
INFORMATION GOVERNANCE

From: Hodgkiss, Robert <Robert.Hodgkiss@chelwest.nhs.uk>
Sent: 07 April 2016 15:09
To: Watts, Lesley
Subject: Fwd: Urgent: Junior Doctors' contract UNIFY2 returns

See trail. I was talking at cross purposes. We submitted out usual returns (with associated IT issues), this request to you appears to be something completely different.

Rob

Sent from my iPhone

Begin forwarded message:

> **From:** "Penn, Zoe" <zoe.penn@chelwest.nhs.uk>
> **Date:** 7 April 2016 at 15:05:20 BST
> **To:** "Hodgkiss, Robert" <Robert.Hodgkiss@chelwest.nhs.uk>
> **Subject: Re: Urgent: Junior Doctors' contract UNIFY2 returns**
>
> I cannot find anything in my email regarding UNIFY2 or submitting data at all. Sorry
> Zoe
>
> Sent from my iPad
>
> On 7 Apr 2016, at 15:01, Hodgkiss, Robert <Robert.Hodgkiss@chelwest.nhs.uk> wrote:
>
> > See trail
> >
> > Sent from my iPhone
> >
> > Begin forwarded message:
> >
> > **From:** "Sands, Catherine" <Catherine.Sands@chelwest.nhs.uk>
> > **Date:** 7 April 2016 at 14:43:00 BST
> > **To:** "Hodgkiss, Robert" <Robert.Hodgkiss@chelwest.nhs.uk>
> > **Subject: FW: Urgent: Junior Doctors' contract UNIFY2 returns**
> >
> > Thankfully not my fault this time – it's yours apparently I have asked Simon to send on the info required.
> >
> > ---
> >
> > **From:** Mortimore, Simon
> > **Sent:** 07 April 2016 14:35
> > **To:** Sands, Catherine; [redacted]
> > **Subject:** RE: Urgent: Junior Do[redacted] contract UNIFY2 returns
> >
> > Yep. This was sent to MD and HR Directors……
> >
> > It is basically how many do we have etc.
> >
> > I can drop a note to Zoe and ask if anything has happened to it

From: Sands, Catherine
Sent: 07 April 2016 14:28
To: Mortimore, Simon; [redacted]
Subject: FW: Urgent: Junior Doctors' contract UNIFY2 returns

What is it they we haven't submitted now???

From: Hodgkiss, Robert
Sent: 07 April 2016 14:15
To: Sands, Catherine
Subject: Fwd: Urgent: Junior Doctors' contract UNIFY2 returns

This is sorted isn't it?

Sent from my iPhone

Begin forwarded message:

> **From:** "Watts, Lesley" <Lesley.Watts@chelwest.nhs.uk>
> **Date:** 7 April 2016 at 14:13:32 BST
> **To:** "Hodgkiss, Robert" <Robert.Hodgkiss@chelwest.nhs.uk>
> **Subject: Fwd: Urgent: Junior Doctors' contract UNIFY2 returns**
>
> Sent from my iPad
>
> Begin forwarded message:
>
> > **From:** '[redacted] (NHS IMPROVEMENT - T1520)" [redacted]
> > **Date:** 7 April 2016 at 14:09:18 BST
> > **To:** '[redacted] (NHS IMPROVEMENT - T1520)" [redacted]
> > **Subject: Urgent: Junior Doctors' contract UNIFY2 returns**
> >
> > **EMAIL SENT ON BEHALF OF TERESA DUE**
> >
> > Dear CEO,
> >
> > The Unify Junior Doctors contract implementation data collection return submission deadline was close of play yesterday. You are receiving this email as our records show that your return is outstanding. Unify will allow submissions up to 3pm today, can you please ensure that you submit the template by this time?

If you have any technical queries regarding UNIFY2 please contact [redacted] from the Business Intelligence Team.

Kind regards

[redacted]

kind regards

[redacted]

[redacted] / W www.improvement.nhs.uk
Southside, 105 Victoria Street, London, SW1E 6QT

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The new 2016 contract for doctors in training

Implementation guidance for employers

March 2016

Index

Version 1

31 March 2016

1. Introduction

1.1. This implementation guidance sets out the steps that employers will need to follow to introduce the new Terms and Conditions of Service for NHS Doctors and Dentists in Training, 2016 (TCS).

1.2. This guidance should be read in conjunction with the TCS, together with the model contract (attached as Annex A) and has been produced to aid staff working in HR / medical staffing departments, education departments and payroll departments in the implementation of the new contract.

1.3. In implementing this contract, each employer will need to take account of their individual Public Sector Equality Duty (PSED). We will providing further guidance to employers on this duty, and how it may impact upon their organisation, in the first week of April 2016.

1.4. This document is divided into a range of separate, pull-out guides that reflect the contract, including:

Safe working:

- A guide to safe working hours and rota design
- A guide to work scheduling
- A guide to exception reporting
- A guide to work schedule reviews
- A guide to the appointment and role of the guardian of safe working hours

Pay:

- A guide to pay

Transitional arrangements:

- A guide to transitional arrangements
    a) Doctors moving to the new contract
    b) Transitional pay protection

1.5. For the purposes of this document, for 'doctor' read 'doctor or dentist in training' throughout.

Scope

1.6. The new contractual arrangements will be introduced by employers as doctors enter training posts from August 2016.

1.7. From 3 August 2016, new contractual arrangements will be introduced for doctors and dentists in training in hospital posts approved by the GMC / GDC for postgraduate medical/dental education, replacing the existing arrangements of:

- The hospital medical and dental staff TCS of service, 2002, as they apply to doctors in training.

1.8. For those doctors already in training, the new terms will be introduced as they move between contracts of employment. However, for these doctors there will be a period of transition during which pay protection arrangements will apply, depending on the stage of training reached. These are described section 10 of this document.

1.9. Where doctors in training are employed by lead employers but work and train within a host organisation, the lead employer and host organisation will need to work together to ensure that systems of communication are in place to support the respective responsibilities of each party. We will be publishing further guidance specifically for lead employers and host organisations in early April.

1.10. The new 2016 contractual arrangements will also apply to doctors on general practice training programmes during approved general practice placements that form part of their postgraduate medical education, and will replace provisions currently contained in Schedules to the Directions to Health Education England (GP Registrars). Again, for doctors in training already employed under the existing arrangements, transitional pay protection arrangements will apply, as described in section 10 of this document.

1.11. These contractual arrangements will not apply to those undertaking vocational training placements in general dental practice (i.e. foundation dentists). The existing contractual arrangements for this group of staff will continue to apply.

Trust doctors

1.12. These contractual arrangements will not apply to doctors who are not doctors in training – i.e. locums appointed for service, trust doctors, clinical fellows, research fellows etc. These 2016 TCS are specific to doctors in training, as they have a strong focus on education and training as well as service delivery.

1.13. It is for employers to decide locally how to set contractual TCS for doctors who are not employed as doctors in training in recognised training posts. Even where employers seek to replicate pay and other terms of these TCS into any local terms, they are advised not to replicate the totality of these TCS but to tailor them to meet the different needs of and service requirements placed upon trust doctors. Additional guidance will be published separately.

1.14. Employers are free to determine what terms and conditions they offer to new staff in such posts, or to those wishing to remain in employment in such posts when existing contracts expire.

Shadowing

1.15. Foundation programme shadowing will take place this year before the introduction of the 2016 contract. The 2016 contract is not suitable to engage F1 appointees for shadowing. Employers are required to issue a separate contract for this period. NHS Employers' guidance on how to engage F1 appointees for the shadowing period will be helpful for trusts when deciding how to provide indemnity and payment for F1 appointees for this period. Payments for the 2016 shadowing period should reflect the first point of the current Foundation Year 1 pay, as set out in the pay circular for the 2002 TCS.

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2. Benefits of the new junior doctor contract

2.1 The new national contract for junior doctors is fairer and encourages stronger safeguards to prevent doctors working excessive hours. The new contract is effective for both doctors and employers.

2.2 **Work scheduling** – This is a new feature of the new contract, and employers will be required to complete work schedules for doctors in training. This will begin as a generic schedule setting out the hours of work, the working pattern, the service commitments and the training opportunities available during the post or placement. This must be done prior to any offer of employment to the post being made.

2.3 Once a doctor commences in post, the work schedule will be personalised to include appropriate and identified personal objectives that have been agreed between the doctor and his or her educational supervisor, and will set out the relationship between these personal objectives and local service objectives. The objectives will set out a mutual understanding of what the doctor will be seeking to achieve over the placement period and how this will contribute to the objectives of the employing organisation. Work scheduling can be used to drive improvements and quality of patient care.

2.4 **Exception reporting** – This is a new feature of the new contract, enabling doctors to raise exception reports where their work schedules do not reflect their work, and to ensure that a work schedule remains fit for purpose. This is beneficial to employers as it will give real-time information and be able to identify key issues as they arise. It also benefits doctors, as issues over safe working or missed educational opportunities can be raised and addressed early on in a placement, resulting in safer working and a better educational experience.

2.5 **Guardian of safe working hours** – This is a new feature introduced in the 2016 contract. The guardian of safe working hours is required to ensure that concerns about the safety of doctors' working hours are resolved in a timely and appropriate fashion. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by continued scrutiny of the quality of training by Health Education England (HEE). These measures should ensure the safety of doctors and therefore of patients.

2.6 **Annual leave** – Annual leave entitlement is unchanged and remains at 27 days incorporating the two statutory days, rising to 32 days following the completion of five years' NHS service.

2.7 **Requests for leave** – Employers are expected to respond to leave requests positively wherever possible, provided that the doctor gives six weeks' notice of the request (or fewer than six weeks' notice if there are reasons beyond the doctor's control).

Employers must allow leave for life-changing events, subject to the standard six weeks' notice period.

2.8 **Fixed leave** – Employers will be asked to end the practice of fixed leave, which makes it difficult for doctors to take leave at a time that suits themselves and/or their families. There will be a mutual obligation to plan leave around requests, balancing the need for adequate staff cover to provide a safe service while ensuring that all staff can take full leave entitlement. While some leave may need to be allocated to ensure that all doctors take their full leave entitlement, the vast majority of leave requests should be managed without the need to resort to allocation of leave.

2.9 **Continuity of service** – will not be affected and will be preserved. It is particularly important where doctors, through educationally approved out-of-training programme arrangements (as at present) or voluntary/overseas service or short gaps between employments will, for example, retain access to maternity pay based on their last year's earnings prior to taking time out. This means that continuity of service would be preserved in a variety of situations where there is a gap in usual working patterns, including when these occur as a result of a transitional situation in the doctor's life.

2.10 **Expenses** – Doctors will continue to have access to expenses relating to travel, subsistence and other business expenses. They will continue to have assistance with relocation, removal or excess travel expenses and can request extra help should they take up employment that requires them to move home or incur extra travel expenses.

2.11 **Statutory rights** – Doctors will also continue to have access to a range of employment rights under statute and through their local employers' own HR policies, which should allow them to seek support should they need it.

2.12 **Benefits** – All doctors will still be able to receive benefits above the statutory minimum. For example, sickness, maternity, paternity, adoption leave in line with the NHS Staff Handbook.

Extra-contractual arrangements

2.13 The contract negotiations also resulted in a separate, tri-partite workstream involving employers the BMA and HEE. Although the following items do not form part of the TCS, they will in future be included in the learning and development agreement (LDA) between HEE and employers, to which the TCS refer, and so form a part of the wider changes involved in implementing the new TCS.

2.14 **Notice of deployment** – HEE will provide employers with sufficient notice of rotations (target: 12 weeks) so that employers can make offers early enough to give doctors time to make the necessary adjustments before being redeployed, including if necessary the need to move their family nearer to their place of employment. This

will be particularly helpful to those junior doctors who need to manage family life whilst being employed in different locations, but will also give employers early warning of gaps, facilitating earlier recruitment, and will allow employment checks to commence earlier, ensuring all doctors are cleared to start work on their first day in employment.

2.15 Notice period – HEE will also commit to using this notice period as part of its own internal performance management systems to ensure that this commitment is being realised. Employers will be asked to make offers of employment (including provision of the generic work schedule and roster information) to doctors eight weeks in advance of starting a post. This will also help facilitate the removal of fixed leave, because doctors will be able to plan their leave requests around advance notice of rosters, without the need for fixed leave.

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Implementation

Phased implementation timeline

3.1 The implementation plan has been developed to enable employers to introduce the contract in phased stages. This is to ensure that employers have sufficient time to make the necessary changes in their organisations, and to enable the delivery of safe working patterns.

3.2 Not every trainee will move on to the new contract in August 2016. Doctors will move on to the new contract as they enter F1 or as contracts of employment expire as they move through training according to table 1 below. When F2s or GP trainees share a rota with doctors on other training programmes, they will move to the new contractual (and where applicable, pay protection) arrangements at the same time as the other doctors.

3.3 The new junior doctors' contract will be implemented in phases from August 2016 where there is a break in the contract of employment and a new contract is taken up. However, employers may choose to offer, and doctors may choose to accept the contract in advance of the timetable, subject to agreement. The initial group will be all F1 grades; ST 1/2/3 GP trainees undertaking practice placements; and all psychiatry and public health trainees. The table below details the full implementation timetable.

Date	Grade	Rotation(s)/Training Programmes
Aug -16	F1	All
Feb to April -17	ST1/2/3 All	GP trainees in a practice placement only* Psychiatry; public health, all pathologies
	ST1+	Paediatrics (core, higher and all sub specialties); dentists
Apr to August-17	CT1-3 /ST3+	All surgical specialties (including orthodontics)
	ST3+	Anaesthetics/ITU/emergency medicine/obstetrics and gynaecology/radiology

	ST1-2/ CT1-2	Core medical training/remaining core surgical training/ ACCS/anaesthetics/radiology/obstetrics and gynaecology/any remaining ST1/2
Aug – Dec -17	All	Any remaining trainees

*Any trainee (e.g. F2; GP trainee in hospital settings) sharing a rota with the above will move the new contractual and transitional arrangements at the same time as those trainees.

3.4 *The new contractual arrangements do not apply to trust-grade doctors.*

3.5 The following implementation steps are a guide for employers to ensure that they are able to introduce the new TCS in accordance with the above timescales.

Processes

3.6 **Guardian of safe working hours** – Agree a local recruitment process for appointing a guardian of safe working hours.

3.7 **Exception reporting** - Agree a local process and have mechanisms in place for exception reporting and work schedule reviews. This should be made available electronically. It may be in the form of an electronic device created by your software provider or it may be developed in-house.

3.8 **Training** – Identify and agree processes for managing exception reports and work schedule reviews, and provide training to those involved (educational supervisors, administrative staff etc).

Prior to offering employment

3.9 For each post that will be offered on the new terms, the following tasks need to be completed before any offer of employment can be made:

a) **Reorganise / remodel rotas** – Identify rotas that breach the new limits of hours and rest (as set out in Schedule 3 of the TCS) and remodel these rotas to fit the new rota rules. Employers who use DRS, Allocate or another provider can consult with their software provider for assistance in building the rotas. Please note that all rotas will need to comply with the provisions of Schedule 3; there is no longer the option to breach the rules and make a penalty payment to the doctor (as is the case with Band 3 under the 2002 TCS).

b) **Consultation** – Arrange a consultation meeting with the doctors currently working on those rotas, and discuss how these might be remodelled to fit the new rules whilst maintaining patient care and meeting the doctors.

c) **Agreement -** Agree the new working pattern. Please note that if there will still be doctors working on the 2002 TCS, the current local arrangements for agreeing and approving rotas will remain in force.

d) **Work schedules** - Create generic work schedules for each post based on the new agreed working patterns.

e) **Pay** – Assess the pay for each working pattern and include in the work schedule.

f) **Offer** – Make conditional offer of employment, using the model contract.

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4. A guide to safe working hours and rota design

4.1 The new national contract places a mutual obligation on employers and doctors to respect the new limits on work hours and consecutive shifts.

4.2 The employer has a contractual and regulatory responsibility for ensuring the doctor is not contracted, or otherwise required, to work outside of the limits set out in Schedule 3 of the TCS.

4.3 Employers must ensure that existing rotas are revised to meet the new limits on hours and safeguards on rest. These need to be incorporated into the new rotas **before** sending out the employment offer and work schedule documentation.

4.4 The limits and safeguards are set out in Schedule 3 of the TCS, and are summarised below:

Weekly hours	
Weekly average hours	**maximum of 48**
Weekly average hours if opting out of WTR	**maximum of 56**
Absolute limit on hours	**maximum 72 in any seven calendar days**
Maximum shift length	**13 hours**
Consecutive shifts	
Night shifts (more than 3 hours between 2300 and 0600)	**maximum 4 consecutive shifts**
Long shifts (more than 10 hours)	**maximum 5 consecutive shifts**
Long late shifts (more than 10 hours, finishing after 2300)	**maximum 4 consecutive shifts**
All shifts (any length or combination of lengths)	**maximum 8 consecutive shifts**
Weekends (Saturday and Sunday)	
No consecutive weekends rostered without written agreement (there may be situations where they are for the benefit of the doctor or	

the service, and then the 1 in 2 rule will ensure weekends off are achieved elsewhere).	
No doctor rostered to work more frequently than 1:2 weekends, averaged over the length of the rota cycle, the length of the placement, or 26 weeks, whichever is the shorter.	
Rest	
Paid meal breaks	30 mins if shift exceeds 5 hours; 2 x 30 mins if shift exceeds 9 hours
After any individual shift	**11 hours' minimum rest**
After 3 or 4 consecutive night shifts	**48 hours' minimum rest**
After 5 consecutive long shifts (more than 10 hours)	**48 hours' minimum rest**
After 4 consecutive long late shifts (more than 10 hours, finishing after 2300)	**48 hours' minimum rest**
After 8 consecutive shifts	**48 hours' minimum rest**
On-call duty	
Length of on-call duty period	**maximum 24 hours**
Rest whilst on call	**minimum 8 hours (minimum 5 continuous)**
Consecutive on-call duties	**maximum of 1 duty period** (maximum of 2 consecutive duty periods if first one begins on a Saturday)*
Shift on day following an on-call duty (or following 2nd on-call duty if 2 are rostered consecutively)	**maximum 10 hours** (maximum 5 hours if overnight rest not likely to be achieved)
Frequency of on-call duties	**maximum 3 in 7 days***

* Doctors and employers may agree locally on an individual level to relax these limits up to a maximum of seven consecutive duty periods, provided that it is safe to do so and no other limits or safeguards would be breached as a result. It is expected that

this would only be in departments where the amount of work carried out whilst on-call is very light and of a low intensity.

4.5 Employers will need to ensure that all team rotas are supported by, linked to and complemented by individual work schedules.

Mixed economy rotas

4.6 Where employers have rotas that contain doctors on both the 2016 TCS, and the 2002 ('New Deal') TCS (i.e. mixed economy rotas), the following should be noted:

a) If the rota complies with the 2016 rota rules, then in the majority of cases, the rota will also comply with New Deal rules.

b) The exception to this will be on-call rotas, where compliance with the 2016 rules may not mean compliance with New Deal rules. Where this is the case it is recommended to make sure that on-call aspects of rotas comply with New Deal rules, which will mean they will also comply with 2016 rules.

4.7 Once a rota is compliant with both sets of rota rules, individual doctors on the rota can be paid according to the TCS on which they are employed.

Rota redesign

4.8 The two main software providers (Allocate Software (formerly Zircadian) and Skills for Health (providers of DRS)) have already released updated software to allow employing organisations to assess their current rotas and to design new working patterns in order to meet the new contractual rules above.

4.9 Employers not using either software provider will need to liaise with their own provider (if any) or draw upon their own resources to ensure that they have a system that is and remains fit for purpose.

4.10 When designing on-call rotas, employers should note that they will be required not only to identify the start and end times of the duty periods, but also to prospectively estimate the number of hours of actual work during the duty period (as is done now, both under the New Deal contract and in consultant and SAS job planning) and the time of day that the work would normally be done (to ensure that it is paid at the correct rate and that it is put into the correct day of the week, which is important for the 72-hour rule). Monitoring data from diary-card exercises, bleep audits and other data available in employing organisations may help with this.

4.11 Although prospective cover as defined in the 2002 TCS does not feature in the 2016 TCS, annual leave does still need to be taken into account when designing rotas. To do this, an average amount of leave should be deducted from each rota cycle before

assessing the average hours. For details, see paragraph 11 of Schedule 4 and paragraph 9 of Schedule 9 of the TCS.

4.12 Where there is a lead employer arrangement, the host organisation will normally be responsible for the redesign of rotas, and the incorporation of these into the work schedule (see section 5). Additional guidance for lead employers and host organisations will be circulated in early April.

4.13 Note: Where limits on safe working hours (48 hours average week under WTR; 72 absolute limit in seven calendar days; breach of more than three hours in the 11 hour minimum rest period) are breached, then the doctor should be paid at 1.5 times the prevailing hourly rate. In addition, a financial penalty will be levied for each hour above these limits at 2.5 times at the prevailing hourly rate. Employers should therefore take care not to run rotas right up to the margins of these limits so as to avoid penalties.

4.14 Full details on the changes made to ensure safe working hours can be found in Schedule 3 of the new TCS.

5. A guide to work scheduling

Purpose of a work schedule

5.1 The work schedule brings together activities to achieve learning and service objectives within contracted hours. A work schedule expressly links work carried out to the training needs identified in the relevant curriculum. This ensures that, alongside commitments for the delivery of patient and other services, the doctor is able to train effectively toward the achievement of the competencies necessary to progress through training.

5.2 Employers may choose to use the work schedule template at Annex B or agree a locally agreed template providing it contains the same information.

5.3 A work schedule will apply for the duration of the doctor's training placement, and will identify:

a) the intended learning outcomes (mapped to the educational curriculum)

b) the scheduled duties of the doctor

c) time for quality improvement and patient safety activities

d) periods of formal study

e) the rota on which the doctor will be working

f) the number and distribution of hours for which the doctor is contracted

g) the pay the doctor can expect to receive for the hours set out in the work schedule.

5.4 Employers are required to ensure that any work pattern described in the schedule:

- complies with the Working Time Regulations
- complies with the rules on working hours detailed in Schedule 3 of the TCS.

5.5 In order to complete the work schedule process, employers may need to access information via a number of sources, including:

a) local Deanery office

b) software systems

c) recent monitoring data

d) ESR

e) Form B

f) information held in the postgraduate medical education department.

Further useful information may be obtained through discussion with junior doctors, senior clinicians and service managers.

5.6 The duties and responsibilities set out in a work schedule will include, as appropriate:

a. Specific training

b. Clinical care and service duties

c. Professional duties for other organisations (required by the employer).

Designing the generic work schedule

5.7 It is the employer's responsibility to complete the generic work schedule prior to the offer of employment being made to the doctor.

5.8 The work schedule should include all of the following details:

a) Name of doctor

b) Name of educational supervisor

c) Contact details for HR / medical staffing

d) Training programme

e) Specialty (if different from above)

f) Grade

g) Working pattern (description of hours to be worked – total hours and distribution of hours)

h) Service commitment to unscheduled urgent or emergency care

i) On–call arrangements (if any)

j) Pay

k) Training opportunities.

5.9 A standard full-time work schedule will be for a minimum of 40 and a maximum of 48 hours per week, averaged over the agreed reference period. The work schedule should also describe the rota commitment.

5.10 The work schedule of doctors working on-call working patterns will contain an estimated average amount of time, calculated prospectively, for anticipated work done during on-call periods. See section 4 for details on how this is done.

5.11 It is the employer's responsibility to ensure that the work schedule takes into account the training aspects of the job, which may be similar to those described in the application for approval of a training post (Form B) where this document is still available.

5.12 Where the Form B is not available, employers should liaise with the doctor's prospective educational supervisor (the supervisor for the current doctor) or contact

the postgraduate medical education department team, from whom this information should be made available. The training information required for the generic work schedule will normally be the same for each post at the same level on the same training programme (e.g. all ST1 posts in obstetrics for trainees on an obstetrics and gynaecology programme should be the same) although there will be exceptions. For example, core training programmes in medicine and surgery, where posts may be in different departments.

5.13 Where there is a lead employer arrangement, the lead employer is responsible for sending the offer letter, along with the generic work schedule, to the doctor, although the host organisation would usually complete the work schedule and forward it to the lead employer prior to the offer of employment being made.

5.14 Once the above has been included in the generic work schedule, this should be sent to the doctor with the employment offer.

5.15 This will be adapted into a personalised work schedule when the doctor commences employment and has the opportunity to discuss any personal objectives with the educational supervisor.

Designing the personal work schedule

5.16 Once the doctor commences employment, a personalised work schedule will need to be agreed with the doctor's educational supervisor. This area of the work schedule will include the doctor's individual personal development plan (PDP), and highlight any learning objectives the doctor may need to achieve in the work placement, in accordance with the Gold Guide.

5.17 Training is central to the personalised work schedule and should be included in the objectives.

5.18 The individual schedule will be discussed at the doctor's regular educational meetings (with the educational supervisor), to ensure that the workplace experience delivers the anticipated learning opportunities.

5.19 These regular meetings/reviews may lead to changes in the doctor's work schedule if aspects of the work schedule are not being achieved, for example where additional hours are found to be required to complete the work, or where educational opportunities cannot be accessed.

In the event of a disagreement

5.20 The work schedule is so central to the work of the doctor that it is worth taking the time to get it right. If an element of the work schedule cannot be agreed then the doctor may invoke the provisions of Schedule 5 of the TCS.

5.21 Work schedules should be kept up to date through educational reviews and work schedule discussions , supported by exception reporting when an individual doctor feels that the workload and/or work pattern is deviating significantly or routinely

from the intended work schedule, or where (s)he feels that (s)he is unable to access the training specified in the schedule.

5.22 Employers need to ensure the generic work schedules remains fit for purpose. They will need to have a locally agreed process in how to manage and review work schedules. Ideally this should be done:

a) annually; and/or

b) at the time of offer; and/or

c) when the service model changes with the educational lead/manager.

6. A guide to exception reporting

6.1 The current New Deal system of monitoring will be replaced by a new system of exception reports and work schedule reviews.

6.2 Monitoring and banding appeals that exist in the 2002 New Deal contract are not a feature of the 2016 contract, as exception reports will flag any issues in real time. However, where employers have rotas involving staff on both the 2002 and the 2016 contracts, there will still be an obligation to monitor those on the 2002 contract until no such doctors remain in employment. This means that, if a rota contains a mix of doctors on both contracts, those on the 2002 TCS will still need to be monitored in line with the 2002 TCS.

6.3 A doctor on the 2016 TCS can report exceptions where day-to-day work varies significantly and/or routinely from that set out in the doctor's work schedule, with respect to either:

a) the hours of work (including rest breaks); or

b) the agreed working pattern, including the educational opportunities made available.

6.4 If rota hours are breached, this should be highlighted at the first available opportunity by an exception report. Employers will need to make assessments of such exceptions to identify whether they indicate breaches that attract a financial penalty, as set out in paragraph 70 of Schedule 2 of the TCS.

6.5 Exception reports, where they arise, will be sent to the educational supervisor for discussion at the next educational meeting.

6.6 The employer (in this instance, the educational supervisor) must assess issues as they arise and where necessary make timely adjustments through either a routine work schedule review held as part of an educational meeting, or an interim review held in advance of the educational meeting, where this is appropriate on grounds of urgency.

6.7 Employers are required by the TCS to have in place a local process, supported by an electronic system, for making and managing exception reports. Doctors using a software provider to manage their rotas and/or e-rostering may wish to discuss with that provider whether or not an exception reporting tool can be made available through the same system. Alternately, such a system could be developed in-house by one or more employers.

6.8 Educational supervisors will need to be trained in how to use the exception reporting system. Additionally, induction processes for new doctors will need to include

information on how / when to make exception reports, and the process for managing these.

6.9 Oversight of the exception reporting process will be the responsibility of the guardian of safe working hours, as set out in Schedules 5 and 6 of the TCS.

6.10 Further details can be found in the Schedule 5 of the TCS.

7. A guide to work schedule reviews

7.1 It is the employer's responsibility to ensure that there is a locally agreed process in place to administer and manage work schedule reviews. All educational supervisors need to be trained in and understand the process.

7.2 This process should be in place by the time doctors commence in August 2016.

7.3 A work schedule review should be undertaken, wherever there are regular or persistent breaches in safe working hours that have not been addressed, or wherever educational opportunities cannot be accessed due to pressures of workload.

7.4 A work schedule review can be triggered by one or more exception report(s), or by a request from either the doctor or the educational supervisor/service manager.

7.5 Reviews should consider safe working issues, including those related to working hours and rest, as well as any educational issues and/or issues relating to service delivery.

7.6 The first stage in any review is an informal discussion between the doctor and the educational supervisor/line manager in an attempt to resolve the issue quickly.

7.7 If this fails, stage two would be a formal meeting including the educational supervisor, the doctor, a service lead, and a nominee of the employer's (or host organisation's) director of postgraduate medical/dental education.

7.8 If agreement can still not be reached at this stage, the final level appeal process will be the employer's final stage grievance appeal (the guardian of safe working hours may, in some circumstances, be involved at this stage). This will mean that even if the review reaches the final stage, the employer can sort the issue promptly, without the need for arranging for external representation on hearing panels, as is the case under the banding appeals that form a part of the 2002 TCS.

7.9 More information about exception reports and work schedule reviews can be found In Schedule 5 of the TCS published on NHS Employers' website.

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8. A guide to the appointment and role of the guardian of safe working hours

8.1 All employers (and/or host organisations, if appropriate) will on the introduction of the new contract, establish a locally agreed recruitment process for the appointment of a guardian of safe working hours (hereafter referred to as 'the guardian'). Doctors in training at the employing organisation will need to be involved in the appointment of the guardian. Schedule 6 of the TCS sets out the principles for the appointment for the guardian. A sample job description and person specification for the role are available on the NHSE website and attached here as Annexes C and D.

8.2 The guardian is a new role, which will oversee the safeguards outlined in the contract and will ensure that issues of compliance with safe working hours are addressed by the doctor and/or the employer/host organisation.

8.3 If a doctor's concerns have not been resolved through the exception reporting and work schedule review processes, then doctors can escalate their concerns to the guardian.

8.4 The guardian can formally raise concerns regarding safe working hours with the management of the employing/host organisation and can insist that steps are taken to resolve matters of concern.

8.5 The guardian will be empowered to require departments to take necessary steps to improve the working conditions of doctors.

8.6 The guardian will levy a financial penalty on the department where the three key safe working hour limits are breached (weekly average of 48 hours; absolute total of 72 hours in seven days; 11 hours' rest between shifts reduced to eight hours or fewer). This fine will go into a budget administered by the guardian, to be spent on improvements to the working and training environment of doctors. For more information on these financial penalties see Schedule 2 and Schedule 3 of the TCS.

8.7 The guardian will present regular reports on working hours to the board and will undertake regular consultation with doctors employed by the organisation for whom the guardian has responsibility.

8.8 The guardian will be directly accountable to a board-level executive and will report to the board, either directly or through a sub-committee of the board. The board must receive a report from the guardian no less than annually. Reports will also be submitted to Health Education England (via the local office) and will be available to other inspectors and regulators (CQC, Monitor, TDA, GMC etc.) on request. The

employer's local negotiating committee (LNC) or equivalent should also receive copies of the guardian's reports.

8.9 For more information on the guardian, see Schedule 6 of the TCS published on NHS Employers website.

9. A guide to pay

The new pay structure

9.1 The current system of basic pay and broad banding supplements is being replaced with a new pay structure. The new pay structure rewards doctors for actual work done and directly links pay to the level of responsibility a doctor is required to discharge while employed in a particular post. The details of this system are outlined in Schedule 2 of the TCS and are summarised in table 1 below:

Table 1

Basic pay on a 5-nodal point structure	
Nodal point 1	F1
Nodal point 2	F2
Nodal point 3	CT1-2 ST1-2
Nodal point 4	CT3,ST3-7
Nodal point 5	ST8
Enhancement	
Every night 9pm–7am	50 per cent enhancement
Saturday 5pm–9pm and Sunday 7am–9pm	30 per cent enhancement
Saturday 7am–5pm (if any shift starting on a Saturday is worked 1:4 or more frequently)	30 per cent enhancement
Flexible pay premia	
General practice	Trainees on general practice programmes whilst in general practice placements
Hard-to-fill training programmes	Emergency Medicine ST4 and above
	Psychiatry ST1 and above
Academia	As per Schedule 2 of the TCS
Leadership	As per Schedule 2 of the TCS

Dual qualification – OMFS	Oral and Maxillofacial Surgery ST3 and above
Additional work	
Shift over-runs	Paid at prevailing rate unless a breach of WTR 48-hour average working hours, contractual 72-hour weekly limit or reducing rest between shifts to fewer than 8 hours, in which case paid at time and a half of the prevailing rate.
Locum work	At rates set out in the pay circular

Values for the above are set out in the Medical and Dental Pay Circular 2/2016.

9.2 For full details on the new pay system, see Schedule 2 of the TCS published on NHS Employers website.

Pay progression

9.3 Pay progression will only take place as doctors move through training to take up positions at higher levels of responsibility (i.e. in line with career progression). The current pay scale will be replaced by a series of five nodal points (as above), each of which has a pay value (as per the pay circular) for the basic salary. Each nodal point will be pegged to a step change in responsibility, when the doctor takes on additional responsibility.

9.4 This system thus provides for increases in rates of basic pay at nodal points through the career pathway where there are distinct and significant increases in responsibility.

9.5 This is evidenced and monitored via the ARCP (Annual Review of Competence Progression) form. HEE (local office) will need to inform employers when a doctor moves from one grade to the next following this process, and will need to inform employers of the stage of training for each doctor at the point of rotation.

9.6 Most doctors will have three progression-linked pay rises as they progress through training. These are when they move:

a) from F1 to F2

b) from F2 to CT1/ST1

c) from CT2/ST2 to CT3/ST3.

9.7 Doctors on pathways running to ST8 will have an additional rise when they take up a post at ST8. This is to reflect the greater level of responsibility discharged at that level. All doctors at the same nodal point will receive the same level of basic salary (pro-rata for those working less than full time).

9.8 Further details on the nodal points and the value of basic pay at each point can be found in the pay circular published on NHS Employer' website.

Pay for additional rostered hours

9.9 Basic pay is for a 40-hour week, including paid breaks. Doctors working less than full-time will be paid a basic salary for all hours set out in their work schedule, up to a maximum of 39.75 hours.

9.10 Additional rostered hours can be worked without the need for an opt-out, provided that they do not take the weekly average hours to over 48 hours per week.

9.11 Hours rostered and worked over the average of 40 per week will be paid proportionately, i.e. at 1/40th of whole-time equivalent pay. This means that a doctor working additional hours will receive 1/40th whole time equivalent pay for each additional hour worked. For example, a doctor employed for 12 months at ST3 level who is contracted to work 46 hours per week would be paid £48,000 for 40 hours, and for the additional 6 hours they will be paid (£48,000 / 40) x 6 = £7,200, making a total amount of £55,200. An enhancement of either 30 per cent or 50 per cent will additionally be added to any hour worked in the designated unsocial hours periods.

9.12 The pay for these additional hours over the 40-hour weekly average is non-pensionable.

9.13 Alternately, such work could be contracted for separately, outside of the main contract of employment, via the locum bank, in accordance with the locum provisions set out elsewhere in the contract.

9.14 Where a doctor works hours above their scheduled hours, and these are authorised (prospectively or retrospectively) they will be paid as follows:

a) At the prevailing hourly rate up to 48 average hours; or

b) At 1.5 times the prevailing hourly rate if the work takes the doctor above the 48 average weekly hours and/or above the 72 absolute limit in a seven-day period, or causes the 11-hour minimum rest period in 24 hours to be reduced to fewer than eight hours.

Enhanced pay for work at night, and on Saturdays and Sundays

9.15 The new pay system recognises and supports appropriately the most onerous and disruptive working patterns. The key principles are:

a) hours worked at night should be paid at the highest rate

b) hours worked on Saturday evenings and on a Sunday should be paid at a higher rate than those worked during the rest of the working week

c) where Saturdays are worked frequently, a higher rate should also apply to the daytime on a Saturday.

9.16 Hours worked during the following periods therefore attract enhancements to the basic pay rate, as follows:

Monday – Friday	7am–9pm	Plain time
Saturday*	7am–5pm	Plain time
Saturday	5pm–9pm	Time plus 30%
Sunday	7am–9pm	Time plus 30%
Any work between 9pm–7am (seven days a week)		Time plus 50%

* Any doctor whose rostered work as set out in the work schedule includes a shift beginning on a Saturday on 1 in 4 weeks or more frequently will be paid time plus 30 per cent for any hours falling between 7am and 5pm on a Saturday (how this payment applies for less-than-full-time workers is described in paragraph 60 of Schedule 14 of the TCS)

9.20 These enhancements will be calculated prospectively, based on the working pattern outlined in the work schedule for a doctor's placement, and paid as a part of the doctor's regular monthly salary. See sections 4 and 5 for details on how this is done.

9.21 The payment for the work schedule/placement will be averaged so that the doctor receives the same amount of pay each month whilst employed on a particular work schedule. It is not the intention that the doctor will receive a different amount of pay each month as a result of monthly variations in rostered hours arising from rota arrangements.

9.22 The additional pay enhancements described above are not a part of the fixed pay element, as they can vary as work schedules change. They are therefore not pensionable.

9.23 For further details see Schedule 2 of the TCS.

9.24 For transitional pay protection arrangements, see section 10 of this guidance and Schedule 14 of the TCS.

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10. A guide to transitional arrangements

What are transitional arrangements?

10.1 There will be an initial period of protection for all doctors currently in training to ensure that no doctor's salary will be no worse than it was on 31 October 2015. Employers will need to ensure that a doctor's pay does not fall during this transitional period, providing the doctor remains and continues to work the same proportion of full time hours.

10.2 Full details on the transitional arrangements, including the time period in which they will continue to apply, are described in Schedule 14 of the TCS.

10.3 Doctors will move onto the new TCS effective from 3 August 2016, or as soon as possible thereafter, in line with the dates set out in the implementation timetable in section 3 of this guidance, when they move between posts and/or contracts of employment. Where required, they will be offered pay protection as described in Schedule 14 of the TCS.

10.4 Doctors covered by the transitional protection arrangements will fall into one of two categories. Those in the lower stages of training will be entitled to protection based on the calculation of a 'cash floor' below which pay cannot drop. Doctors in the higher stages of training will be entitled to have their pay expectations protected. This will be achieved by continuing to be paid on their existing payscale, with annual increments, and to be paid, where appropriate, a banding supplement, based on a modified form of the New Deal arrangements.

10.5 Transitional arrangements will last for three years for each doctor, starting at the point at which the doctor first moves onto the new TCS. Doctors who take time out of training (e.g. for maternity leave) or who train part time can have this period extended. Details on this are set out in Schedule 14 of the TCS. In both cases, transition can only last until 5 December 2022 (inclusive). Any doctor whose three-year period has not elapsed by that point will nevertheless cease to be protected under these arrangements following that date.

Doctors who are entitled to cash floor pay protection.

10.6 The following doctors will be granted cash floor transitional protection under the arrangement described in Schedule 14 of the TCS:

a) All doctors remaining on F1 or remaining on F2 as at 3 August 2016.

b) All doctors entering F2 directly from F1 or from other training programmes on 3 August 2016.

c) All new entrants to core or run-through speciality training (CT1 / ST1) from F2 or from other training programmes on 3 August 2016.

d) All doctors moving into CT2, ST2 or CT3 grades from the grade immediately below or from other training programmes on 3 August 2016.

e) All doctors remaining in the CT1, ST1, CT2, ST2 or CT3 grades as at 3 August 2016

f) All doctors progressing directly from core training or from other training programmes to higher training at ST3 point (or for doctors entering higher training in psychiatry or emergency medicine at the ST4 point) from 3 August 2016.

10.7 Doctors entitled to cash floor protection will have their total pay, including basic pay and banding, as of 31 October 2015, set as a cash floor below which their pay cannot fall whilst they are covered by the provisions of Schedule 14. This protection will end either when the doctor exits training, or when three years of continuous employment have elapsed from the point that the doctor is first employed on the new TCS, or on 5 December 2022, whichever is the sooner.

10.8 Detail on how to calculate the cash floor for each doctor can be found in paragraph 9 of Schedule 14 of the TCS.. Employers should note subsection 9 (c) for details on how to assess the banding supplement to be used for this purpose.

10.9 Provisions for calculating the cash floor for doctors who were out of programme or otherwise absent from work on 31 October are set out in paragraph 14 of Schedule 14 of the TCS

10.10 Employers may request to see the doctor's payslip to determine basic pay and banding supplement received. Alternatively, this can be done via an Inter Authority Transfer (IAT) request. However, where the doctor is entitled to have the banding calculated slightly differently, as described in paragraph 9 of Schedule 14 of the TCS, employers may need to request evidence of the reason for this approach.

10.11 We are currently working with ESR to see whether a field could be included to hold the cash floor total and the date on which entitlement will expire, so that for future rotations, these can be transferred via the IAT process. This will not be available when a doctor first accepts employment under the new TCS, as there is no requirement for it to be calculated prior to that point.

Doctors who are entitled to transitional pay protection in higher training grades

10.12 The following doctors will be granted the transitional pay protection under the arrangement described in Schedule 14 of the TCS:

a) Already at ST3 or above on a run through training programme on 2 August 2016.

b) Already in higher specialty training programmes on 2 August 2016.

c) Specialist registrars (SpRs) on pre-2007 training programme.

d) Doctors who are given extra time within their training programme with the approval of their deanery to achieve satisfactory progress.

10.13 The doctor's described in paragraph 10.10 will have their pay protection value calculated as being:

a) basic salary on the pay scale (MN37) as per the 2002 contract, with annual increments to continue as per the doctors previously agreed increment date, until the doctor exits training or until the period of protected pay expires, whichever is sooner; *plus*

b) Banding supplement for the rota on which they will be working, set at a maximum of 1A (50 per cent) or a maximum 2A (80 per cent) for those working more than 48 hours per week and having opted out of the Working Time Regulations.

10.14 Employers should follow existing processes for assessing the point on the payscale at which these doctors should be paid. The banding supplements should be calculated based on the provisions set out in paragraphs 26 to 53 of Schedule 14 of the TCS.

Doctors who are not entitled to transitional pay protection

10.15 The following doctors will not be granted the transitional pay protection under the arrangement described in Schedule 14 of the TCS:

a) Doctors who exit training.

b) Trust doctors.

c) Locum appointment for service (LAS) or other locally arranged locum positions or contracts.

d) Doctors who take a break in training between programmes (i.e. doctors with a gap in their employment).

e) Doctors not currently in training who enter training on or after 3 August 2016.

10.16 The TCS are published on the NHS Employers website containing a temporary Schedule 14, which will expire on 5 December 2016, detailing transitional arrangements in full.

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