NHS Employers

Junior doctors' contract -

Summary of the new 2016 contract

February 2016

Introduction

In November 2015, NHS Employers published a firm but not final offer of a new junior doctor contract, for introduction in England in August 2016. Following discussions under the auspices of Acas, on 30 November the British Medical Association (BMA) agreed to re-enter negotiations, taking the cost neutral November offer as the starting point for further discussions on a number of specified issues.

Discussions during December 2015 and January 2016 with the BMA focused on three key areas:

- Safe working
- Training and deployment
- Pay

Constructive and hugely helpful discussions to address the concerns raised by the BMA continued until 9 February. Significant agreement was reached in most areas and, with both parties having now signaled that reaching agreement on the outstanding issues is not possible, this document sets out a summary of the final contract made to trainee doctors working in the English NHS.

Scope of the new contract

From 3 August 2016, new contractual arrangements will be introduced in England for trainees in hospital posts approved for postgraduate medical/dental education. These will replace the existing New Deal arrangements, 2000 and the Hospital Medical and Dental Staff Terms and Conditions of Service, 2002, as they apply to trainees. The new 2016 contractual arrangements will also apply in England to general practice trainees during the approved general medical practice placements that form part of postgraduate medical education, and will replace provisions currently contained in Schedules to the Directions to Health Education England (GP Registrars).

The introduction of such a major contract reform will significantly change working patterns for doctors in training. Careful implementation will be crucial to ensure continued delivery of safe and effective care to patients.

A phased implementation plan has been developed that will enable employers to introduce the new working patterns enshrined in the new contract more safely.

Doctors / dentists will therefore transfer onto the new contract on different dates over a 12-month period, commencing in August 2016 under the phased implementation plan. The proposed national timetable for this is set out in Appendix B, although this may be subject to some regional modification.

Doctors / dentists in training will retain their existing New Deal contract pay, terms and conditions until the date on which they transfer to the new contract and its associated terms and conditions, according to the national timetable.

For the purposes of the remainder of this document, for 'doctor' read 'doctor / dentist' throughout.

Features of the new contract

a) Safe working

While the current contract complies with the UK Working Time Regulations, it does not go far enough to promote and protect the safety of doctors. The new contract provides a comprehensive package to address concerns raised by junior doctors and proposes additional safeguards and restrictions, beyond those in the Working Time Regulations, on the hours that doctors are required to work. These safeguards reflect the legitimate concerns raised by many doctors and so go even further than those originally proposed in the November offer.

The arrangements will be overseen in every trust by an independent guardian of safe working, who will from August 2016:

• act as the champion of safe working hours for doctors

• provide assurance to the board that doctors are both rostered safely and actually work safely

• require work schedule reviews to be undertaken where there are regular breaches in safe working hours

• directly escalate to the trust executive or equivalent, issues over safe working hours that are not being addressed locally

• take appropriate steps to intervene directly where, in the view of the guardian, the safety of doctors or patients is being compromised

• provide regular and timely reports on the safety of doctors' working hours to the local negotiating committee and to the board for incorporation into annual reports to the Care Quality Commission (CQC), and to be made available to Health Education England (HEE) and the General Medical Council (GMC) as part of inspection visits and to the Review Body on Doctors' and Dentists' Remuneration (DDRB).

Current contract	November offer	Final contract
		Guardian of safe working appointed jointly with junior doctors.
		Appraisal of guardian by board level director based on multisource feedback and agreed key performance indicators (KPIs).
		Safe working hours enshrined as a KPI for performance management framework for all managers.
Twice-yearly hours-monitoring exercises.	Exception reports to replace hours monitoring.	Exception reports to replace hours monitoring.
Departmental rota.	Individual work scheduling.	Individual work scheduling.
		Work schedules for GP trainees in practices to reflect guidance on work plans from Committee of GP Education Directors.
	Work schedule reviews on request.	Work schedule reviews on request and when required by the guardian.
Maximum average 56-hour working week.	Maximum average 48-hour working week.	Maximum average 48-hour working week.
Opt out capped at maximum average of 56 working hours per week.	Opt out capped at maximum average of 56 working hours per week.	Opt out capped at maximum average of 56 working hours per week.
Maximum 91 hours' work in any seven-day period.	Maximum 72 hours' work in any seven-.day period.	Maximum 72 hours' work in any seven-day period.
Maximum shift length of 14 hours.	Maximum shift length of 13 hours.	Maximum shift length of 13 hours.
Maximum of seven consecutive long shifts.	Maximum of five consecutive long shifts.	Maximum of five consecutive long shifts.
Maximum of seven consecutive night shifts.	Maximum of four consecutive night shifts.	Maximum of four consecutive night shifts.

Current contract	November offer	Final contract
Minimum 11 hours' rest after final night shift.	Minimum 11 hours' rest after final night shift.	Minimum 48 hours' rest after a run of either three or four consecutive night shifts.
Minimum 11 hours' rest after final long shift.	Minimum 11 hours' rest after final long shift.	Minimum 48 hours' rest after five consecutive long shifts.
Maximum of 12 consecutive long, late evening (twilight into night) shifts.	Maximum of five consecutive long, late evening (twilight into night) shifts.	Maximum of four consecutive long, late evening (twilight into night) shifts.
Minimum 11 hours' rest after final long, late evening (twilight into night) shift.	Minimum 11 hours' rest after final long, late evening (twilight into night) shift.	Minimum 48 hours' rest after four consecutive long, late evening (twilight into night) shifts.
Maximum 12 consecutive shifts.	Maximum 12 consecutive shifts.	Maximum eight consecutive shifts.
48 hours' rest after 12 consecutive shifts.	48 hours' rest after 12 consecutive shifts.	48 hours' rest after eight consecutive shifts.
Rigid on-call rules with limited flexibility.	More flexible on-call arrangements linked to intensity or work.	Limits on on-call working: • No more than three rostered on-calls in seven days except by agreement. • Guaranteed rest arrangements where overnight rest is disturbed.
Rigid paid rest-break requirements.	Paid 30-minute rest breaks at intervals in line with working time regulations.	Paid rest breaks: 30 minutes if shift exceeds 5 hours; 2 x 30 minutes if shift exceeds 9 hours, taken flexibly across the shift.
		Best practice guidance on rostering.
		Financial penalty levied on employer for breaches of WTR 48-hour average working hours or contractual 72 hour weekly limit. Doctor to be paid 1.5 times the prevailing hourly rate. Financial penalty of 2.5 times the rate to be e vested with the Guardian to be invested in educational resources and facilities for trainees (over and above monies already allocated to those areas).

b) Training and deployment

The current contract is largely silent on the educational needs of doctors in training. This contract includes both contractual terms and additional pledges from Health Education England that support the training needs of doctors. (Separately, the Secretary of State is commissioning a review of the more longstanding issues relating to junior doctors' morale, well-being and quality of life).

Current contract	November offer	Final contract
	Work schedule to be linked to the educational curriculum.	Work schedule to be linked to the educational curriculum.
	Training needs to be identified and included in the work schedule.	Training needs to be identified and included in the work schedule.
		HEE commitment to performance manage Local Education and Training Boards (deaneries) against code of practice on notice of deployment.
		HEE to establish benchmark standards for educational facilities.
		Contract will facilitate both standard and lead employer models.
		HEE commitment to identify ways of reducing the costs of training through centralised provision and other means.
		Improved access to less-than-full-time training.

Current contract	November offer	Final contract
		Enhanced continuity of service provisions to ensure that trainees returning from out of programme (OOP) are not unfairly deprived of occupational maternity pay.
		Fixed leave to be replaced by a mutual obligation for employers and doctors to appropriately manage leave arrangements.

c) Pay

The current contract has insufficient links between pay and level of responsibility. It also makes minimal distinction between different working patterns through a broad-based system of banding supplements, which sees doctors potentially having to manage huge variations in pay as they move from one job to another.

The new contract addresses these issues and delivers a model of pay that is fairer, more stable and more transparent, while ensuring that average pay across the junior medical workforce, for the current average hours rostered, remains unchanged. It also guarantees no change in average earnings for existing trainees, and that the level of average earnings will be maintained for those entering training in the future.

Average pay for junior doctors will remain the same under the new contract. That applies equally to those entering training in the future.

Doctors working the most onerous working patterns will be more fairly rewarded.

Doctors' pay will link directly to the work that they do and the level of responsibility that they discharge.

The approach in the final contract reflects agreements on a revised model of pay progression reached with the BMA during December 2015 and January 2016. The flatter nodal structure proposed by and agreed with the BMA protects the interests of doctors wishing to have families, to train part-time, to undertake research or otherwise to take breaks from training. Additionally, the pay structure has been 'frontloaded' at the request of the BMA, so that doctors benefit earlier on in their careers. The most noticeable change as a result of the BMA's preferred approach is an increase in the relative value of the F1 nodal pay point and a reduction in the new ST8 nodal pay point.

Current contract	November offer	Final contract
Basic pay linked to length of service rather than level of responsibility.	Basic pay on a 6-nodal point structure (F1, F2, ST1-2, ST3-4, ST5-6, ST7-8).	Basic pay on a 5-nodal point structure (F1, F2, ST1-2, ST3-7, ST8), as proposed by the BMA, with indicative values highlighted in Appendix A.
Pay progression not linked to progress through training / employment.	Pay progression linked to responsibility.	Pay progression directly linked to key changes in level of responsibility.
	Pay structure that stakeholders worried might provide disincentive for academia or breaks from training.	Even flatter pay structure agreed with BMA to minimise impact on those taking academic route and / or breaks from training.
Banding system that results in huge variations in pay when doctors rotate from one post to another.	Increased basic pay with a lesser proportion of pay being variable, providing for a more stable salary for doctors and increased pension benefits.	Increased basic pay - increase at transition on average of 13.5% with a lesser proportion of pay being variable, providing for a more stable salary for doctors and increased pension benefits.
Inflexible banding system that does not properly distinguish between unsocial and social hours worked.	• 50% premium for night work (2200 - 0700) • 33% premium for Saturday evening (1900 - 2200) and Sunday (0700 - 2200) work.	• Every day 2100 – 0700: 50% premium. • Sunday 0700 - 2100 and Saturday 1700 – 2100: 30%. • Saturday 0700 – 1700 will also be 30%, if any shift starting on a Saturday is worked 1:4 or more frequently

Current contract	November offer	Final contract
	Availability supplement payable for on-call duty at the rates of 2, 4 and 6% of basic salary, depending on frequency.	Doctors from ST1-ST8 will be paid an on-call availability allowance based on the frequency of the rota commitment. The value of the allowance will be a cash sum, which will rise in cash terms in line with any increases in base pay and will be set at 10% of the ST3-7 nodal point if rostered 1:4 or more frequently, and at 5% of that nodal point if rostered less frequently. Doctors in foundation years working on-call will be paid an availability allowance calculated at the same percentages but based on their own nodal point values.
	Pay premium paid to trainees on emergency medicine or psychiatry training programmes to incentivise recruitment.	Pay premium* paid to trainees on emergency medicine or psychiatry training programmes to ensure appropriate pay incentives to support recruitment.
	Pay premium paid to clinical academics or other trainees holding a training number who complete higher degrees, to offset impact on pay progression.	Pay premium* paid to clinical academics or other trainees holding a training number who complete higher degrees, approved courses (e.g. leadership) and / or approved work in the wider interests of the NHS, to ensure appropriate pay incentives to support academic research.
Supplement paid to GP trainees in practices to ensure parity of pay with hospital-based trainees.	Pay premium paid to GP trainees in practices to ensure current level of pay is matched in the new system.	Pay premium* paid to GP trainees in practices to ensure current level of pay is matched in the new system.

Current contract	November offer	Final contract
	Time off in lieu for additional work.	Additional work paid at prevailing rate unless a breach of WTR 48-hour average working hours or contractual 72-hour weekly limit, in which case, time and a half would be paid.

*Doctors receiving pay premia will receive them throughout all periods of paid employment under these terms and conditions from the point that they become eligible for payment until the point that they exit the training programme, at the rate applicable at the time that they first became eligible. GP trainees will only receive the pay premium whilst working in practice placements.

Locum work

This contract also sets a clear limit on weekly average hours of work in any setting at 56 hours (where a doctor has opted out of the Working Time Regulations). Doctors have a responsibility to ensure that when working any additional hours outside their work schedule those hours are safe and in line with contractual limits that are binding on both the employer and the doctor.

Before undertaking additional locum work, doctors will need to offer their employer (the employing trust, or the host trust where there is a lead employer) first refusal on any such locum work, and this will be paid in line with NHS terms and conditions as set out in the annual pay circular. The employer must act reasonably, in accordance with guidance and respond to requests within rapid, defined timescales. Where employers do not wish to take up that first refusal, they will need to be informed of additional work that doctors are doing to ensure that they are working safely; employers can withhold permission if that is not the case.

Transitional arrangements

The new contractual arrangements will be phased in over the year beginning August 2016. Individual doctors affected will have salary protection throughout the period of transition to the new system, until 31 July 2019, as outlined below:

1. For those trainees remaining at F1 or F2; those entering F2 from F1; those entering core or run-through specialty training (including general practice) at ST1 or CT1 directly from F2; those remaining in core training at CT1, CT2 or CT3; those remaining in run-through specialty training at ST1 or ST2; those remaining in general practice training at ST1, ST2, ST3 or ST4 or those entering higher training at ST3 or ST4:

'Cash floor' protection as described in the November offer, based on the incremental point reached on 31 October 2015, *plus* any cost of living award made in April 2016, *plus* the value of any banding supplement / GP supplement payable in October 2015 (excluding Band 3 payments). This would set a cash level below which pay will not fall during transition, for so long as the doctor remains in training provided that the doctor continues to work the same proportion of full-time hours.

2. For trainees already in run-through specialty training or higher specialty training at ST3 level or above before 3 August 2016, and moving to ST4 or above in August 2016.

Pay will continue to be calculated as per the current New Deal contract, as described in the November offer, including annual increments on the current pay scale, subject to a maximum banding payment of 50 per cent (or 80 per cent for those opting out of the Working Time Regulations), and subject to minor modifications of the New Deal rules to allow them to comply with the new safeguards on working time in the new contract.

Trainees falling into category 1 who were on maternity leave or on a recognised out-of-programme activity (OOP) will have their salary calculated for pay protection purposes as being the basic salary that they would have earned on 31 October 2015 had they not been out of programme, *plus* any cost of living award made in April 2016, *plus* the value of the banding supplement earned during the final NHS placement prior to the break from training.

Trainees falling into category 2 who were on maternity leave or on a recognised OOP will be paid upon return to training as described in category 2.

As the proposal is for a phased implementation over 12 months from August 2016, further detail will be provided about how the transitional provisions will apply to different groups of doctors moving onto the new contract at different times.

Appendix A

Nodal pay values

November offer		Final contract	
Level of responsibility	Indicative basic pay value	Level of responsibility	Basic pay value
F1	£25,500	F1	£27,000
F2	£31,600	F2	£30,000
CT1 / ST1	£37,400	CT1 / ST1	£37,000
CT2 / ST2		CT2 / ST2	
CT3 / ST3	£42,500	CT3 / ST3	£48,000
ST4		ST4	
ST5	£48,400	ST5	
ST6		ST6	
ST7	£55,000	ST7	
ST8		ST8	£52,000

Flexible pay premia values

November offer		Final contract	
Academia[1]	£3,125	Academia[1]	£4,000
Emergency medicine training programmes at ST4 and above	£1,500	Emergency medicine training programmes at ST4 and above	£1,500
General practice[2]	£8,200	General practice[2]	£8,200
		Oral and Maxillofacial Surgery	£1, 500
Psychiatry training programmes at ST1 and above	£1,500	Psychiatry training programmes at ST1 and above	£1,500

Notes on pay values

The values of the nodal points have been set to reflect both the BMA's preference for a front loaded structure but also to reflect the costs of improvements compared to the November offer in relation to unsocial hours and availability payment.

1. Academic premia will be paid to those on recognised academic programmes upon successful completion of a higher degree; or to those completing higher degrees whilst holding a training number and on an OOP approved by the postgraduate dean, upon successful completion of the higher degree and return to training. A similar premium will be paid to trainees taking time out of programme to undertake work deemed to be of wider benefit to the NHS, as defined in the contract schedules.

2. The general practice premium will only be paid to doctors undertaking general practice placements as part of a general practice training programme (replacing the GP supplement). It will not be paid to those trainees whilst they are in hospital or other community placements, or to trainees on other programmes (e.g. F2) undertaking placements in general practice.

Appendix B

Implementation of new 2016 contract, as trainees enter F1 or as contracts of employment expire as trainees move through training.

Date	*Grade(s)*	*Rotation(s) / Training programmes*
Aug-16	F1	All
	ST1/2/3	GP trainees undertaking practice placements
	All	Psychiatry; Public Health
Sept	ST1+	Paediatrics (Core, higher and all sub-specialties) ; dentists
Oct	CT 1-3 /ST3+	All surgical specialties (including orthodontics)
Nov		
Dec		
Jan-17		
Feb	ST3+	Anaesthetics / ITU / Emergency Medicine / Obstetrics and Gynaecology
	ST1-2	Core Medical Training /remaining Core Surgical Training / ACCS / Anaesthetics
Mar	ST3+	Any remaining Paediatrics trainees
Apr	ST3+	Any remaining surgical and all higher medical specialties
May		
Jun		
Aug-17		Any trainees not already included above

Note: Any trainee (e.g. F2; GP trainee in a hospital setting) sharing a rota with the above will move to the new contractual (and where applicable, pay protection) arrangements at the same time as those trainees.