerns: the principles**
- Everyone should be aware of the importance of preventing and eliminating wrongdoing at work. You should be watchful for illegal or unethical conduct and report anything of that nature that you become aware of.
- Any matter raised should be investigated thoroughly, promptly and confidentially, and the outcome of the investigation reported back to the worker who raised the issue.
- No one should be victimised for raising a concern. This means that your continued employment and opportunities for future promotion or training should not be prejudiced because you have raised a legitimate concern.
- If you are victimised after having made a disclosure under the Public Interest Disclosure Act 1998 you can bring a claim at an employment tribunal. Your employer should treat any acts of victimisation as a disciplinary offence.
- An instruction to cover up wrongdoing is itself a disciplinary offence. If told not to raise or pursue any concern, even by a person in authority such as a manager, you should not agree to remain silent. You should report the matter following the steps outlined in the BMA guidance documents on this issue.
- If you make a false allegation it may be a disciplinary offence.
- It can be hard to know whether a situation should be raised as a concern. You should be guided by this question: if you let the situation carry on is it likely to result in harm to others? If in doubt, you should always err on the side of raising the concern with your manager/immediate superior, and you should do it as soon as you can. There is no burden on you, as the person raising the concern, to establish all the facts and provide all the necessary evidence.

**The Francis Inquiry**
The Francis Inquiry was a Public Inquiry chaired by Robert Francis QC into the breakdown of oversight and management over the failures at the Mid Staffordshire NHS Foundation Trust.

The report made a large number of recommendations about the scrutiny of NHS services and there has been a renewed focus on whistleblowing and raising concerns within the NHS. Robert Francis identified the vital role that junior doctors can play in raising concerns over quality of care and the importance of ensuring that junior doctors receive training in appropriate environments.

The BMA is committed to making the most of the opportunities presented by the recommendations in the Report to ensure that the NHS is providing the best possible quality of care for all of its patients. It is essential that medical staff and management jointly promote the ethos that raising concerns is not only acceptable but positive. Further information can be found on the BMA website: bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture

**Concerns about training**
Concerns about training may well be bound up with patient care issues, and complaining about training may sometimes lead to raising concerns about patient care, particularly regarding clinical supervision. Issues with training may be a cause for concern for both trainees and trainers, and the GMC and postgraduate deaneries are empowered to address this type of concern.
If you want to contact the postgraduate deanery/LETB for this, your Training Programme Director would be the best first point of contact. You can and should approach them if local routes, such as speaking to the educational supervisor, are unsuitable or unsuccessful.

The BMA has detailed guidance available (bma.org.uk/whistleblowing) on raising concerns which covers the following areas:

- what are my contractual entitlements?
- what are my professional obligations?
- who do I approach in order to raise a concern?
- raising a concern
- will there be personal consequences for me if I raise my concerns?

Who can help you?

All NHS organisations should have a policy on raising concerns about patient safety, which sets out how concerns should be escalated within the organisation.

If you are unable to access your employer’s policy, the BMA can locate this on your behalf. Approach your local BMA representative or the Local Negotiating Committee Chairman to arrange this. Your LNC Chairman and local BMA representatives can be identified by calling the BMA.

You can call the BMA on 0300 123 1233 and you will be given initial guidance on the issue. If there is particular support we can provide locally, you will be transferred to a relevant adviser. If in the course of raising your concern at work you feel you have been victimised, we will also put you in touch with an adviser. You can also email us on: support@bma.org.uk.

Doctors for doctors, (telephone 08459 200 169) is the BMA counselling service, which can offer support for the emotional aspect of the dispute, you may be going through.

Whistleblowing agreement with HEE

As a junior doctor you have a unique employment arrangement, which sees you contracted to work as employees – of a hospital trust for example – while you are simultaneously undergoing training in an arrangement with Health Education England (HEE). Despite it not being established that they are your employer, HEE can have significant influence over your career, ultimately having the right to terminate employment. It is important therefore that junior doctors are able to make protected disclosures of wrongdoing without fear of unfair treatment by HEE, yet the law on whistleblowing only covers the employer-employee relationship.

It is vital that junior doctors are able to blow the whistle on any risks to patient safety in their workplace, free from fear that their job security may be threatened as a result. The BMA has worked with HEE, NHS Employers and the Department of Health to development a legal agreement that will extend the whistleblowing protection in the law to the relationship between junior doctors and HEE.

HEE have accepted that they have significant influence over junior doctors’ careers, and as a result they have agreed to take on the legal liability for detrimental treatment linked to whistleblowing, extending the provisions of the Employment Rights Act 1996 which apply to the employer-employee relationship to cover the trainee-HEE relationship as well. HEE will be treated in law as though they were your employer just for the purposes of whistleblowing protection.

This agreement covers all postgraduate trainees In England, whoever their contract of employment may be with or is intended to be with when they commence or recommence training. You’re also covered if you are seeking to start training, or recommence it after leaving, or if you’ve gone Out of Programme.

If you feel that you have been treated unfairly by HEE as a result of raising concerns in the workplace, you should contact the BMA. Our legal advisers will be able to assess whether you have grounds to bring proceedings against HEE and, if so, to support you in bringing this claim.

Further information

The BMA guidance is available at bma.org.uk/practical-support-at-work/whistleblowing

Guidance on the new HEE agreement is available at bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations/whistleblowing-protection-faqs

BMA information on the Francis Inquiry and NHS Culture work: bma.org.uk/working-for-change/doctors-in-the-nhs/nhs-culture

Public Concern at Work website www.pcaw.org.uk/
27. The regulatory framework

Summary

This chapter provides a summary of the regulatory framework and provides details on the BMA and the work of the junior doctors committee. It also includes information on occupational health services and sources of professional advice.

Freedom of Information Act

The Freedom of Information Act 2000, which came into force on 1 January 2005, gives the right of access to information held by public bodies. These include the DH, NHS Trusts and independent medical practitioners. The ICO (Information Commissioner’s Office) is charged with the responsibility of implementing and enforcing the Act. The Act also requires that each public body produces and maintains a publication scheme which details the types of documents produced and held by the organisation and whether they are accessible to the public. Some NHS Trusts have already established such schemes.

Under the Act, an individual is able to make a request in writing to a public body for information. The body must comply with the request within 20 working days. If it fails to comply the Information Commissioner can be asked to intervene. Non-compliance could ultimately be regarded as contempt of court leading to an unlimited fine or imprisonment.

There are, however, 24 exemptions to access that are specified in the Act. They include information relating to defence, international relations and national security. However, 16 of the exemptions are subject to the public interest test. This is a test used by public authorities to determine whether the public interest in withholding the information is greater than the public interest in disclosing it.

It should be noted that the Data Protection Act does not protect members against the release of information on clinical performance or complaints. The Data Protection Act is designed ‘to protect the private lives of individuals’. Hence, if a request is received for information to be released relating to an individual’s ‘private life’ (e.g. details of the person’s family life or personal finances) this information is likely to deserve protection under the terms of the Data Protection Act and hence would not normally be disclosed. However, if the information relates to an individual’s ‘non-private’ life, for example, if it concerns someone acting in an official or work capacity, this information would normally be disclosed.

GMC

The GMC is the regulatory body of the medical profession and is established as such by Act of Parliament. The overarching objective of the GMC is ‘the protection of the public’. To this end, the GMC controls entry to the medical register and determines the principles and values that underpin good medical practice. Where a doctor fails to meet the standards it has set the GMC acts ‘to protect patients from harm – if necessary, by removing the doctor from the register and removing their right to practise medicine’.

The GMC exercises its powers by determining whether individuals should be registered as doctors in the UK and setting the educational standards for medical schools. The GMC’s Good medical practice guidance sets out a doctor’s professional obligations and duties, and advises on standards of good clinical care, professional relationships with colleagues, matters of probity and doctors’ health.

The GMC does not deal with general complaints and can only take action when a doctor’s fitness to practise is called into question. Broadly it can act in the following circumstances:

− when a doctor has been convicted of a criminal offence
− when there is an allegation of serious professional misconduct that is likely to call into question a doctor continuing in medical practice
− when a doctor’s professional performance may be seriously deficient, whether or not it is covered by specific GMC guidance
− when a doctor with health problems continues to practice while unfit.

The GMC’s procedures are only activated when a case is referred to the Council Members. Convictions of doctors are usually reported directly by the police. Complaints can be made by individual doctors, members of the public, or employing or other public authorities. However, the JDC advises that trainees should in most cases bring concerns about their colleagues to the attention of their supervising consultant in the first instance. The GMC has produced guidance for doctors and other healthcare professionals on referring a doctor to the GMC which is available on its website (www.gmc-uk.org/concerns/23339.asp).

It is a duty of a doctor under Good medical practice to report any concerns about a doctor’s fitness to practise that may be putting patients at risk, to an appropriate person from the employing authority, such as the medical director. If there are
either no local procedures, or they do not resolve the problem satisfactorily the concerns should be passed to the GMC. Doctors are advised to discuss any concerns with an impartial colleague or their defence body. The GMC can also give advice and, before a referral is made, any concerns can be discussed with one of its caseworkers. It can be contacted on 0161 923 6602 or email via the following page: www.gmc-uk.org/about/contactus/contact_5.asp

The GMC has previously taken action in circumstances where a doctor has:
- made serious or repeated mistakes in diagnosing or treating a patient’s condition
- not examined patients properly or responded to reasonable requests for treatment
- misused information about patients
- treated patients without obtaining their informed consent
- behaved dishonestly in financial matters, with patients or in research
- made sexual advances towards patients
- misused alcohol or drugs.

The GMC can normally only consider complaints within five years of the incidents that are the reason for the complaint.

Fitness to practise
Fitness to practise procedures are divided into two separate stages: ‘Investigation’ and ‘Adjudication’. In the investigation stage, the GMC investigates cases to assess the need for referral for adjudication. At the end of the investigation by the GMC of allegations against a doctor, the case will be considered by two senior GMC staff known as case examiners (one medical and one non-medical). They can:
- conclude the case with no further action
- issue a warning (which will be disclosed to a doctor’s employer), where ‘there has been a significant departure from Good medical practice or ‘there is a significant cause for concern following an assessment of the doctor’s performance’
- refer the case to the Medical Practitioners Tribunal Service (MPTS) for a medical practitioners tribunal hearing
- agree undertakings with the doctor.

The adjudication stage consists of a hearing of those cases that have been referred to a tribunal run by the MPTS. At any stage of the investigation the GMC may refer the doctor to an MPTS interim orders tribunal (IOT) hearing. An IOT can suspend or restrict a doctor’s practice while the investigation continues. MPTS tribunals hear evidence and decide whether a doctor’s fitness to practise is impaired.

The civil standard of proof (the balance of probabilities) is used at fitness to practise tribunal hearings when tribunal members are making decisions on disputed facts. The criminal standard of proof (beyond reasonable doubt) was used before May 2008. The requirement to move to the civil standard of proof was a result of the Shipman inquiry and the Government’s subsequent white paper, Trust, assurance and safety: the regulation of health professionals in the 21st century published in February 2007. The balance of probabilities, as applied in the civil standard of proof, means that the tribunal need only be satisfied that the alleged facts are more likely than not to have happened.

The criminal standard of proof of ‘beyond reasonable doubt’ meant that the tribunal had to be sure that the case was proven. Tribunal hearings are the final stage of the procedures following a complaint against a doctor. Tribunals normally have three members. There must be at least one medical and one non-medical member on each tribunal. Each hearing will have a legal assessor, who advises the tribunal, or a legally qualified chair.

Once the tribunal has heard the evidence, it must consider three matters: whether the facts alleged have been found proved; whether, on the basis of the facts found proved, the doctor’s fitness to practise is impaired; and if so, whether any action should be taken against the doctor’s registration. The application of the standard of proof applies only to the first of these questions.

In deciding on the appropriate sanction, which could be from taking no action to erasing the doctor from the Medical Register, the tribunal must have regard to the sanctions guidance. Doctors have a right to appeal to the relevant court against any decision by a tribunal to restrict or remove their registration. The GMC and the Professional Standards Authority (PSA) may also appeal against certain decisions if they consider the decision was too lenient.

Duties of a doctor
The GMC sets out the duties of a doctor registered with the Council. Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:
- make the care of your patient your first concern
- protect and promote the health of patients and the public
- provide a good standard of practice and care
- keep your professional knowledge and skills up to date
- recognise and work within the limits of your competence
- work with colleagues in the ways that best serve patients' interests
- treat patients as individuals and respect their dignity
- treat patients politely and considerately
- respect patients' right to confidentiality
- work in partnership with patients
- listen to patients and respond to their concerns and preferences
- give patients the information they want or need in a way they can understand
- respect patients' right to reach decisions with you about their treatment and care
- support patients in caring for themselves to improve and maintain their health
- be honest and open and act with integrity
- act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- never discriminate unfairly against patients or colleagues
- respect patients' right to reach decisions with you about their treatment and care
- support patients in caring for themselves to improve and maintain their health
- be honest and open and act with integrity
- act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- never discriminate unfairly against patients or colleagues
- never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

**Good medical practice**
The Council published the most recent edition of *Good medical practice* in 2013. The guidance sets out the principles and values on which good practice is founded and standards of competence, care and conduct expected of doctors in all aspects of their professional work. *Good medical practice* sets broad standards on clinical care; teaching, training and appraisal; relationships with patients; dealing with problems in professional practice; working with colleagues; probity and health.

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**Further information**
GMC website: [www.gmc-uk.org](http://www.gmc-uk.org)
PSA website: [www.professionalstandards.org.uk](http://www.professionalstandards.org.uk)

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**Occupational health services**
All NHS employers must ensure that their staff have access to confidential occupational health services, including a consultant in occupational health medicine. Where the occupational health team is made up of an occupational health nurse and/or non-consultant occupational health physicians, managers are obliged to ensure that there is access to and advice from a consultant.

The DH has provided a national policy lead on occupational health issues for some years through *The management of health, safety and welfare issues for NHS staff* (1998) and *The effective management of health and safety services in the NHS* (2001). In 2004, the DH circulated a draft of the first NHS Occupational Health and Safety Strategy for England, which set out its vision for a safer, healthier NHS.

The strategy was developed in response to The National Audit Office report *A safer place to work* (2003). The responsibility for encouraging the implementation of good occupational health and safety policy across the NHS has now been transferred to the NHS Employers organisation, which will act in an advocacy and advisory role to NHS senior managers. See [www.nhsemployers.org](http://www.nhsemployers.org)

Through their occupational health services, NHS employers should protect the health of their staff from physical and environmental health hazards arising from their work or conditions of work; reduce risks at work which lead to ill-health, staff absence and accidents, and help management to protect patients, visitors and others from staff who may represent a hazard, such as from infectious disease.

The functions of an occupational health service are to advise employees and employers about the interaction between health and work, to maximise the beneficial effects of this interaction and to minimise the adverse effects. It should be noted that occupational health is primarily a preventative and not a treatment service, but much of the output of an effective occupational health service is directly or indirectly therapeutic to organisations and the individuals employed by them.
Further information
NHS Employers [www.nhsemployers.org/](www.nhsemployers.org/)

Violence against doctors

The British Crime Survey has reported that doctors and nurses are among those most at risk of threats and assaults in the workplace. A BMA report, *Violence at work, the experience of UK doctors* reported that a third of hospital doctors had experienced some form of violence in the workplace in the previous year and that doctors working in A&E, psychiatry and obstetrics and gynaecology were even more likely to have experienced violence. The paper also noted that the under-reporting of incidents was a widespread problem.

The paper recommended training for doctors on the management of potentially violent situations, partnerships with other relevant local agencies (such as the police) and raising awareness of patients’ responsibilities and acceptable behaviour. Doctors are advised and encouraged to report violent incidents and, through their LNC, to ensure that employers put in place protocols for recording such incidents and effective strategies for dealing with the problem. The HSE has also produced guidance on the assessment and management of violence against staff in the healthcare sector.

The misuse of alcohol and other drugs

The misuse of alcohol and other drugs is a major threat to health, family, livelihood and potentially, in the case of doctors, a threat to patients. The problems are widespread, a 1998 BMA report suggesting that some one in 15 doctors in the UK may suffer from some form of dependence, and noting that two-thirds of all cases referred to the GMC health procedures involve the misuse of alcohol and other drugs. Although it is widely perceived that those affected are predominantly male and approaching retirement, specialist units with experience of treating doctors note that both female and male doctors of all ages are affected. Doctors who misuse alcohol are often at the same time involved in misuse of other drugs, and doctors whose primary problem appears to be alcohol may also be misusing hypnotics, anxiolytics, opioids or amphetamines.

Guidance from the GMC in *Duties of a doctor* is explicit in the responsibility that doctors have to prevent any risk to patients arising from their own ill-health or that of their colleagues. There are additional responsibilities under health and safety regulations, which impose duties on all individuals regarding their own health and safety and that of their colleagues.

Once in treatment, medical practitioners do remarkably well, and early recognition and treatment considerably increase the chance of successful rehabilitation. To facilitate this, the BMA recommends that every employing authority must have a well-publicised drug and alcohol policy. Such a policy must include an acknowledgement that organisations within the health service exist to provide high standards of healthcare and such high standards should also be available to employees of these organisations. Policies should provide for involvement of occupational health services, appropriate sick leave, access to treatment services and retention of employment when the employee cooperates. Policies should be supportive rather than punitive. Advice on responsibilities for their own health and that of colleagues should be included in any induction programme. Given below under ‘Sources of professional advice’ is a list of organisations, which are able to provide further advice and counselling.

Transmission of infection

In March 2007 the DH published *Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers*. This aims to clarify the position on testing for blood-borne viruses for NHS staff.

The guidance recommends that, on appointment, all new healthcare workers should have standard healthcare clearance checks. All new workers should have checks for tuberculosis disease/immunity and be offered hepatitis B immunisation, with post-immunisation testing of response and the offer of tests for hepatitis C and HIV. It states that where a new member of staff’s duties include performing exposure-prone procedures (EPPs), additional healthcare clearance should also be obtained before confirmation of an appointment. This includes being non-infection for:

- HIV (antibody negative)
- hepatitis B (surface antigen negative, or if positive e-antigen negative with a viral load of 10 genome equivalents/ml or less); and
- hepatitis C (antibody negative or, if positive, negative for hepatitis C RNA).

The DH guidance does not recommend mandatory large-scale screening of healthcare workers for blood-borne viruses. It instead recommends that only the following groups of staff should be tested:

- healthcare workers who are new to the NHS
healthcare workers moving to a post that involves EPPs (where workers have not undertaken EPPs before); and
returning healthcare workers.

Further information

BMA guidance: bma.org.uk/occupationalhealth

Further information is available from HPA, now Public Health England
www.hpa.org.uk/topics/infectiousdiseases/infectionsaz/bloodbornevirusesandoccupationalexposure/ukap/

Sources of professional advice

BMA Counselling is a service available 24/7 and allows doctors to speak to a team of fully-qualified counsellors. Any issue causing distress or difficulty can be discussed including:
- workplace problems
- exam pressures
- stress and anxiety
- loss of confidence
- personal and relationship difficulties
- alcohol and drug misuse
- bereavement
- debt and other financial concerns.

The telephone number for the BMA counselling service is 0330 123 1245. All calls are charged at local rates.

The Doctors Advisor service is run by the BMA and offers doctors in distress or difficulty the option of speaking in confidence to another doctor. Our team of doctor-advisors work with you to gain insight into your problems, supporting and helping you to move on by adopting a holistic approach to your situation. A wide range of concerns are dealt with including doctors who have been referred to the GMC, bullying at work, mental health issues and alcohol problems. The Doctors Advisor service is completely confidential and is not linked to any other internal or external agencies. Simply call 0330 123 1245 and ask for a doctor-advisor. Please visit www.bma.org.uk/advice/work-life-support/your-wellbeing/bma-counselling-and-doctor-advisor-service for further information or email info.d4d@bma.org.uk

Other sources of advice

The Sick Doctors Trust provides a proactive service for doctors with addiction problems, and provides a 24-hour advice and intervention service. It facilitates admission to appropriate treatment centres and introduction to support groups. The telephone number is 0370 444 5163 and the website is www.sick-doctors-trust.co.uk

The British Doctors and Dentists Group is a support group of recovering medical and dental drug and alcohol misusers. The telephone number is 020 7487 4445 and the website is www.bddg.org/

The Sick Doctor Scheme of the Association of Anaesthetists is available to all anaesthetists and can be contacted on 020 7631 1650. The website is www.aagbi.org/professionals/welfare/welfare-schemes

British International Doctors Association has a health counselling panel, which can advise in particular those with problems where cultural or linguistic factors are prominent. For further information see www.bidaonline.co.uk/ Contact details are 0161 456 7828, email is bida@btconnect.com.

The Doctors' Support Network is a self-help group for doctors who are currently suffering from or have suffered from a serious mental health problem. The telephone number is 0844 395 3010 and the website is www.dsn.org.uk

The BMA (British Medical Association)
The BMA is a voluntary association set up in 1832 ‘to promote the medical and allied sciences and for the maintenance of the honour and interests of the medical profession’. It is the professional association of doctors in the UK and is registered and certified as an independent trade union under employment legislation. The BMA has sole bargaining rights for all NHS
doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields. The BMA offers advice to members on contractual and professional matters and provides individual and collective representation at a local level through BMA regional services. As a spokesperson for the medical profession to the public, the Government, employers, MPs and the media, the BMA addresses matters as wide ranging as medical ethics and the state of the NHS.

**BMA JDC (junior doctors committee)**
The JDC’s purpose and remit is to consider and act in matters affecting those engaged in hospital practice in the training grades, including matters arising under the National Health Service Act or any Act amending or consolidating the same and to watch the interests of hospital medical staff in the training grades in relation to those Acts. bma.org.uk/jdc

**National and regional junior doctors committees**
Junior doctors in the three devolved nations of Scotland, Wales, and Northern Ireland are represented by their national JDCs. Junior doctors in the English regions are represented by RJDCs (regional junior doctors committees). These committees send members to the UK JDC which is responsible for representing all junior doctors in the UK.

**JNC(J) (Joint Negotiating Committee (Juniors))**
It is through the JNC(J) that the JDC Terms and Conditions of Service and Negotiation Subcommittee negotiate with the Department of Health, NHS Employers and the devolved administrations on matters concerning terms and conditions of service of hospital junior staff.

**BMA divisions**
The BMA divisions are the local branches of the Association, based on geographical areas, and cover all branches of practice. Every UK member of the BMA is automatically a member of one of 204 divisions. Each division should have a chairman, secretary and an executive committee including representatives of the branches of practice locally. bma.org.uk/divisions

**LNCs (local negotiating committees)**
LNCs are now established in almost all NHS organisations which employ doctors. LNCs consist of local representatives of all grades of doctor including junior doctors employed by the organisation who will meet regularly to identify issues for negotiation with local management and agree their objectives. They will meet with management representatives in a joint negotiating committee in order to conclude and monitor the application of local agreements and agree and monitor arrangements for the implementation of national agreements within the organisation. Professional and administrative support to LNCs is provided by BMA regional services. bma.org.uk/lnc

**BMA council**
The council is the principal executive committee of the trade union and sets the strategic direction of the BMA in line with policy decided by the representative body at the annual representative meeting. Council is responsible for the formulation of policy throughout the year and for ensuring the implementation of that policy.

Council members are elected from a single UK constituency. Half of BMA council is elected biennially by postal ballot of the membership of the BMA. Council delegates its authority to seven major branch of practice committees including the JDC. There are also committees for armed forces doctors (which has representatives of the medical reserves) and for private practice. bma.org.uk/ukcouncil

**BMA board of directors**
The directors are responsible for the management of the finances and general administration of the BMA. They ensure the implementation of the strategic and operational objectives and resolutions made by council, pursuant to the Articles of the Association.

**ARM (annual representative meeting)**
The ARM determines the policy of the BMA. The representatives are either elected by the BMA divisions or are appointed by branch of practice committees.

**The Joint Medical Consultative Council**
The Joint Medical Consultative Council was established in 1948 as the JCC (Joint Consultants Committee). It was set up by the medical royal colleges and the BMA, as a committee able to speak for the consultant body with one voice. In a review of its constitution in 2007, the Council agreed to modify its terms of reference and explicitly acknowledge changes to its constitution over a number of years, so that it was no longer a consultant committee. While consultants continue to predominate among its members, there is now strong representation from the JDC on the committee.
The JMCC represents the medical profession in discussions with the DH on matters relating to the maintenance of standards of professional knowledge and skill in the hospital service, the encouragement of education and research, and to discuss with it the key medico-political issues of the day. The members of the Council include the presidents of the royal colleges and their faculties and representatives of the main BMA branch of practice committees representing consultants, GPs, staff and associate specialist doctors, and trainees. Half of each quarterly meeting is devoted to discussions with the Department of Health led by the chief medical officer for England. The Council also has a number of working groups on which its constituent bodies (and other organisations) are represented and through which it undertakes further work and seeks advice. The areas of work covered include independent healthcare, the GMC, NHS IT and liaison with the NHS Confederation. Further information is available here www.jointconsultantscommittee.org.uk/index.php?p=What+is+the+JMCC%3F

BMA advice and support
Each of the BMA branch of practice committees and conferences, as well as the ARM, are supported by a professional secretariat based in BMA House in London. There are also national offices for Scotland, Wales and Northern Ireland based in Edinburgh, Cardiff and Belfast where the committee secretariats for the national branch of practice committees are based. The BMA also has a number of regional centres staffed by secretaries, employment advisers and industrial relations officers who provide support to regional and local committees, help and advice in disputes or negotiations with hospital management. The first point of contact for all individual queries is on 0300 123 1233 or email support@bma.org.uk

The BMA can also provide specialist advice through its board of medical education, medical ethics committee and board of science. All these committees and the branches of practice are also assisted by the BMA’s public affairs division, including its parliamentary unit. The BMA press office aims to maintain a high profile for the Association, the BMJ Publishing Group and the wider medical profession. It promotes positive news and features coverage of BMA activities and events and of the work of individual doctors and medical teams. The press office offers media training to members who have agreed to act as spokesmen and women, whether as members of national committees such as the JDC or as locally elected honorary public affairs secretaries. Individual members of the BMA who are facing media enquiries can seek help from the press office at any time by calling 020 7383 6254.

Further information
MyBMA: A guide to membership benefits bma.org.uk/membership/my-membership
Articles of the Association and Byelaws of the BMA
Appendices

Appendix 1

Model Contract

MODEL CONTRACT FOR DOCTORS AND DENTISTS IN TRAINING

Information for employers (this page does not form part of the contract of employment and should be omitted when the contract is issued).

This contract is for use only for doctors and dentists in training where the post is accredited for training by the General Medical Council (GMC) / Health Education England (HEE) and the post holder is registered as having been accepted as a trainee under the auspices of the Postgraduate Dean.

The contract may be adapted as indicated below for full-time appointments, less than full-time appointments and locum appointments for training (LAT). Employers may need to add additional clauses to reflect local agreements and policies; any such insertion should be placed before the current paragraph 23.

This contract should not be used for service posts (trust doctor / clinical fellow), either temporary or permanent; nor should it be used for locum posts, other than for appointment as a locum for training (LAT).

This template is not for use by lead employers; a separate template has been prepared for employers acting as lead employer on behalf of host organisations.

This template has been designed to support mail-merge functionality; mail-merge fields are indicated with footnotes. Employers should use these fields to create mail merges as required.

The obligations of the employer under this contract should be read in conjunction with the learning and development agreement between the employer and HEE for the employer to provide training to a standard acceptable to the GMC/GDC.

The doctor also has obligations under a separate training agreement with HEE (local office).
STATEMENT OF TERMS AND CONDITIONS OF EMPLOYMENT

THIS CONTRACT IS BETWEEN:

[Insert name of employing organisation] and

[Insert name and address of employee]
THE POST

1. Doctor in Approved Training
   1.1. Your job title is [iii] in [iv].
   1.2. The appointment is subject to the national Terms and Conditions of Service for doctors and dentists in training ("the TCS"), 2016, which may be amended from time to time. A copy of the TCS is available on the NHS Employers website.
   1.3. Your employment is conditional upon you continuing to hold a place in an approved postgraduate training programme.
   1.4. It is a condition of your employment that you sit and pass such examinations as are required for the completion of your training. These must be completed in accordance with the curriculum and within the timescale approved by the General Medical Council (GMC) and/or for dentistry the General Dental Council (GDC) or other relevant body.
   1.5. It is a condition of your employment that you have, and retain throughout your employment, the correct level of professional registration commensurate with your grade, and that during this period, you additionally continue to hold a licence to practise.

2. Commencement of Employment and Pay Point
   2.1. Employment under this contract commences on [v] and will terminate/terminates on [vi].
   2.2. Your continuous employment with this employing organisation, for the purposes of the Employment Rights Act 1996, begins on [vii].
   2.3. For the purposes of certain NHS conditions of service, previous service within the NHS, whether with this employer or another NHS employer, although not continuous for the purposes of the Employment Rights Act 1996, will count as reckonable. For some purposes, dates prior to the dates in paragraphs 2.1 and 2.2 above may, therefore, be taken into account.
   2.4. The standard full-time working week under this contract is 40 hours per week. Your actual hours of work under this contract will be no more than 48 hours per week on average and will be as set out in your work schedule. Should the hours in your work schedule be varied following a change of post or placement or following a work schedule review (as detailed in Schedule 5 of the 2016 TCS), your salary will be amended accordingly.
   2.5. Your salary will be assessed in accordance with the pay framework set out in Schedule 2 of the 2016 TCS. If you are working less than the standard full-time working week, your salary will be adjusted pro rata in accordance with your contracted hours of work.
   2.6. The maximum number of hours that may be worked in any given week is set out in Schedule 3 of the 2016 TCS.
   2.7. Up to 40 hours of work per week are pensionable in the NHS Pension scheme.
3. General Mutual Obligations

3.1. While it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a professional employee. It is essential that you and your employer work in a spirit of mutual trust and confidence. Your employment in a training post requires you to actively progress in your training, including the sitting and passing of such examinations as are set out in your training curriculum, and requires your employer to provide an appropriate training environment. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:

3.1.1. to co-operate with each other and maintain goodwill;

3.1.2. to carry out our respective obligations in operating a work schedule;

3.1.3 to carry out respective obligations in accordance with educational and training requirements;

3.1.4 to carry out our respective obligations relating to the employer’s policies, objectives, rules, working practices and protocols; and

3.1.5 to carry out our respective obligations as defined in the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

THE WORK

4. Location

4.1. Your principal place of work is [viii]. Other work locations, including off site working, may be incorporated in your work schedule where appropriate. You will be expected to undertake duties at the principal place of work, other sites where your employer offers services or other locations identified in the work schedule. You may also be required to travel between work sites and attend official meetings at other locations.

5. Duties

5.1. Except in emergencies or where otherwise agreed with your manager, you are responsible for fulfilling the duties and responsibilities set out in Schedule 1 of the 2016 TCS and undertaking the activities set out in your work schedule, as reviewed from time to time in line with the provisions in paragraph 7.2 below.

6. Emergency Responses

6.1. In exceptional circumstances you may be asked to return to site or remain at work for emergencies outside of the expectations in your work schedule; however, you are not required to be available for such eventualities.

7. Work Scheduling

7.1. In accordance with Schedule 4 of the 2016 TCS, the purpose of your work schedule is to set out in clear and transparent terms the service commitments expected of you while in the post, and the parts of your training curriculum
which can be achieved in the post. Additionally, you will be required to meet with your educational supervisor to agree and to include in your personalised work schedule other objectives that should reasonably be covered during this employment. The work schedule is not contractually binding in itself, but you have a duty to make all reasonable efforts to follow it.

7.2. The process for discussion and review of work schedules is set out in Schedules 4 and 5 of the 2016 TCS.

7.3. Scheduling of Activities

7.3.1. The work schedule will set out the hours and range of activities that are necessary to fulfil your duties and responsibilities under this contract, and include the duration and locations at which these activities are scheduled to take place.

7.3.2. Additional hours (up to the maximum set out in Schedule 3 of the TCS) may be contracted for separately from time to time. The rates for basic pay are set out in the latest pay circular.

7.3.3. Any variations in your scheduled weekly commitments should be averaged out over the length of the rota cycle, the length of your placement or 26 weeks, whichever is shorter, so that your average commitment is consistent with the provisions of the Working Time Regulations 1998 as amended from time to time.

7.4. Where emergency work takes place at regular and predictable times and / or in predictable amounts, it will be accounted for prospectively within the work schedule. You may be required to participate in an on-call rota to respond to unpredictable emergencies.

7.5. Where you have approved external duties included in your work schedule, you will provide six weeks' written notice to your employer of the dates upon which the external duties will be carried out. Shorter notice periods may be agreed by local arrangement or by agreement between you and your manager.

8. Spare Professional Capacity

8.1. The 2016 TCS, Schedule 3, outlines contractual limits on working hours and rest periods. While in this employment, you should not ordinarily undertake work outside of this contract. Where you do wish to undertake any such work as a locum, you must first offer your services to the NHS as set out in the paragraphs pertaining to locum work in Schedule 3 of the TCS.

9. Hours which attract a pay enhancement

9.1. To recognise the unsocial nature of work undertaken at nights and on weekends, the provisions of Schedule 2 of the 2016 TCS will apply.

10. On-Call Rotas

10.1. If you are required to be on an on-call rota, the provisions of Schedule 3 of the 2016 TCS will apply.

10.2. Your on-call commitment will be set out in your work schedule.
PAYMENT

11. Pay

11.1. The full-time equivalent basic salary applicable on commencement in this employment is \[£ \times \] per annum. Your actual salary will be assessed on the basis of your work schedule and may comprise one or more of the following:

11.1.1. If your work schedule requires you to undertake additional hours of work over and above the standard week of 40 hours, you will be paid at the rate of 1/40th of the full time equivalent basic pay;

11.1.2. If part of the work in your work schedule is undertaken at a time which attracts an enhanced hourly rate of pay, that part will be paid as set out in Schedule 2 of the 2016 TCS;

11.1.3. If you are required to participate in work at the weekend, you will receive a weekend allowance calculated in accordance with Schedule 2 of the 2016 TCS;

11.1.4. If you are required to participate in an on-call rota, you will receive an on-call availability allowance calculated in accordance with Schedule 2 of the 2016 TCS;

11.1.5. Flexible pay premia is payable in certain circumstances as specified in Schedule 2 of the 2016 TCS. If you are eligible for one or more premia, payments will be made in accordance with this Schedule;

11.1.6. London Weighting (where applicable) is payable in accordance with Schedule 2 of the 2016 TCS.

11.2. Your salary will be payable monthly in arrears on [ x ].

12. Deductions from Pay

12.1. We will not make deductions from, or variations to, your salary as set out at paragraph 11.1 other than those permitted by law without your express written consent.

13. Pension

13.1. Unless you are deemed ineligible, you will automatically be enrolled as a member of the NHS Pension Scheme subject to its terms and rules, which may be amended from time to time.

13.2. Pensionable pay will include basic salary and any other pay expressly agreed to be pensionable in Schedule 2 and Schedule 14 of the 2016 TCS.

14. Expenses

14.1. You may be entitled to reimbursement for travel, subsistence and other expenses, as set out in Schedule 11 of the 2016 TCS. Claims for expenses must be submitted in a timely manner (normally within one month of the time that the expenses were incurred).
OTHER CONDITIONS OF EMPLOYMENT

15. Leave and holidays

15.1. Full details of annual leave and public holidays, professional and study leave and sick leave are set out in Schedule 9 of the 2016 TCS.

15.2. Schedules 9 and 13 of the 2016 TCS set out where arrangements for special leave, maternity, paternity, parental, carer’s and adoption leave can be found.

16. Transfer of information

16.1. Where you are required to rotate between employing organisations, you acknowledge that we may receive and transfer personal and confidential information regarding your employment and training, as necessary for the continuation of your training. Such personal and confidential information may include personal and sensitive personal data for the purposes of the Data Protection Act 1998.

17. Policies and Procedures

17.1 You are required to familiarise yourself and comply with your employer’s policies and procedures and those of any other sites, identified in your work schedule, where your employer offers services.

18. Disciplinary Procedure

18.1 The procedure for dealing with matters of alleged misconduct is detailed in your employer’s policy and procedure which can be found [Note: employing organisation to add reference to local procedures].

19. Grievance Procedure

19.1 The procedure for dealing with grievances is detailed in your employer’s policy and procedure which can be found [Note: employing organisation to add reference to local procedures]. This procedure does not have contractual effect.

20. Intellectual Property


21. Termination of employment

21.1 The provisions governing termination of employment are set out in Schedule 10 of the 2016 TCS

22. Governing Law

22.1 This contract and any dispute or claim arising out of or in connection with it, or its subject matter, or formation, shall be governed and construed in accordance with English law and the parties agree that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim that arises out of
or in connection with this contract.

23. Entire terms

23.1 This contract, together with the TCS and any local agreements, contains the entire terms and conditions of your employment with us, such that all previous agreements, practices and understandings between us (if any) are superseded and of no effect. Where any external term is incorporated by reference, such incorporation is only to the extent so stated and not further or otherwise.

AGREEMENT

I [insert name or employee]

and

[insert employer]*

have understood and agree to honour the terms and conditions set out in this contract.

[ ] Doctor’s signature

Date:……………………………….

[ ] Representative of employing organisation’s signature
Date:……………………………….

Date of this agreement [ ]
Notes

You are normally covered by the NHS indemnity scheme against claims of medical negligence. However, in certain circumstances you may not be covered by the indemnity. We therefore advise you to maintain membership of a medical defence organisation. Details of the NHS indemnity scheme may be obtained from the Human Resources department upon request.

If you are on a training programme which includes placements in a general practice setting, you may be required to effect and maintain membership of a recognised medical defence organisation, commensurate with your professional duties, throughout the period of your employment. This may initially be at your own expense. You are advised to check with your employer what arrangements apply locally in relation to GP indemnity.

Updates on salary values are published in the NHS Employers website www.nhsemployers.org

Data required for mail merge

i Name of employing organisation
ii Name and address of employee
iii Job title
iv Specialty or department
v Insert date (actual start date under this contract)
vi Insert end date
vii Insert date [ERA date]
viii Insert location [base or main location for this contract]
ix Insert value of pay point
x Insert date/ day in month of payday
xi Name of employee
xii Name of employing organisation
MODEL CONTRACT FOR DOCTORS AND DENTISTS IN TRAINING WITH SCHEDULE 14, SECTION 2 TRANSITIONAL PAY PROTECTION

Information for employers (this page does not form part of the contract of employment and should be omitted when the contract is issued).

This contract is only for use for doctors and dentists in training where the post is accredited for training by the General Medical Council (GMC) / Health Education England (HEE) and the post holder is registered as having been accepted as a trainee under the auspices of the Postgraduate Dean.

This version of the template has been adapted to reflect the pay and working hours provisions of Schedule 14, Section 2 on transitional pay protection for trainees in the higher training grades and other stages of run-through training.

It can therefore be used for doctors who on 2 August 2016 were either in a higher specialty programme, at ST3 or above on a run-through programme, or on a pre-2007 SpR training programme.

The contract may be adapted as indicated below for full-time appointments, less than full time appointments and locum appointments for training (LAT). Employers may need to add additional clauses to reflect local agreements and policies; any such insertion should be placed before the current paragraph 23.

This contract should not be used for service posts (trust doctor / clinical fellow), either temporary or permanent; nor should it be used for locum posts, other than for appointment as a locum for training (LAT).

This template is not for use by lead employers; a separate template has been prepared for employers acting as lead employer on behalf of host organisations.

This template has been designed to support mail-merge functionality; mail-merge fields are indicated with footnotes. Employers should use these fields to create mail merges as required.

The obligations of the employer under this contract should be read in conjunction with the learning and development agreement between the employer and Health Education England for the employer to provide training to a standard acceptable to the GMC/GDC.

The doctor also has obligations under a separate training agreement with Health Education England (local office).
STATEMENT OF TERMS AND CONDITIONS OF EMPLOYMENT

THIS CONTRACT IS BETWEEN:

[Insert name of employing organisation] and

[Insert name and address of employee]
1. Doctor in Approved Training

1.1. Your job title is [iii] in [iv].

1.2. The appointment is subject to the national Terms and Conditions of Service for doctors and dentists in training ("the TCS"), 2016, which may be amended from time to time. A copy of the TCS is available on the NHS Employers website.

1.3. Your employment is conditional upon you continuing to hold a place in an approved postgraduate training programme.

1.4. It is a condition of your employment that you sit and pass such examinations as are required for the completion of your training. These must be completed in accordance with the curriculum and within the timescale approved by the General Medical Council (GMC) and/or for dentistry the General Dental Council (GDC) or other relevant body.

1.5. It is a condition of your employment that you have, and retain throughout your employment, the correct level of professional registration commensurate with your grade, and that during this period, you additionally continue to hold a licence to practise.

2. Commencement of Employment and Pay Point

2.1. Employment under this contract commences on [v] and will terminate/terminates on[vi].

2.2. Your continuous employment with this employing organisation, for the purposes of the Employment Rights Act 1996, begins on[vii].

2.3. For the purposes of certain NHS conditions of service, previous service within the NHS, whether with this employer or another NHS employer, although not continuous for the purposes of the Employment Rights Act 1996, will count as reckonable. For some purposes, dates prior to the dates in paragraphs 2.1 and 2.2 above may, therefore, be taken into account.

2.4. The standard full-time working week under this contract is 40 hours per week. Your actual hours of work under this contract will be no more than 48 hours per week on average and will be as set out in your work schedule. Should the hours in your work schedule be varied following a change of post or placement or following a work schedule review (as detailed in Schedule 5 of the 2016 TCS), your salary will be amended accordingly.

2.5. Your salary will be assessed in accordance with the pay framework set out in Schedule 2 of the 2016 TCS, taking into account the transitional provisions of Schedule 14. If you are working less than the standard full-time working week, your salary will be adjusted pro rata in accordance with your contracted hours of work.

2.6. The maximum number of hours that may be worked in any given week is set out in Schedule 3 of the 2016 TCS.

2.7. Up to 40 hours of work per week are pensionable in the NHS Pension scheme.
3. General Mutual Obligations

3.1. While it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a professional employee. It is essential that you and your employer work in a spirit of mutual trust and confidence. Your employment in a training post requires you to actively progress in your training, including the sitting and passing of such examinations as are set out in your training curriculum, and requires your employer to provide an appropriate training environment. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:

3.1.1. to co-operate with each other and maintain goodwill;
3.1.2. to carry out our respective obligations in operating a work schedule;
3.1.3 to carry out respective obligations in accordance with educational and training requirements;
3.1.4 to carry out our respective obligations relating to the employer’s policies, objectives, rules, working practices and protocols; and
3.1.5 to carry out our respective obligations as defined in the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

THE WORK

4. Location

4.1. Your principal place of work is [viii]. Other work locations, including off site working, may be incorporated in your work schedule where appropriate. You will be expected to undertake duties at the principal place of work, other sites where your employer offers services or other locations identified in the work schedule. You may also be required to travel between work sites and attend official meetings at other locations.

5. Duties

5.1. Except in emergencies or where otherwise agreed with your manager, you are responsible for fulfilling the duties and responsibilities set out in Schedule 1 of the 2016 TCS and undertaking the activities set out in your work schedule, as reviewed from time to time in line with the provisions in paragraph 7.2 below.

6. Emergency Responses

6.1. In exceptional circumstances you may be asked to return to site or remain at work for emergencies outside of the expectations in your work schedule; however, you are not required to be available for such eventualities.

7. Work Scheduling

7.1. In accordance with Schedule 4 of the 2016 TCS, the purpose of your work
The schedule is to set out in clear and transparent terms the service commitments expected of you while in the post, and the parts of your training curriculum which can be achieved in the post. Additionally, you will be required to meet with your educational supervisor to agree and to include in your personalised work schedule other objectives that should reasonably be covered during this employment. The work schedule is not contractually binding in itself, but you have a duty to make all reasonable efforts to follow it.

7.2. The process for discussion and review of work schedules is set out in Schedules 4 and 5 of the 2016 TCS.

7.3. Scheduling of Activities

7.3.1. The work schedule will set out the hours and range of activities that are necessary to fulfil your duties and responsibilities under this contract, and include the duration and locations at which these activities are scheduled to take place.

7.3.2. Additional hours (up to the maximum set out in Schedule 3 of the TCS) may be contracted for separately from time to time. The rates for basic pay are set out in the latest pay circular.

7.3.3. Any variations in your scheduled weekly commitments should be averaged out over the length of the rota cycle, the length of your placement or 26 weeks, whichever is the shorter, so that your average commitment is consistent with the provisions of the Working Time Regulations 1998 as amended from time to time.

7.4. Where emergency work takes place at regular and predictable times and / or in predictable amounts, it will be accounted for prospectively within the work schedule. You may be required to participate in an on-call rota to respond to unpredictable emergencies.

7.5. Where you have approved external duties included in your work schedule, you will provide 6 weeks’ written notice to your employer of the dates upon which the external duties will be carried out. Shorter notice periods may be agreed by local arrangement or by agreement between you and your manager.

8. Spare Professional Capacity

8.1. The 2016 TCS, Schedule 3, outlines contractual limits on working hours and rest periods. While in this employment, you should not ordinarily undertake work outside of this contract. Where you do wish to undertake any such work as a locum, you must first offer your services to the NHS as set out in the paragraphs pertaining to locum work in Schedule 3 of the TCS.

9. Hours which attract a pay enhancement

9.1. The unsocial nature of any work undertaken at nights and on weekends will be recognised via the banding provisions of paragraphs 24-32 of Schedule 14 of the 2016 TCS.

10. On-Call Rotas

10.1. If you are required to be on an on-call rota, the provisions of Schedule 3 of the 2016 TCS will apply.
10.2. Your on-call commitment will be set out in your work schedule.

PAYMENT

11. Pay

11.1. As your appointment is covered by the provisions of Schedule 14 of the TCS, your salary while in this appointment will be as follows:

11.1.1. You will be paid a base salary in the range of £30,302 to £47,647, paid pro-rata if you are working less than full time;

11.1.2. Your incremental point on the above scale on appointment (as set out in the relevant pay circular) will be determined in accordance with the provisions of the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002, based on information provided by your previous employer and / or via your last payslip, and you will be entitled to annual incremental pay progression in accordance with the provisions of Schedule 14 of the 2016 TCS;

11.1.3. You will in addition be paid a salary supplement (also known as a banding supplement) of [ ] in accordance with the provisions of Schedule 14 of the 2016 TCS; [Note: delete if not applicable]

11.1.4. London Weighting (where applicable) is payable in accordance with Schedule 2 of the 2016 TCS.

11.2. Your salary will be payable monthly in arrears on [ ].

12. Deductions from Pay

12.1. We will not make deductions from, or variations to, your salary as set out at paragraph 11.1 other than those permitted by law without your express written consent.

13. Pension

13.1. Unless you are deemed ineligible, you will automatically be enrolled as a member of the NHS Pension Scheme subject to its terms and rules, which may be amended from time to time.

13.2. Pensionable pay will include basic salary and any other pay expressly agreed to be pensionable in Schedule 2 and Schedule 14 of the 2016 TCS.

14. Expenses

14.1. You may be entitled to reimbursement for travel, subsistence and other expenses, as set out in Schedule 11 of the 2016 TCS. Claims for expenses must be submitted in a timely manner (normally within one month of the time that the expenses were incurred).
OTHER CONDITIONS OF EMPLOYMENT

15. Leave and holidays

15.1. Full details of annual leave and public holidays, professional and study leave and sick leave are set out in Schedule 9 of the 2016 TCS.

15.2. Schedules 9 and 13 of the 2016 TCS set out where arrangements for special leave, maternity, paternity, parental, carer’s and adoption leave can be found.

16. Transfer of information

16.1. Where you are required to rotate between employing organisations, you acknowledge that we may receive and transfer personal and confidential information regarding your employment and training, as necessary for the continuation of your training. Such personal and confidential information may include personal and sensitive personal data for the purposes of the Data Protection Act 1998.

17. Policies and Procedures

17.1 You are required to familiarise yourself and comply with your employer’s policies and procedures and those of any other sites, identified in your work schedule, where your employer offers services.

18. Disciplinary Procedure

18.1 The procedure for dealing with matters of alleged misconduct is detailed in your employer’s policy and procedure which can be found [Note: employing organisation to add reference to local procedures].

19. Grievance Procedure

19.1 The procedure for dealing with grievances is detailed in your employer’s policy and procedure which can be found [Note: employing organisation to add reference to local procedures]. This procedure does not have contractual effect.

20. Intellectual Property


21. Termination of employment

21.1 The provisions governing termination of employment are set out in Schedule 10 of the 2016 TCS.

22. Governing Law

22.1 This contract and any dispute or claim arising out of or in connection with it or its subject matter or formation shall be governed and construed in accordance with English law and the parties agree that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this contract.

7
23. Entire terms

23.1 This contract, together with the TCS and any local agreements, contain the entire terms and conditions of your employment with us, such that all previous agreements, practices and understandings between us (if any) are superseded and of no effect. Where any external term is incorporated by reference, such incorporation is only to the extent so stated and not further or otherwise.

AGREEMENT

I [insert name or employee]

and

[insert employer]

have understood and agree to honour the terms and conditions set out in this contract.

[ ] Doctor’s signature

Date:……………………………….

[ ] Representative of employing organisation’s signature

Date:……………………………….
Date of this agreement [ ]
Notes

You are normally covered by the NHS indemnity scheme against claims of medical negligence. However, in certain circumstances you may not be covered by the indemnity. We therefore advise you to maintain membership of a medical defence organisation. Details of the NHS indemnity scheme may be obtained from the Human Resources department upon request.

If you are on a training programme which includes placements in a general practice setting, you may be required to effect and maintain membership of a recognised medical defence organisation, commensurate with your professional duties, throughout the period of your employment. This may initially be at your own expense. You are advised to check with your employer what arrangements apply locally in relation to GP indemnity.

Updates on salary values are published in the NHS Employers website www.nhsemployers.org

Data required for mail merge

i Name of employing organisation
ii Name and address of employee
iii Job title
iv Specialty or department
v Insert date (actual start date under this contract)
vi Insert end date
vii Insert date [ERA date]
viii Insert location [base or main location for this contract]
ix Insert banding supplement (delete paragraph where not applicable)
x Insert date/day in month of payday
xi Name of employee
xii Name of employing organisation
## Template Generic Work Schedule

<table>
<thead>
<tr>
<th>Work Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Programme:</td>
</tr>
<tr>
<td>Specialty placement:</td>
</tr>
<tr>
<td>Grade:</td>
</tr>
<tr>
<td>Length of placement:</td>
</tr>
<tr>
<td>Employing organisation:</td>
</tr>
<tr>
<td>Host organisation (if different from the above):</td>
</tr>
<tr>
<td>Site(s):</td>
</tr>
<tr>
<td>Educational Supervisor:</td>
</tr>
<tr>
<td>Clinical Lead/Rota Co-Ordinator:</td>
</tr>
<tr>
<td>Name of Guardian:</td>
</tr>
<tr>
<td>Contact details of Guardian:</td>
</tr>
<tr>
<td>Medical Workforce Department Contact Details:</td>
</tr>
</tbody>
</table>

**Working pattern:**
Basic hours only / Full shift /On-call rota (delete as appropriate)

**Rota Template:**

Your working pattern is arranged across a rota cycle of <<insert number>> weeks, and includes:

- Normal days
- Long days
- Night shifts
- Weekend shifts
- On-call duties

(Delete any that do not apply)

A copy of your rota template is attached to the end of this document

*to be appended*
**Average Weekly Hours of Work:** *to insert*

Your contract is a full-time / less-than-full-time (delete as appropriate) contract for <<Insert number up to a maximum of 40>> hours

You will in addition be contracted for an additional <<insert number up to a maximum of 8>> hours, making for total contracted hours of <<insert sum of the above two figures>>

The distribution of these will be as follows:

Average weekly hours at basic hourly rate:

Average weekly hours attracting a 37% enhancement:

Note: these figures are the *average weekly hours*, based on the length of your rota cycle, as required by Schedule 2 of the Terms and Conditions of Service. These may not represent your actual hours of work in any given week.

**Annual pay for role** (select elements as appropriate)

Basic Pay (Nodal Point): <<insert annual cash amount>>
Pay for additional hours above 40: <<insert cash amount>>
Enhanced pay at 37% rate: <<insert cash amount>>
Weekend allowance: <<insert cash amount>>
On-call availability supplement: <<insert cash amount>>
Flexible Pay Premia [Type]: <<insert cash amount>>

Total pensionable pay: <<insert cash amount>>
Total non-pensionable pay: <<insert cash amount>>

**Total annual pay for this role:** <<insert cash amount>>

Should your placement be for less than 12 months, your pay will be pro-rated to the length of your placement.

*Please note- if you are entitled to pay protection in line with Schedule 2 of the TCS or to transitional pay protection in line with Schedule 14 of the TCS, then your actual salary may be greater than the above figure. Where this is the case, your salary will contain one or more additional pay protection elements so as to maintain your salary at its protected level.

**Training Opportunities:**

Insert the curriculum mapped outcomes that can be achieved whilst in this placement, together with the formal and informal learning opportunities available to the post-holder.

**Other:**

Insert any other items relevant to the placement
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAC</td>
<td>Advisory Appointments Committee</td>
</tr>
<tr>
<td>ACCEA</td>
<td>Advisory Committee on Clinical Excellence Awards</td>
</tr>
<tr>
<td>AL</td>
<td>Advance Letter</td>
</tr>
<tr>
<td>AVC</td>
<td>Additional Voluntary Contribution</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>CHRE</td>
<td>Council for Healthcare Regulatory Excellence</td>
</tr>
<tr>
<td>CC</td>
<td>Consultants committee</td>
</tr>
<tr>
<td>CCST</td>
<td>Certificate of Completion of Specialist Training</td>
</tr>
<tr>
<td>CCT</td>
<td>Certificate of Completion of Training</td>
</tr>
<tr>
<td>CEA</td>
<td>Clinical Excellence Award</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical commissioning groups</td>
</tr>
<tr>
<td>CoPMED</td>
<td>Conference of Postgraduate Medical Education Deans</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>DCC</td>
<td>Direct Clinical Care</td>
</tr>
<tr>
<td>DDRB</td>
<td>Doctors and Dentists Review Body</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EL</td>
<td>Executive Letter</td>
</tr>
<tr>
<td>EPP</td>
<td>Exposure Prone Procedure</td>
</tr>
<tr>
<td>EWTD</td>
<td>European Working Time Directive</td>
</tr>
<tr>
<td>GDC</td>
<td>General Dental Council</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GWC</td>
<td>General Whitley Council</td>
</tr>
<tr>
<td>HA</td>
<td>Health Authority</td>
</tr>
<tr>
<td>HC</td>
<td>Health Circular</td>
</tr>
<tr>
<td>HMRC</td>
<td>HM Revenue &amp; Customs</td>
</tr>
<tr>
<td>HSC</td>
<td>Health Service Circular</td>
</tr>
<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>HSG</td>
<td>Health Service Guideline</td>
</tr>
<tr>
<td>ICO</td>
<td>Information Commissioner’s Officer</td>
</tr>
<tr>
<td>JMCC</td>
<td>Joint Medical Consultative Council</td>
</tr>
<tr>
<td>JNCC(J)</td>
<td>Joint Negotiating Committee (Juniors)</td>
</tr>
<tr>
<td>LETB</td>
<td>Local Education Training Board</td>
</tr>
<tr>
<td>LNC</td>
<td>Local Negotiating Committee</td>
</tr>
<tr>
<td>MAC</td>
<td>Medical Advisory Committee</td>
</tr>
<tr>
<td>MASC</td>
<td>Medical academic staff committee</td>
</tr>
<tr>
<td>MHO</td>
<td>Mental Health Officer</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>NCAS</td>
<td>National Clinical Assessment Service</td>
</tr>
<tr>
<td>NCSSD</td>
<td>National Counselling Service for Sick Doctors</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHSLA</td>
<td>National Health Service Litigation Authority</td>
</tr>
<tr>
<td>NHSPS</td>
<td>National Health Service Pension Scheme</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
</tr>
<tr>
<td>NWDB</td>
<td>National Workforce Development Board</td>
</tr>
<tr>
<td>PA</td>
<td>Programmed Activity</td>
</tr>
<tr>
<td>PASs</td>
<td>Planned Additional Sessions</td>
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<tr>
<td>PFI</td>
<td>Private Finance Initiative</td>
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<tr>
<td>SPA</td>
<td>Supporting Professional Activity</td>
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<td>SpR</td>
<td>Specialist Registrar</td>
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<td>TCS</td>
<td>Terms and Conditions of Service</td>
</tr>
<tr>
<td>TUPE</td>
<td>Transfer of Undertakings (Protection of Employment) Regulations 1981</td>
</tr>
</tbody>
</table>