Draft heads of terms for negotiations to achieve a new contract for doctors and dentists in training
June 2013

This document relates to all doctors and dentists in approved postgraduate training programmes in the UK, including:

- doctors in training including GP training
- dentists in dental core and higher training posts when employed on hospital terms and conditions, and dental public health trainees when also employed on national hospital terms and conditions
- less than full time trainees (which can be doctors or dentists)
- academic and public health doctors in training when they are employed on national terms and conditions and where they have an NHS employment contract

For ease of reading, this document will use the term ‘doctor in training’ throughout to represent all the groups above.

Background
NHS Employers and the British Medical Association have held exploratory talks about possible changes to the contracts which cover the employment terms and conditions for the UK’s doctors and dentists in training. The talks have included representatives from all the devolved nations.

The current contract was agreed in 2000. There have been increasing concerns that it is not working as well as it could for either NHS employers or doctors in training.

At the end of 2012, NHS Employers published a ‘scoping report’. It proposed working towards an affordable new contract which ensures doctors in training feel valued and engaged, leads to better patient outcomes and improves the relationship between doctors, employers and deaneries. On behalf of doctors in training, the BMA has raised a number of areas for exploration including working hours, the fairness and stability of pay, quality of life and training.

The exploratory talks have resulted in this draft heads of terms – a document that sets the scope for possible formal negotiations to achieve a new contract. NHS Employers and the BMA are considering the heads of terms to determine whether or not they wish to proceed to formal negotiations and to seek the necessary mandates for such negotiations.

For further information please visit:
bma.org.uk/juniorcontract
www.nhsemployers.org
1. **Preamble**

1.1 Doctors in training are professionals\(^1\) whose first responsibility, like that of their employers, is the care of patients. A new contract will respect and support this.

1.2. The contract must promote safe care for patients and safety for doctors in training, and be fair for doctors in training, employers and other NHS staff.

1.3. The contract must be affordable for employers now and in the foreseeable future; this means that any proposals for a new contract must not result in changes to the pay bill compared with keeping the current contracts. Average gross pay across the doctors in training workforce should not change.

1.4. It is intended to apply to employers in all four UK nations.

1.5. This draft heads of terms document has been agreed through discussion between NHS Employers and the BMA. In order to receive a mandate to commence negotiations the document will require approval by Ministers in the four Health Departments and by the BMA.

The contract must:

1.6. Be consistent with all aspects of UK law, including working time regulations and the Equalities Act.

1.7. Facilitate high quality NHS patient care through sustainable service provision, delivered by suitably trained doctors and dentists, working in an approved training environment. GP trainees work in an environment where work is split into sessions and this needs to be accommodated in the new contract. They are an integral part of the practice team but are additional, not intrinsic, to the practice workforce. At no point should the effective running of the practice be dependent on the GP trainee’s attendance and they will not be used as a substitute for a locum in the practice.

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1 As defined in the GMC’s Good Medical Practice guidance
1.8. Accommodate likely future changes in the training and working practices of doctors in training in the medical and dental professions, and in the location and nature of NHS services. This will include any qualified provider.

1.9. Ensure that the pay system remains fit for purpose in the future by basing arrangements on robust modelling.

1.10. Recognise that training and service provision by doctors in training are interrelated and be clear that the work schedule for the post will include service provision, training, periods of formal and organised study (other than study leave), rest breaks and prospective cover where applicable.

The contract will:

1.11. Promote professionalism and an environment where doctors in training are engaged and valued.

1.12. Deliver both safe working patterns and safe total hours of work.

1.13. Address the current dissonance between New Deal and EWTD.

1.14. Promote transparency around both the expected working patterns and the total hours of doctors in training.

1.15. Reflect reasonable expectations around work-life balance.

1.16. Offer fair rewards for work done, without exploitation and offer value for money in the administration of the contract.

1.17. Minimise conflict and misinterpretation so as to facilitate good relations between doctors in training and their employers.

Any contract negotiations will take into account detailed analysis of the way junior doctors are paid and the impact of any proposed changes. This will be jointly undertaken by all those involved, including the BMA and NHSE.

The New Deal for junior doctors was introduced in 1991 to set standards in areas such as working hours, the nature of work and food and accommodation provision. The current junior doctors’ contract, agreed in 2000, was designed partly around the New Deal. However, the European Working Time Directive sets some limits and definitions which are different from those in the New Deal. We would discuss these differences as part of contract negotiations.

There is sometimes a significant difference between junior doctors’ job descriptions and the reality of their working lives. This does not help doctors, employers or patients. We want to make sure that everyone is clear what will be expected of a junior doctor right from the start of his or her post. We will also discuss the amount of notice and information doctors in training should expect before they move to a new role.

Progress has been made under the existing contract towards addressing the issue of junior doctors’ working hours. It remains important for doctors in training, their employers and for patients to ensure that sufficient safeguards (such as minimum rest periods) are in place.

The introduction of a work schedule for every post would be new to doctors in training. The details of its aims and contents remain open to discussion and would form part of any contract negotiations.

Service reconfiguration and new ways of working will continue to affect many parts of the NHS. Any new junior doctors’ contract should recognise and encompass those changes, now and in the future.

The current contract is complex and not always clear about what is expected from junior doctors and employers. This can lead to damaging disputes. We want to address the issues that can cause tension and ill feeling.
2. **Scope of talks**

We agree that:

2.1 The contract will cover all doctors in approved postgraduate training programmes in the UK, including those in GP training and approved less than full time training programmes, and academic and public health doctors in training where they have an NHS employment contract. It will exclude regular doctors and dentists in the armed forces.

2.2 The contract will cover dental core and higher training posts offering hospital terms and conditions of employment and include those in approved less than full time training programmes, as well as dental public health trainees when employed on hospital terms and conditions. It will exclude those for whom remuneration is specified in the Dental Statement of Financial Entitlement or the Statement of Dental Remuneration and those employed on salaried primary and community dental care service terms and conditions.

3. **Overall design of the contract**

We agree that:

3.1 The contract must be as simple as possible to understand, administer and implement, and be suitable for all specialties and for all four UK administrations.

3.2 Each of the administrations will apply the contract with agreed necessary adjustments to reflect local circumstances.

3.3 The contract will minimise reference to extra documents in the interest of simplicity, and to ensure that employers and doctors in training are able to maintain the contract in an effective way in the future.

3.4 The contract will be designed in line with other NHS employment contracts if the parties agree it is appropriate.

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2 Regular in this context means doctors and dentists employed in the armed forces who are neither civilians nor reservists.
3.5 We will continue to use the existing national negotiating mechanisms to ensure that the contract can be maintained at a UK-wide and national level. This will include provision for maintenance of the contract at a local level through existing local negotiating committee (LNC) structures.

3.6 The contract will be adaptable to changes in medical and dental policies and practices and future organisational and training structures.

4. Work planning

We agree that:

4.1 The contract will support forward planning providing for a more predictable pay bill for employers and more predictable earnings for doctors in training.

4.2 Both employers and doctors in training benefit from receiving adequate notice about where doctors in training will be working and what they will be doing.

4.3 The contract will be useable in a number of employment models, allowing for both lead employer and local employer arrangements.

4.4 The contract should seek to make it easier for employers to offer longer contracts of employment than the present contracts do.

4.5 This is an employment contract which encompasses training, personal development and service delivery required as part of the job.

4.6 Jobs should come with a work schedule describing how a doctor in training in a job is expected to spend their time and the duties of the post holder, including the available training provision and learning opportunities.

4.7 The work schedule for a post should be based on hours of work, rather than sessions, and should be prospectively designed in partnership between employers and doctors in training.
4.8 The work schedule must be adaptable to allow adjustments in response to changes in numbers of doctors in training, the training curricula, or service needs. Where an adjustment cannot be mutually agreed, doctors in training or employers will be able to seek a ‘Work Review’.

4.9 Doctors in training and employers will have access to robust Work Reviews where the agreed work schedule no longer matches the duties being undertaken. Where a doctor or doctors in training are consistently exceeding their work schedule hours through unplanned changes to their working hours, a review will be triggered by exception reporting. This will ensure unsafe working patterns are addressed and that the training aspects of the placement remain at an appropriate level.

4.10 The group will explore the information currently contained within the Code of Practice to determine how much of the information specifically relating to employers and doctors in training could be included in the contract.

4.11 The amount of, and access to, study leave will be discussed in the negotiations.

5. Working hours

5.1 The working hours and pattern of working hours for doctors in training need to:

- comply with relevant legislation
- be safe for patients and for doctors in training
- recognise that both service delivery and training will continue to take place throughout the seven day week

5.2 The contract will provide safeguards against unsafe working hours and patterns.

5.3 There will be a whole time working week of 40 hours. The working hours of a job may be up to 48 hours on average to meet the needs of the service, provided that this is consistent with statute, safety and the demands of the training programme.
5.4 Negotiations will determine how average working hours are defined and the period over which they are referenced.

5.5 We will explore a model based upon a work schedule, hours based contract and exception reporting, aiming to replace the current practice of routine monitoring of working hours. This will require agreement of a robust mechanism for ensuring appropriate payment and / or compensation for additional work over and above that in the work schedule.

5.6 Where it is possible to opt out of all or part of statutory working hours limits, the employment contract will enable doctors in training who wish to opt out to do so, but they will not be required by employers to opt out.

5.7 We will investigate limiting the number of actual working hours (as defined by statute) in a defined (in days) period.

5.8 Where agreed patterns of hours are regularly altered in terms of start or finish times or breaks within shifts, then that working pattern should be reviewed to ensure it is appropriately designed.

5.9 The parties will consider agreeing guidance on the rights and obligations of both employers and doctors in training under UK working time regulations.
6. Pay

We agree that:

6.1 Cost modelling must demonstrate that proposed new pay arrangements would not (of themselves) change the pay bill compared to a scenario in which the contracts do not change.

6.2 For the purpose of cost modelling, that pay bill comprises the following, using staff numbers appropriate for the 2012/13 financial year:

- Total value of current basic pay
- Total value of current additional earnings (including banding payments but excluding non-contractual fees)
- Total value of employer National Insurance contributions as at 31.3.13
- Total value of employer pension contributions as at 31.3.13

Planned changes to National Insurance contributions outside the scope of these negotiations will take place regardless of whether a new contract is negotiated. Modelling (and the counterfactual) will take into account any planned changes to contributions.

Additional employer pension contributions arising from any increase to basic pay as a result of a new contract will be funded separately, from outside the doctors in training pay bill.

6.3 Joint analysis and modelling by analysts from the BMA, NHSE and the devolved administrations will be undertaken to explore the range of options available.

6.4 Negotiations will also include assessment of the way in which any changes would interact with the move to a CARE pension scheme.

6.5 There should be a higher than basic rate for OOH work and the negotiations will determine which periods are considered OOH.

6.6 We will agree rules within the new contract for pay progression.
7. **Other**

**Fixed leave**

We agree that:

7.1 We recognise that the use of fixed leave is a concern for doctors in training. We will explore the reasons why fixed leave arrangements are currently used, the consequences for doctors in training and for employers and how the position could be improved.

**Facilities**

We agree that:

7.2 We will review the existing contractual arrangements for facilities bearing in mind changes in working practices and the importance of safety.

**Salary packaging**

We agree that:

7.3 We will consider whether the contract could make it easier to have the legitimate professional costs of doctors in training recognised.

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This might include somewhere to rest, mess rooms and catering facilities.

Some of the costs incurred by junior doctors as they progress are categorised by HMRC (the tax office) as an integral part of their training. Others, such as certain college examination fees, are not. That means some are tax deductible and others are not. We will discuss possible changes to this system.