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The junior doctors' handbook 2005-2006

The *Junior doctors' handbook* is the guide to the main contractual issues that may arise in junior hospital doctors' employment and on which they may need to seek advice. As with previous editions, this latest version of the handbook is being distributed to all junior doctors who are BMA members. The guidance in this handbook covers the position in England and (usually) in Wales, but where there are any different arrangements in Scotland and Northern Ireland*, these have also been highlighted.

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. **BMA members may seek advice on specific problems relating to the terms of their employment by contacting *ask*BMA (for contact details see page** 175).

Junior doctors working in the Channel Islands or the Isle of Man should note that their conditions of employment may be different and should seek advice from *ask*BMA (see page 175).

Every effort was made to check accuracy at the time of printing but there may have been later changes.

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 me at BMA House; a reply-paid card can be found inside the back cover of the handbook.

Peter Corpe
Secretary of the JDC
June 2005

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* In northern Ireland for GWC read joint Council for Department of Health, Social services and Public Safety, and for NHS read Health and Personal Social Services.

Junior doctors who work outside the NHS

Junior doctors may work outside the NHS in a number of different areas. There are specific committees within the BMA dealing with each of the following broad fields of medicine:

- armed forces
- occupational health trainees working in industry
- public health trainees (currently employed under different terms and conditions of service from those applying to hospital doctors, although it has been agreed in principle that they will soon be employed under hospital terms and conditions of service).

Advice on any of these areas can be obtained from *ask*BMA (see page 175) in the first instance.

Staff grade and other associate specialists doctors

Advice on terms and conditions of service can be obtained from *ask*BMA. The BMA has a committee which negotiates the terms and conditions of service for the staff and associate specialists doctors, staff and associate specialists committee.

Representation of junior doctors

The British Medical Association

The British Medical Association is the professional association of doctors in the UK and is registered as an independent trade union to represent doctors both locally and nationally. Officially recognised by the Doctors and Dentists Review Body, the government and NHS Employers, 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 junior doctors committee (JDC) of the BMA represents all junior hospital doctors. The JDC has sole negotiating rights with the Department of Health for all junior doctors employed in the NHS. There are also national junior doctors committees for Scotland, Wales and Northern Ireland. As a result of devolution the Scottish JDC negotiates directly with the Scottish Executive on some areas. The Welsh and Northern Ireland JDCs will deal with certain issues in Wales and Northern Ireland in discussion with their respective national assemblies. However, the Scottish, Welsh, Northern Ireland and UK JDCs are committed to retaining the same terms and conditions of service for all UK junior doctors.

The JDC has representatives on other BMA committees, and outside committees and affiliated organisations.

BMA council, the central executive of the BMA, has elected junior doctor representatives.

Regional representation

The regional junior doctors committee (RJDC) represents junior doctors at regional level. The RJDC consists of junior doctors from hospitals from within the region and appoints representatives to the JDC. Each RJDC may appoint one or two regional negotiators to act on behalf of junior doctors in any regional negotiations that take place, for example on removal expenses.

The national committees for Scotland, Wales and Northern Ireland also send representatives to the JDC.

If you wish to attend a regional JDC meeting or a meeting of the Scottish, Welsh or Northern Ireland JDC please contact *ask*BMA, who will put you in contact with your BMA national office or BMA regional centre.

Representation at local level

References

EL(95)133 and HSG(95)61 – Revised arrangements for the management of the employment contracts of doctors in training.

NHS MEL (1996)10.

PCS(DD) 1996/3 (Scot).

DGM(96)28 (Wales).

HSS (TC8) 2/96 (NI).

It is essential that junior doctors are represented at trust level. Since the abolition of regional health authorities in April 1996, the contracts of all junior doctors have been held by trusts. Trusts are required to adhere to a national model contract, but may seek to negotiate for specialist registrars variations around the margins of the terms and conditions of service subject to certain conditions. Junior doctors should therefore be represented at trust level to ensure that variations to the model contract do not adversely affect their working conditions and quality of training.

Local negotiating committees (BMA)

BMA local negotiating committees (LNCs) which have been established in most NHS trusts most frequently negotiate local variations to the terms and conditions of service of specialist registrars. The RJDCs seek to maintain close links with LNCs. It is extremely important that junior doctors are represented on LNCs.

BMA junior doctor representatives

Each hospital mess should appoint at least one BMA junior doctor representative to represent colleagues at trust level on the LNC and other staff liaison groups and to help solve basic work-related problems for members. The role also includes providing advice to BMA members concerning such issues as hours of work, accommodation and catering, pay scales and leave entitlements.

The local BMA office accredits the representative and this provides certain protections and rights. Any junior doctors interested in becoming a BMA junior doctor representative should contact *ask*BMA (see page 175) for further information.

Local procedures for dealing with problems

Grievance procedure

References
HSG(91)28

HSS(TC8)5/91(NI)

Each trust should have a procedure that permits junior doctors to resolve differences that they may have with that employer. Grievance procedures are usually designed to deal with individual grievances. The procedure should state the nature of the differences that can be resolved by using the procedure and should specify the number of levels of appeal available. Copies of the local procedure should be available from the human resources department of the trust. October 2004 legislation requires all trusts to have a grievance procedure. Members are strongly advised to contact their *ask*BMA before lodging a grievance.

Disputes procedure

References
AL(GC)3/95

PCS(GC)95/3 (Scot)

HSS(TC1)4/95 (NI)

GWC handbook, section 42

NHS Staff Council NHS Terms and conditions of service handbook (for information only)

Each trust should have a disputes procedure to be used where there is a collective dispute between the employer and a number of staff. Such a dispute could be about, for example, annual leave arrangements or accommodation difficulties*. Section 42 of the *General Whitley Council handbook* sets out a protocol that should be used by employers when drawing up a disputes procedure. Copies of the local procedure should be available from the medical staffing department of the trust. It is recommended that you seek specialist employment advice from *ask*BMA before a grievance is lodged.

* Appeals against pay banding allocation and changes in banding should first be directed through *ask*BMA (see page 175). See page 46 for information on banding appeals.

Disciplinary matters

Any allegations of misconduct or capability about doctors in training should be considered initially as a training issue and dealt with via the educational supervisor, with close involvement of the postgraduate dean from the outset. However, in England, if it becomes clear that further investigation is needed or disciplinary action may be required, the trust is obliged to follow the procedures set out in 'Maintaining high professional standards in the modern NHS', and must appoint a trained case investigator. The trust must consider whether restriction of practice or exclusion is necessary whilst the investigation is conducted and must involve the National Clinical Assessment Service (NCAS).

References

Maintaining high professional standards in the modern NHS

TCS paras189-190

NHS circular 1990 (PCS) 8 (Scot) updated by PCS (DD) 1999/7 PCS (DD) 2001/9

WHC(90)22

DGM(95)44 (Wales)

HSS(TC8)15/91 (NI

Depending on the outcome of the investigation and NCAS involvement, a formal disciplinary procedure may be followed. If the allegation is about misconduct (eg a refusal to comply with a reasonable request from the trust), the trust's local misconduct procedure for all hospital staff should be followed. If the allegation is about the doctor's professional capability (eg incompetent clinical practice), the trust should follow a capability procedure based on the national framework for handling concerns about capability. The NCAS should continue to be involved throughout the procedure.

If junior doctor members are advised that disciplinary action is being contemplated against them, they should contact *ask*BMA immediately (see page 175). Doctors should not respond to any disciplinary allegation until they have had the opportunity to seek advice and representation.

Complaints procedure

On 1 April 1996 a new system was implemented to deal with complaints by patients against doctors. The new simplified procedure places more emphasis on solving complaints at an early stage locally. All trusts must establish their own complaints procedure which complies with national guidelines and make this available to staff. More detail is available in the BMA's consultants handbook, available from *ask*BMA.

References

Guidance on implementation of the NHS complaints procedure (NHSE March 1996)

Handling complaints in the HNS toolkit (DoH website)

S1 2004 1768

Guidance to support the implementation of NHS (complaints) regulations 2004

NHS MEL(1996)31 (Scot)
NHS MEL(1999)49

Guidance on implementation of the HPSS complaints procedure (NHS Executive March 1996) (NI)

Revalidation

The introduction of licensing and revalidation due to begin in April 2005 has been postponed until the completion of a review by the Chief Medical Officer instigated in December 2004 in the aftermath of the fifth report of the Shipman Inquiry. Until December 2004 the GMC's plans for changing the system for registering doctors were to be along the following lines.

Those who wished to practise medicine in the UK would need to hold a licence to practise. Doctors would need to participate in revalidation in order to retain this license. The purpose of revalidation is to ensure that patients can have confidence that their doctors are up-to-date and fit to practise. The process should encourage doctors to reflect meaningfully on their work, using evidence gathered through various methods such as audit. Doctors would be expected to undergo the process of revalidation itself once in every five years but also to participate on a continuing basis by being expected to:

- keep a folder of information, drawn from their medical practice over the revalidation period
- reflect regularly on their medical practice, primarily within the context of a formal appraisal
- satisfy the GMC that there are no unresolved significant local concerns about their fitness to practise
- provide a description of their medical practice, including clinical and non-clinical activities.

The information that doctors would be expected to provide to the GMC would depend on whether they work in a GMC approved environment such as the NHS, or other organisations with appropriate quality assurance measures in place as well as an annual appraisal system based on the principles of the GMC's *Good medical practice*. Further details on the definition of GMC approved environments and the differing requirements of those who work within and outside of these environments are available on the GMC website www.gmc-uk.org.

Until the completion of the CMO's review and the GMC's final proposals for revalidation are established, junior doctors are advised to continue to collect evidence for the professional development folders based on the principles of competence, care

References

Fifth report on the proceedings of the public inquiry into the case of Harold Shipman. Safeguarding patients: lessons from the past, proposals for the future. December 2004

GMC. Good medical practice. May 2001.

and conduct set out in *Good medical practice*. Further information is available on the GMC website.

The BMA is committed to self-regulation and supports revalidation as an important part of doctors' accountability to patients and the wider public but is also mindful of the need to have a system that is practical for working doctors. Since the concept of revalidation was first discussed, the BMA has maintained that it should not become an unnecessary burden on doctors.

The BMA has worked closely with the GMC on revalidation and supports the view that revalidation should generally be built on appraisal. The BMA believes that doctors should not normally need to collect any information for revalidation in addition to that which they will need for their appraisals, provided that their appraisals are effective and linked to the principles of *Good medical practice*.

The BMA understands that it is necessary to have a review but would want the delay in implementing reforms to be a short one. It is important that both doctors and patients have confidence in the revalidation system and that includes whether it is workable.

The CMO aims to report back to the government towards the end of 2005. Further developments will be posted in the GMC's bi-monthly newsletter, GMC News accessible on its website www.gmc-uk.org .

GMC fitness to practise procedures

As the regulatory body for doctors in the UK, the GMC is responsible for registering and licensing doctors for practice. The fitness to practise procedures enable the GMC to take action against a doctor whose professional performance is alleged to be seriously deficient. The GMC may undertake an investigation and a professional assessment of the doctor and take remedial action where necessary. Where it is deemed necessary for the protection of patients, conditions may be imposed on the doctor's registration or s/he will be removed from practice while the procedure is taking place. In some cases, immediate suspension will take place.

If a doctor's professional performance is found to need further consideration s/he will be referred to a fitness to practise panel. If the panel finds that the performance is so deficient that there is no

prospect of the doctor ever achieving an acceptable standard, the panel may suspend or remove the doctor from the medical register. Further information on the GMC's fitness to practise procedures can be found on the GMC website www.gmc-uk.org .

Self-regulation of the profession

The JDC has produced guidance on professional self-regulation for junior doctors which outlines what a junior should do if they have concerns about the performance of a junior doctor colleague. This guidance is available to members on the BMA's website.

BMA counselling service

The BMA provides a 24-hour telephone counselling service. The service is run by professional counsellors and provides help for doctors and their families on personal, emotional and work-related problems. There is no limit to the number of times the service can be used, it is strictly confidential and callers can remain anonymous if they wish. The counselling service can be accessed on **0845 200169** 24 hours a day. All calls are charged at local rates.

On phoning the BMA counselling service, doctor will be able to speak directly to a counsellor or be put in touch with a doctor adviser. If they wish to speak to a doctor adviser their name, contact details and presenting problem will be obtained and they will then be given the name and contact details of the doctor adviser. Advisers' details are available from a list held by the BMA counselling service and provided by the BMA's Doctors for Doctors Unit. In addition the list details advisers' availability and any special interest the adviser may have such as dealing with minority groups.

It should be noted that the advisory service is not an 'emergency service'. Should more urgent help be needed, the caller will be directed to a counsellor for immediate advice.

Contracts of employment

Model contracts of employment

There are several model contracts of employment for junior doctors, depending upon the grade and type of post. One is used for pre-registration house officers, senior house officers, and remaining registrars and senior registrars. For specialist registrars, there are two different types of model contract, depending upon whether the doctor is on a Type I training programme leading to a CCT or in a Type II fixed term training appointment. **The three model contracts are reproduced in Appendices I to III of this handbook**. A separate model contract exists for specialist registrars pursuing post-CCT sub-specialty training; such post-CCT training should be extremely rare and the model has not therefore been reproduced. Further details about such contracts are available from *ask*BMA (see page 175).

PRHOs spending part of their year in general practice will have a slightly different contract. Again, further details are available from *ask*BMA. A model contract is also available for GP registrars.

The contract covers the specific terms of each individual's employment contract and is also subject to the *Terms and conditions of service of hospital medical and dental staff* (TCS) and the *General Whitley Council* (GWC) conditions of service.

The model contract has been agreed at national level between the JDC and the health departments. All pre-registration house officer and senior house officer contracts must follow the national model. At the time of writing foundation year one (F1) and foundation year two (F2) posts will attract the same pay scales and terms and conditions of service as the PRHO and SHO1 grades respectively. Although two-year contracts may be issued for foundation programmes, the contracts should be broadly based on existing model contracts on a no-detriment basis. Although there is room for some local flexibility for specialist registrars, junior doctors should be extremely wary about any deviations from the nationally agreed model and seek advice from *ask*BMA before signing their contract.

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 agreed between the JDC and the health departments, but some hospitals are including unacceptable clauses which differ from those national agreements. Even seemingly advantageous clauses are unlikely to be without problems. Junior doctors who are BMA members can and should seek professional advice from *ask*BMA(see page 175) before signing a contract. **If a contract does not conform to the national model, juniors should give written notice that they do not accept a non-standard contract and should not sign it without first seeking advice from *ask*BMA: there is too much to lose**.

Job descriptions

A job description should accompany the contract, and indeed forms part of the contractual relationship between the junior doctor and the trust. Ideally, the doctor should be given a copy of the job description on application for the post. In any case, it is a legal requirement that the doctor be given a job description within two months after the beginning of the employment.

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. Alterations to the job description should be by mutual agreement.

Notice periods

The following minimum periods of notice should apply, unless there is an agreement between both parties to a contract that a different period should apply.

Pre-registration house officer	2 weeks
Senior house officer	1 month
Specialist registrar	3 months
Registrar	2 months
Senior registrar	3 months

Information

AL(MD) 1/92

HDL(2000)17 PCS(DD) 2001-13

HSG(93) 1

AL(MD) 2/96

PCS(DD)1993/10 (Scot)

HHS(TC8) 2/96 (NI)

HSC 1998/135 PRHOs spending periods in general practice

A guide to specialist registrar training: NHS Executive (February 1998)

Doctors and dentists in training: terms and conditions of service/model contract guidance (NHSME January 1993) (August 1993 in Scotland)

AL(MD)1/2001

Additionally, Section 86 of the Employment Rights Act 1996 provides entitlement to minimum periods of notice, dependent upon an employee's length of continuous employment. For hospital medical and dental staff these are as follows:

Period of continuous employment	Notice entitlement
1 month or more but less than 2 years	Not less than 1 week
2 years or more but less than 12 years	Not less than 1 week for each year of continuous employment
12 years or more	Not less than 12 weeks

Information

AL(MD)1/99 Pay and conditions of service of hospital medical and dental staff

Employment documentation

It is worth remembering to obtain the relevant documentation when starting work in a new trust for the first time. A staff transfer form, a P45, a GMC annual registration certificate, a recent annual pay slip and proof of hepatitis B status would all, if readily available, facilitate your early days in a new job.

Trusts should accept an original recent pay slip as provisional confirmation of a doctor's salary increment and incremental date and should pay the doctor accordingly, pending receipt of the NHS transfer form which will give final confirmation. Having a recent pay slip will ensure that you are not placed on the lowest increment of a grade pending confirmation.

A model letter of acceptance, including the bandings for each part, is attached at Appendix I.

Junior doctors' employers

Since April 1996 almost all junior doctors' contracts have been held at trust level. The exceptions to this are the contracts of trainees in public health medicine and GP registrars in their vocational year. The JDC objected strongly to the movement of contracts to trust level as it feared that it would jeopardise training rotations and threaten nationally agreed contracts and terms of service for junior doctors. As a result of these objections, the NHS Executive built in a number of safeguards to the new arrangements (see below). Postgraduate deans have a key role in monitoring the quality of training and may withdraw funding if training is found to be inadequate. Despite this, it is worth being aware that each trust in a rotation may issue a different contract and members should seek advice from *ask*BMA (see page 175) before signing if in any doubt.

Information

EL(95) 133

HSG (95)61

MEL (1996)10 (Scot)

DGM(96)28 (Wales)

HSS (TC8) 2/96 (NI)

It is open to trusts to join together to agree an arrangement whereby one trust administers contracts on behalf of a group of trusts. In such cases the 'lead' trust may hold all contracts and second junior doctors from that trust to others. Such arrangements should assist in better planning and organisation of training rotations. Members offered contracts in which they will be seconded from one trust to another should seek advice from *ask*BMA (see page 175) before signing the contract.

Variations to national agreements on contracts and terms of service

Although trusts are required 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 registrars, registrars and senior registrars. However, this flexibility should be only at the **margins** of terms and conditions of service, and should usually involve additions or modifications to **enhance** rather than reduce existing rights. It is thus 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, for example, the local negotiating committee

(see page 6); **and**

- the postgraduate dean is satisfied that they will not adversely affect quality of training; **and**
- they are agreed by all the trusts in the rotational training programme.

Information

EL(95)133

HSG(95)61

MEL(1996)10 and

PCS(DD) 1996/3 (Scot)

DGM(96)28 (Wales)

HSS (TC8)2/96 (NI)

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 trust and its local negotiating committee. It is therefore crucial that the local negotiating committee should have a junior doctor representative who is able to attend meetings. Regional JDCs (see page 5) may have appointed negotiators who are taking the lead in any discussions at deanery level. **Junior doctors should seek advice from *ask*BMA (see page175) 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 the 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.

Training agreements

In addition to the employment contract, junior doctors should also have an individual training agreement agreed between the postgraduate dean, the employer, and the trainee to ensure that each party knows how the training and service components of the post will fit together. In practice a significant proportion of junior doctors do not have training agreements, and the JDC has been pressing for all juniors to be issued with such agreements.

Recruitment of doctors and dentists in training

Information

HSC 1998/229

MEL (1999)36 (Scot)

All training posts must have educational and dean's approval and this should be clearly stated in advertisements. Junior doctors should be extremely wary about applying for non-approved or non-standard posts that could be seriously disadvantageous to future career prospects and are unlikely to be recognised by medical royal colleges. Junior doctors who have any concerns about a post should seek advice from their postgraduate dean (see page 208). See appendix III for information about training grade job descriptions.

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 (eg'trust SHO', 'visiting fellow', 'research registrar') cannot be regarded as a recognised training placement or programme. Experience in such non-training posts cannot be assumed to count towards the completion of specialist 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 advertisements should contain the following statement from the postgraduate dean: **'The postgraduate dean confirms that this placement and/or programme has the required educational and dean's approval'**
- all recruitment procedures should comply with equal opportunities policies.

Trusts 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 postgraduate dean's approval:

- posts must meet agreed standards on training, supervision, contractual terms, compliance with the New Deal , 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, dean's approval must not be granted to placements which may cause these targets to be breached.

Job advertisements appearing in the *British Medical Journal* which comply with the above procedures are emboldened to make it clear to junior doctors that other posts may carry significant risks, for example that they may not be recognised for training.

The Specialist Training Authority (PMETB will have responsibility for this area from 30 September 2005, for further information) has agreed that training or experience obtained in NHS placements which have not received the appropriate training approvals will not be considered in assessing training for the award of a certificate of completion of specialist training.

Educational and training approval is also needed for those placements not funded by the postgraduate dean but by other bodies, eg universities, charitable institutions, or research bodies, non-NHS providers etc.

Information

HSG (97)18

MEL (1997)42 (Scot)

Overseas doctors

Overseas doctors appointed to posts without relevant approval will not be eligible for permit free status and may not be granted registration by the General Medical Council.

Honorary appointments

Trusts offering honorary NHS appointments to doctors wishing to pursue clinical specialist training must obtain the dean's approval before the placement is advertised or the appointment confirmed. Honorary appointments to the SpR grade must follow the procedure set out in *A guide to specialist registrar training*.

Locum appointments

Locum doctors and dentists should not be appointed to training grades where there is no substantive placement to be covered. Locum appointments (apart from LATs in the SpR grade 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 the completion of specialist or GP training.

Advice about prospective approval of training for locum hospital placements should be sought from the relevant medical royal college or faculty or from the Postgraduate Medical Education and Training Board.

Career grade titles

Trusts have been told by the BMA that non-standard career grade titles can also be misleading and that they should not use them unless there is an exceptional and overriding need to do so.

Responsibility for educational approval

PRHO foundation year 1 grade

The Medical Act 1983 gives the GMC responsibility to secure arrangements for basic medical education, and universities responsibility for educational approval of all PRHO F1 placements. In practice, the postgraduate dean normally undertakes this function.

SHO/SpR grade

From 30 September 2005 PMETB will be required to recognise and approve placements and programmes for basic specialist training and for higher specialist training leading to the award of a CCT (ie from F2 onwards). PMETB 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 lead to the award of a CCT, eg fixed term training appointments in the SpR grade.

Hours of work, the European Working Time Directive (EWTD) and the New Deal

The European Working Time Directive (EWTD) and the New Deal both impose different limits on working time and rest requirements for doctors. This section should be read in its entirety to understand the key provisions and how they apply to doctors in training. Please note that information on the EWTD should be read in conjunction with information on the New Deal.

European Working Time Directive (EWTD)

The EWTD, which came into force on 1 October 1998 for consultants and other career grade hospital doctors, originally excluded junior doctors. Agreement was reached in May 2000 between the European Parliament and the Council of Ministers on the arrangements and a timetable for doctors in training to be included within the Working Time Directive (WTD). The EWTD is designed to protect the health and safety of workers by restricting the number of hours an individual can work and imposing minimum rest requirements for all workers. **Since 1 August 2004 the EWTD rest requirements have applied in full to all doctors in training (PRHO, SHO and SpR)**. A limit of 58 working hrs has also applied.

Unlike the New Deal, EWTD is enshrined in UK and European law and is therefore not optional. Since August 2004 an individual junior doctor can voluntarily sign a waiver and 'opt out' of the 58 hour WTD ceiling, but contractually (under the New Deal) can do no more than an average of 56 hours actual work a week. Junior Doctors are not able to 'opt out' of the rest requirements.

The main elements of the EWTD, as applied to junior doctors, are as follows:

Timetable

August 2000	Timetable was set to incorporate juniors into the directive
August 2004	Interim limit of an average 58 hour maximum working week and EWTD rest requirements
August 2007	Interim limit of an average 56 hour maximum working week
August 2009	Deadline for the average 48-hour maximum working week – this deadline may be extended by another three years with an interim limit of an average 52 hours maximum working week.

EWTD rest requirements

The rest requirements which came into effect in August 2004 are as follows (derogations apply - see below):

- 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 7 day period (or 48 hours in a 14 day period)
- a minimum of 4 weeks paid annual leave
- a maximum of 8 hours work in each 24 hours for night workers*.

* Night workers are defined as 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 can not be assumed and should be looked at on an individual basis.

The SiMAP and Jaeger cases

The SiMAP judgement refers to a case brought before the European Court of Justice (ECJ) on behalf of a group of Spanish doctors. The ECJ was asked to pronounce on whether time spent by doctors 'on call', either at their place of work or away from it, counted as 'working time' and therefore towards the 48-hour week. It had previously been the BMA's position that the EWTD working week limit should apply to hours of actual work as defined in the New Deal. The New Deal definition does not count all resident hours as work, but makes a distinction between actual and duty periods.

Information

HSC 2003/001

Time's up (JDC)

Working Time Regulations 1998 (S1 2003 No. 1684)

The ruling declared that all time spent resident on-call would count as working time. Whilst the ruling applies to a specific case, the assumption must be that if British doctors work under similar arrangements, then a similar interpretation of 'working time' applies. The ECJ judgement on 09 September 2003 in the 'Jaeger case' involving secondary care doctors confirmed the SiMAP judgement.

Information

HSC 2003/001 (JDC)

Working Time Regulations 1998 (S1 2003 No. 1684)

The implications of the case are that application of SiMAP will make resident on-call rotas unworkable and new ways of working will need to be developed. Guidance is available on the BMA website which includes 'Rota design made easy'.

Information

Junior Doctors - the New Deal (NHSME 1991)

JDC, Monitoring compliance with the New Deal, August 1997

HSS (TC8)5/98, including Supplement no 1 (NI)

HSC 1998/240 - Reducing junior doctors' hours: continuing action to meet New Deal standards

MEL(1999)40 (Scot)

Wales

HSS(TC8)6/99 (NI)

JDC Guidance on the latest New Deal Circular HSC 1998/240, March 1999

HSC 2000/031

HSC 2000/036

AL(MD)1/2001

Derogations – compensatory rest

The introduction of the directive is non-negotiable and it is not possible for the BMA to negotiate a collective opt-out from the maximum weekly hours' limit. However the UK government has decided to derogate from the rest requirements noted above, as allowed in the Directive (Section 21). This means that employers do not have to apply these rest limits but that they must provide equivalent compensatory rest for every occasion that the employee does not achieve the rest to which they are entitled. The exact method to provide compensation for periods of rest not achieved by the employee are still being discussed. The BMA strives to seek a solution that protects safety at work whilst protecting opportunities for training.

The New Deal

The New Deal is a package of measures designed to improve the conditions under which junior doctors work. It dates from 1991 and formed an agreement between representatives of junior doctors, consultants, the royal colleges, NHS managers and the government. Following the implementation of the EWTD in August 2004 the New Deal will continue to be relevant and, where there is variation between the conditions, the most favourable will apply (fewer hours, longer rest periods). One of the key features of the New Deal is limits on the working hours of junior doctors. Further areas covered by the New Deal include improvements to facilities such as catering and accommodation, and an examination of working practices with a view to transferring from junior doctors work which might be better undertaken by other health care professionals.

Regional improving junior doctors' working lives action teams or regional action teams (RATs) (who used to be responsible for overseeing and monitoring the implementation of the New Deal at a local level and the allocation of posts into pay bands in accordance with the pay banding system have now been brought under the jurisdiction of the local Strategic Health Authorities. The role, nevertheless, has remained.

In Scotland the Scottish Executive's New Deal Implementation Support Group (ISG), which includes representation from the Scottish JDC, monitors the New Deal although this is subject to review (August 2005). In Northern Ireland the New Deal &

EWTD is monitored by the NI Implementation Support Group (NI ISG). This Group was set up by the Department of Health Social Services & Public Safety (DHSSPS) in August 2001 to facilitate the implementation of the New Deal and the EWTD. NIJDC have been and continue to be actively involved in the work of the group and its sub-committees, two members of NIJDC meet every two months with the Medical Project Officer to scrutinise monitoring data and rotas to approve rebandings – no posts are rebanded without liaison with the NIJDC reps. In Wales, the New Deal was relaunched in spring 2001 under the SAFER initiative, which stands for safety-accommodation-facilities-education-rest.

Trusts have a contractual responsibility to monitor regularly the hours of work of junior doctors. As part of that responsibility, junior doctors are also obliged to take part in monitoring as designated by their trust. This obligation is a contractual requirement. Each trust should have a named individual at trust board level responsible for New Deal implementation. Regional action teams should work with trusts to solve any problems with hours' limits or rest requirements.

No doctor should be pressurised in to changing monitoring data to ensure compliance. Monitoring forms should be completed accurately to reflect the hours worked and rest achieved. If you feel you are being pressurised talk to your BMA representative or call *ask*BMA.

Information

Junior doctors – the New Deal (NHSME 1991)

Time's up, JDC Aug 2004

Time's running out JDC May 2003

HSS (TC8)5/98, including supplement no 1 (NI)

HSC 1998/240 – Reducing junior doctors' hours: continuing action to meet New Deal standards

MEL(1999)40 (Scot)

Wales

HSS(TC8)6/99 (NI)

JDC guidance on the latest New Deal circular HSC 1998/240, March 1999

HSC 2000/031

HSC 2000/036

AL(MD)1/2001

Information
AL(MD)1/2001

Limits on contracted hours, hours worked and duty periods

Hours of duty and hours of actual work

As explained in the last section, the EWTD has applied to doctors in training since 1 August 2004. The number of hours juniors can work in a week and the rest breaks that are needed are therefore prescribed by the regulations.

Prior to August 2004 and under the New Deal:

- Hours of **duty** were counted as all time working or on-call, including rest while available.
- Hours of **actual work** were defined as all time spent on duty carrying out tasks for the employer, including any periods of formal study leave/teaching.

Since August 2004:
As noted above, following the application of the SiMAP ruling, hours of duty and hours of actual work are treated the same, with all hours spent 'at the disposal of the employer' whether working or resting counting as working time for the purpose of the working hours restrictions.

Information
AL(MD)1/2001
DH website – September 2002 (last updated 6 Feb 2004 by AL(MD)1/2004

See NHS Employers website www.nhsemployers.org

Contracted hours

The New Deal on junior doctors' hours and the EWTD both apply limits to the number of hours junior doctors can work on average in one week.

Since 1 December 2000 the New Deal has specified the maximum number of duty hours for all junior doctors' posts as:

- 72 hours a week on on-call rotas on average
- 64 hours a week on partial shifts on average
- 56 hours a week on full shifts on average.

However, since 1 August 2004 under the EWTD, junior doctors can no longer work more than 58 hours on average per week. In August 2007 this reduces to 56 hours on average and further still to 48 hours in August 2009.

Both the New Deal and the EWTD apply simultaneously, and this can sometimes cause confusion. Compliance with both regulations can be achieved by following the least number of

working hours and the most rest required (see below for further information).

These limits are a contractual requirement. Contracted hours should take into account routine early starts and late finishes, time off during the working day (eg, half days) and, where applicable, prospective cover for annual and study leave.

The New Deal's 56 hour rule

Irrespective of the number of contracted hours, the number of hours on duty and the working arrangement, no junior doctor should be expected to work for more than 56 hours of actual work a week on average over a rota cycle. This restriction has applied since 31 December 1994.

New Deal controls on duty periods and rest requirements

From 1 August 2001 for PRHOs and from 1 August 2003 for all other training grades, all New Deal hours limits and rest requirements (see below) are a contractual requirement.

In addition to the limits on contracted hours and hours worked, the New Deal lays down maximum periods of continuous duty, minimum periods of off duty between duty periods and minimum periods of continuous off duty for each type of working arrangement. These are as follows:

Working arrangement Maximum	continuous duty (hours)*	Minimum period off duty between duty periods (hours)*	Minimum continuous period off duty (hours)
Full shift	14	8	48 + 62 in 28 days
Partial shift	16	8	48 + 62 in 28 days
On-call rota	32 (56 at weekends)	12	48 + 62 in 21 days

There is a limit on the maximum continuous duty days for all working arrangements: 13 days

* Except when two shifts are worked consecutively.

Where the maximum periods of continuous duty, minimum periods of off duty between duty periods and minimum periods of continuous off duty differ to those set out in the European Working Time Directive (see above) the shorter of the duty hours and the longer of the periods between duty periods will prevail.

The New Deal lays down the following periods of rest during duty periods:

On-call rotas

At least eight hours rest during a period of 32 hours on duty, principally within the on-call period. Most of this should be continuous if possible.

Partial shifts

At least four hours of rest during every duty period of 16 hours.

Full shifts

All of the duty period, except for natural breaks, should be spent working or available for work.

Below is a table setting out the rest requirements for each working pattern as laid down in HSC 1998/240. The rest requirements apply equally to less than full-time as to full-time juniors; the hours' limits should be adjusted pro rata. Flexible trainees (and any other less than full-time juniors) should not be disadvantaged in terms of rest periods or work intensity.

The following factors should also be taken into account when assessing whether a working pattern fulfils the rest requirements:

- total rest within duty periods must not be made up of short interrupted periods of rest
- natural breaks must be provided during the normal working day for doctors on on-call rotas or partial shifts, as well as full shifts, and should be in addition to their rest periods
- at weekends, all duty periods are out-of-hours
- **out-of-hours rest targets should be met during at least three-quarters of all duty periods.**

Summary

Working pattern	Natural breaks	Minimum rest during the whole of each duty period	Minimum continuous rest guide	Timing of continuous rest
Full shift	Yes	Natural breaks	At least a 30 minute continuous break after approximately 4 hours continuous duty	At least a 30 minute continuous break after approximately 4 hours continuous duty
Partial shift	Yes	Natural breaks if no out-of-hours duty. Otherwise one quarter of the out-of-hours duty period*	Frequent short periods of rest are not acceptable	At any time during the duty period
24 hour partial shift	Yes	6 hours	4 hours	Between 10pm and 8am
On-call rotas	Yes	One half of the out-of-hours period**	Minimum 5 hours	Between 10pm and 8am

* eg: 5pm – 9am (Mon-Fri) = 4 hours or 9am – 9pm (Sat/Sun) = 3 hours

** eg: 5pm – 9am (Mon-Fri) = 8 hours or 9am – 9am (Sat/Sun) = 12 hours

Weekend rest requirement alteration for on-call rotas

With effect from 1 December 2000, a minor change was introduced in the amount of rest required at a weekend for on-call posts to meet the New Deal. The revised weekend rest requirements modify those detailed above in HSC 1998/240, under which for those on on-call rotas there is a total rest expectation of 50 per cent of the out-of-hours duty period on at

Information

HSC 1998/240

HSC 2000/031

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least 75 per cent of occasions ie 24 hours during a weekend duty period of 9am Saturday to 5pm Monday. If this amount of rest is not achieved, it will still be possible for a post to be compliant with the New Deal if all the following conditions are met:

- the rest requirement equivalent to that for a weekday is achieved (eight hours for 24-hour period, five of which are continuous between 10pm and 8am, on at least 75 per cent of occasions)
- equivalent paid rest is built into the rota for each weekend worked, where the total rest requirement (ie 24 hours during a 48 hour weekend) is not met, in the form of working days or half days, as follows:

Greater than 20 but less than 24 hours rest achieved per 48 hour weekend:
= half day (4 hours) equivalent paid rest

Less than or equal to 20 hours rest achieved per 48 hour weekend:
= full day (8 hours) equivalent paid rest

- the equivalent paid rest must be taken by the end of the Monday of the following week, ie within eight days. In exceptional circumstances, the period of equivalent paid rest built into the rota may be taken at another time in the rota cycle. However, it is important to note that this must be with the agreement of the individual trainee and apply to no more than 25 per cent of weekends worked.
- the trust must clearly demonstrate that in all other respects the post is fully compliant with the hours' limits and rest requirements of the New Deal, including the 56 hours of actual work limit.

If any of these conditions are not met, the post will continue to be New Deal non-compliant until action is taken to meet New Deal weekend rest requirements. Junior doctors should be aware of the fact that the equivalent rest is paid time and must be included in the total hours of duty (the typical intensity must be monitored) and must be built into the rota cycle. The equivalent paid rest is not an automatic day off, but applies to rotas where the total rest requirement is not met.

On-call posts at weekends in which less than 16 hours rest is attained are New Deal non-compliant. Changes should be made to the working pattern, but in the meantime, a full day of equivalent paid rest should be awarded for each weekend worked.

Impact of EWTD on periods of duty and rest

As explained above, the EWTD imposes additional limits on periods of duty and requires that certain periods of continuous rest are achieved throughout the day and during the week. Of particular significance is the requirement to provide compensatory rest when the prescribed rest periods are not met. The planning of rotas must therefore take account of the requirement to provide compensatory rest when 11 hours of continuous rest each day, and /or an additional 24 hours continuous rest per week (or 48 hours per fortnight), are not achieved.

Compliance with both the EWTD and New Deal can be achieved by following the least number of working hours and the most rest required.

Posts which breach New Deal and/or EWTD limits

Information
AL(MD)1/2001

Contracted duty hours and work intensity

There are still many posts in which doctors are expected to work for hours in excess of New Deal and EWTD limits. Special provision within the pay banding system has been made to ensure that juniors currently working the longest hours and/or the most intensively are remunerated the most. Nevertheless, junior doctors and their employers are now contractually required to work together to identify appropriate working arrangements or other organisational changes in working practice which move non-compliant posts to compliant, and juniors are required to comply with reasonable changes following such discussion.

More commonly, many junior doctors are unable to get the amount of rest they should for their working pattern and thus work in excess of 56 hours actual work per week. If adequate rest is not received during the night hours of a particular duty period, time off work the following day, or as soon as practicable, should be provided.

Taking action to resolve New Deal and EWTD problems

Junior doctors should seek advice from *ask*BMA (see page 175), regional action team or equivalent and, possibly, their consultant in order to try to resolve New Deal problems. The following should be considered in any effort to resolve New Deal/EWTD problems:

Duty Hours

- It might be possible to reduce hours by redistributing workload.

Intensity

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

In both problem areas, the following might improve hours and intensity:

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.
- Introduction of hospital at night arrangements
- 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 bureaux 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.

The JDC has produced detailed guidance on working patterns jointly with the Departments of Health and NHS Confederation. There is also JDC guidance on designing rotas. All guidance is available on the BMA website.

Protection on rebanding of posts

The New Deal became a contractual obligation for all junior doctors from August 2003 and the European Working Time Directive (EWTD) took effect from August 2004. Many trusts have needed to change working patterns for junior doctors in order to comply and some are still making changes. Moves toward achieving compliance must not result in juniors being told, with little or no notice that their rotas will change and that they will be paid less as a result. This lack of notice is not allowed under the terms and conditions of service.

There are very specific rules about how a post can be rebanded. These are contained in the 'Rebanding Protocol' available from the DoH website. A summary, taken directly from the proforma is listed in the table below. The full proforma must be signed off by all parties to indicate all steps have been followed. If not, then the post has not been rebanded properly and the salary should remain at the previous level.

If members have any concerns about proposed changes or pressure to agree to them, they should be raised with *ask*BMA (see page 175).

The stages necessary to reband a training post

Stage	Evidence Required	Documentation
1a. Consult post-holders on proposed changes and obtain agreement of the majority participating in the working arrangements.*	Approval of majority of current/incoming post-holders**	Template signed by trust junior doctor representative confirming agreement of majority of current/incoming post-holders
1b. Submit details of the new working arrangements to the action team for information and invited comment.	Full details of proposed working arrangements and/or rota summary	Letter signed by action team chair or delegated authority confirming theoretical compliance of working arrangements
1c. Obtain agreement from clinical tutor for education purposes.	Full details of proposed working arrangements Comments of action team	Letter signed by dean or delegated authority confirming educational acceptability of working arrangements
If exceptionally and because of the impracticality of full implementation of new working arrangements a trust wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the regional action team (or its equivalent) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements		
2. Submit request for provisional approval of working arrangements to action team	Signed letter from trust giving reasons for inability to fully monitor before rebanding. Evidence of full or partial testing/monitoring of proposed arrangements	Letter signed by action team chair or delegated authority authorising an offer of provisional banding.
3. Monitoring of working pattern and confirmation of banding	Completed monitoring returns from 75 per cent of doctors on rota over full two week period Summary of monitoring results	This signed template [Meaning whole proforma as explained above table]

* The requirement for the junior doctors approval of changes does not permit demands to remain in band 3 but does allow junior doctors to ensure the rota is workable and agreed by those concerned.

** 'Incoming post-holders' includes anyone who knows they will be rotating into that post.

If changes are to be introduced at the change of postholder, agreement should be obtained from both outgoing and incoming doctors. A clear indication of the proposed change should be detailed in the job advertisement and job description. **Before starting a new post, juniors are advised to contact the previous postholder to clarify their current working arrangements, and then to check if they are being offered something different**. It should not be a condition of appointment that a prospective postholder agrees to a change resulting in him/her working longer hours than the present incumbent. If members have any concerns, they should seek advice from *askBMA* (see page 175) before signing their contract.

Information
HSC 2000/031

AL(MD)1/01

Monitoring of work and rest

Since 1 December 2000, employers have been contractually obliged to monitor junior doctors' New Deal compliance and the application of the pay banding system. It should also be stated in the individual doctor's contract that they have an obligation to cooperate with those monitoring arrangements.

Monitoring will require the collection of a variety of different data, including contracted hours, hours of duty and when those hours occur, hours of actual work and when those hours occur, and total and continuous rest periods. Monitoring should occur under representative conditions of work intensity (ie not at exceptionally quiet or busy periods, not when many or no doctors are away on leave) and should usually occur once during every six month post. The one exercise should cover both purposes, ie banding allocation of posts and New Deal compliance. A monitoring period of two weeks is usually sufficient but, if more representative, it should be carried out over a cycle of the rota pattern. Hours information must use the agreed local recording methods (eg diary cards, barcode readers). Hours should be recorded during the agreed monitoring period, preferably during or at the end of each duty period, rather than by less reliable methods. Junior doctors must be notified adequately in advance of the monitoring period. They should be informed where to send the information recorded and how to get feedback on the outcome of their participation.

If monitoring does not occur, or is felt to be unrepresentative, this should be brought to the attention of the trust human

resources department, *ask*BMA (see page 175) and the regional action team or equivalent.

Information

HSC 2000/031

AL(MD)1/2001

When monitoring does not occur

A trust failing to meet its contractual requirement to monitor will be served with an improvement notice by the Strategic Health Authority. If it fails to implement an appropriate monitoring system within six months, it will be required to pay the junior doctors concerned at Band 3 rates until the SHA confirms that the trust now meets its contractual requirement to monitor.

If a junior or a group of juniors fails, without good reason, to supply monitoring data, they will receive written notice reminding them of their contractual obligation to cooperate, and be required to participate in a further round of monitoring. **Juniors should be aware that persistent failure to comply with monitoring arrangements represents a breach of contract and may result in disciplinary procedures.** If juniors do not supply monitoring data, the trust will determine what it regards as the correct pay band, on the basis of the available information. **It is essential, therefore, that junior doctors cooperate with monitoring.**

The English clause for specialist registrars

The English clause was named as such as it was drawn up by a former president of the Royal College of Surgeons, Sir Terence English. It was applicable only to specialist registrars and is now disallowed under the EWTD (although the provision for individuals to opt-out of the hours limits of the EWTD is available nevertheless).

Under the English clause, a specialist registrar who was on an on-call rota could extend their contract to a maximum of 83 hours a week, if the following conditions were met:

- the doctor concerned wished to do so; and
- it was to the benefit of their training; and
- proper support staffing existed; and
- the duties were not harmful either to the trainee or to patients.

Employers were responsible for ensuring that these criteria were met. The relevant Joint Higher Training Committee had to satisfy itself of the training need for average contracted hours in excess of 72 a week each time the post was reviewed.

Although the English clause enabled specialist registrars to contract to be available more often, the hours of actual work were still not to exceed 56 per week. The clause could only therefore apply in posts with low work intensity, where in a 72 hour contract there is unlikely to be 56 hours of actual work, unless all of it is resident.

Information
Terms and conditions of service paragraph 20

The English clause may be helpful for trainees in specialties in which long hours are necessary to permit exposure to a range of rare emergency cases. However, individuals would need to opt-out of the hours limits of the EWTD to allow it to apply, and the JDC's policy is that only doctors who can control their own working hours should be able to opt-out.

Different working arrangements

The pattern of work, the length of duty period and the workload intensity undertaken by a junior doctor are the key features in deciding whether the working arrangement should be a full shift, a partial shift, a 24-hour partial shift, an on-call rota, or a hybrid of the above. It is important to ensure that the correct working arrangement is adopted for the actual work involved and the amount of rest which can be taken during duty periods. When drawing up shift or rota arrangements, junior doctors should remember that colleagues will be taking annual and study leave. This must be taken into account particularly if prospective cover made easy, applies. See the JDC's guidance on rota design for further information on the BMA website.

Information
Terms and conditions of service, paragraph 19

HSC 2000/031

AL(MD)1/2001

Guidance on working patterns for junior doctors (DoH, BMA, NAW, NHS Confederation) Nov 2002

Rota Design made easy JDC 2004

On-call rotas

The following guidance sets out the position for on-call arrangements under the New Deal. However, it is important to remember that the EWTD and, more importantly, the SiMAP and Jaeger rulings also impose limits on working hours and requirements for rest breaks (or compensatory rest in lieu of rest breaks). Resident on-call rotas are therefore unlikely to comply with the EWTD because all time spent resident counts towards the average weekly working hours limit of 58 hours (reducing to 48 hours in 2009).

On-call rotas are a suitable working arrangement where junior doctors work a normal day, Monday to Friday, and are 'on call' in rotation for the remainder of the 24-hour period and for weekends. Duty periods will be more than 24 hours in length.

An arrangement where a junior doctor is on call for only part of the day, for example until midnight or 9am to 5pm at a weekend is **NOT** an on-call rota. It is a shift system, regardless of work intensity.

The frequency of on-call depends on the number of junior doctors providing cover and is normally expressed as 1 in 4 etc.

Rotas are appropriate for those posts where the workload is of such a nature that, when working the standard working week, junior doctors on-call, whether in hospital or at home, **are not required to work for a substantial portion of their out-of-hours duty.**

The New Deal stipulates that junior doctors on on-call rotas should expect to get at least eight hours' rest during a period of 32 hours on duty, principally within the on-call period. Where possible the greater part of this rest period should be continuous. HSC 1998/240 clarifies this, so that at least one half of the out-of-hours duty period should be taken as rest. For a weekday on-call, for example, this would mean at least eight hours rest during a period of 32 hours on duty. There must be a minimum of five hours' continuous rest between 10pm and 8am.

Partial shifts

Partial shifts are appropriate where the workload is such that a junior doctor is unable to take eight hours' rest during the on-call period, but the work is not of full shift intensity. Partial shifts are thus suitable for many hard-pressed posts. They involve a variety of work patterns, particularly for night cover, but there is usually a significant routine workload during the day. Under the New Deal, a duty period should generally not exceed 16 hours, but up to 24 hours is permitted provided rest is adequate and an adequate period of time off is allowed afterwards. **However, it is important to remember, in addition, the limits on hours and the requirement to achieve rest breaks (or obtain compensatory rest instead) set out in the EWTD.**

The New Deal states that doctors working partial shifts should be able to take, in addition to natural breaks, **at least four hours of rest during every duty period of 16 hours**. HSC 1998/240 clarifies this, so that at least one quarter of the out-of-hours period should be taken as rest. For example, a duty period of 5pm to 9am, Monday to Friday should allow four hours rest.

Partial shifts have been given a bad name in the past for reasons that are often not valid. Problems have resulted from a too-literal interpretation of the (poor) examples given in the New Deal itself and from badly designed and poorly thought-out partial shifts. There are several points to remember:

- partial shifts need not adversely affect training
- partial shifts need not involve a week of nights
- partial shifts need not ruin weekends off: on a well designed six person partial shift, part of two weekends would be worked, which would be little different from a 1 in 6 rota with split weekends, but with more time off during the week
- continuity of care can actually be improved by building in handover periods.

How to plan a partial shift

Advice should be sought from the regional action team (or equivalent) at an early stage as they have a great deal of experience in designing shifts.

- A workload study should be undertaken: this will also provide useful documentary evidence to justify a change in working practices.
- Other methods should be used first to reduce hours or intensity.
- Junior doctors should be involved in designing the shift. The regional action team (or equivalent) may be able to provide advice and examples of other partial shifts already operating.
- Consultants should be involved and their support is crucial. A partial shift sometimes involves changing from a firm to a team approach. Other affected staff groups should be involved (eg nurses, managers).
- It is essential to build in teaching sessions and handover time.
- Any partial shift should comply with the rest periods outlined above.
- The planned shift should be piloted and then evaluated; often the final shift has to be redesigned several times.

Experience has shown that it is not possible to run successful partial shifts with only four or five doctors on a rota.

It is worth noting that simply changing an on-call rota to a partial shift is unlikely to resolve problems of New Deal non-compliance. Partial shifts must be planned properly.

The JDC has produced detailed guidance on working patterns jointly with the Departments of Health and NHS Confederation. There is also JDC guidance on designing rotas and on the relationship between the New Deal and the EWTD (*'Time's up'* August 2004). All guidance is available on the BMA website.

24 -hour partial shifts

It is possible for two shifts within a partial shift arrangement to be worked consecutively **provided the period of continuous duty does not exceed 24-hours.** Such shifts must be scheduled to include any time needed for handovers, ward rounds etc. Doctors should not be on duty for more than four hours following the 16-hour period of out-of-hours duty. For weekday working, this means that the shift must finish by 1pm. The next duty period should not start until at least the beginning of the next normal working day.

Full shifts

Full shifts are based on those used in other services and industry and other health professions, eg nursing. Shifts are usually of 8-12 hours' duration, but may be up to 14 hours (although the EWTD rest requirements mean that unless compensatory rest is given shift lengths can be a maximum of 13 hours). This means that there will be two or three shifts to cover 24 hours although there can, of course, be more than one doctor on duty at a time. The principles for planning full shifts are the same as those outlined above for partial shifts.

This type of shift pattern is appropriate for providing medical cover where the work is intensive and potentially continuous throughout the 24 hour period, for example, in neonatal or other intensive care units or accident and emergency departments or busy acute admission units. In such situations the doctors on duty can be expected to spend virtually all of the duty period, except for natural breaks, working or being immediately available for work in the unit. Any shift system

which does not achieve four hours' rest overnight is of full shift intensity.

Hybrid working arrangements

A hybrid working arrangement consists of **two or more distinct working patterns**, for example, an on-call rota in gynaecology and a partial shift in obstetrics. These working patterns are either worked concurrently in the same rota or alternate within a time limit of up to one month. Such an arrangement will be appropriate where juniors' duties comprise work of substantially different levels of intensity due to different clinical responsibilities.

A shift/rota with insufficient rest or excessive duty periods is not a hybrid but a shift/rota that breaches the New Deal.

The following criteria must be taken into account when implementing a hybrid working arrangement:

- which particular working patterns are used in the hybrid arrangement is defined by expectation of rest (work intensity), and the length of the duty period is calculated accordingly
- New Deal hours' limits will apply to each working arrangement used
- contracted duty periods for hybrid working arrangements should be determined by the point, calculated as a proportion of the part that each arrangement makes to the hybrid, between the New Deal contracted hours' limits of each of the working patterns comprising the hybrid. For example, a hybrid combining 50 per cent full shift and 50 per cent on-call rota will have a contracted duty limit of 64 hours (between 56 and 72).

Information

Terms and conditions of service, paragraphs 18 and 21

Doctors and dentists in training: terms and conditions of service/model contract guidance (NHSME January 1993) (August 1993 in Scotland)

AL(MD)1/2001

Pay banding system

With effect from 1 December 2000, junior doctors have no longer been paid according to an exclusively time-based contract. All hours required should be set out in a job description attached to the contract and agreed in advance between the junior doctor(s) and employer. The weekly total represents an average over the period of the duty roster (usually at least as many weeks as there are doctors on the roster).

A full time contract consists of:
40 hours, plus
Such further contracted hours as are agreed with the employing authority (subject to the New Deal and European Working Time Directive controls) including:

- all out-of-hours work
- agreed prospective cover for annual/study leave of colleagues
- any other regular commitments, eg early starts and late finishes
- any duty hours necessary for continuity of patient care.

The December 2000 contract replaced the Additional Duty Hours (ADH) pay system with a pay banding system. The pay bands reflect whether the post is compliant with the New Deal hours controls and rest periods, and also whether the doctor works up to 40, 48 or 56 hours a week, the type of working pattern, the frequency of extra duty and the unsocial nature of the working arrangements.

The new pay banding system covers both full-time and part-time doctors and dentists in training, in posts and placements in the Hospital and Community Health Service (HCHS), including public health medicine trainees. These posts or placements are in the training grades of PRHO, HO, SHO and SpR (including registrars and senior registrars).

How the system works

Full time doctors, whose entire working week consists of a maximum of 40 hours between 8am and 7pm, Monday to Friday, receive no additional supplement and their post is therefore not allocated to one of the bands below. Likewise, flexible trainees who work less than 40 hours per week and perform no duty outside 8am to 7pm, Monday to Friday, receive no supplement.
There are four bands in the new system:

- Band 3 includes all juniors whose posts are non-compliant with the hours' limits or the rest requirements of the New Deal, as stipulated in HSC 1998/240, modified by agreement on weekend rest periods for on-call rotas as detailed in HSC 2000/031

- Band 2 includes all juniors whose posts are compliant with the New Deal and who work over 48 hours and up to and including 56 hours of actual work per week

- Band 1 includes all juniors whose posts are compliant with the New Deal and who work up to and including 48 hours of actual work per week

- F bands includes all juniors who work less than 40 hours of actual work per week

- Band 2 is split into Bands 2A and 2B, Band 1 is split into Bands 1A, 1B and 1C, and Band F is split into Bands FA, FB and FC:

- Bands 2A, 1A include all juniors who, within their respective hours' limits, work the most frequently and at the most unsocial times, as defined by the banding criteria

- Bands 2B, 1B include all juniors who, within their respective hours' limit, work less frequently and at less unsocial times

- Band 1C includes all juniors who, within the 48-hour limit, work on a low frequency on-call rota from home

The pay banding criteria flow chart can be found in Appendix VI.

The total salary of full-time junior doctors will comprise the *full base salary* to which a *supplement*, calculated as a proportion of the base salary, will be added according to the band to which the doctor is allocated, as set out below. Figures in brackets show total salary expressed as a multiple of the full base salary:

Banding multipliers for full-time trainees

Band/date	1 December 2000	1 December 2001	1 December 2002	From 1 December 2004
Band 3	62% (1.62)	70% (1.7)	100% (2.0)	Future pay banding multipliers will be the responsibility of the Doctors and Dentists Review Body (DDRB). Any changes in pay band multipliers will be posted on the BMA website.
Band 2A	50% (1.5)	60% (1.6)	80% (1.8)	
Band 2B	42% (1.42)	42% (1.42)	50% (1.5)	
Band 1A	42% (1.42)	42% (1.42)	50% (1.5)	
Band 1B	30% (1.3)	30% (1.3)	40% (1.4)	
Band 1C	20% (1.2)	20% (1.2)	20% (1.2)	

Banding multipliers for flexible trainees

	1 December 2000	1 December 2001	1 December 2002	From 1 June 2005
Band FA	25% (1.25)	25% (1.25)	25% (1.25)	New banding arrangements apply to flexible trainees from 1 June 2005. See below for further details.
Band FB	5% (1.05)	5% (1.05)	5% (1.05)	
Band FC	Hours of duty/40 x full base salary	Hours of duty/40 x full base salary	Hours of duty/40 x full base salary	

Flexible trainees

From 1 June 2005, new banding arrangements apply to doctors in training who work less than 40 hours of actual work per week (flexible trainees). The new system was agreed between the JDC, NHS Employers, COPMeD and the Department of Health in March 2005 with the aim of widening access to flexible training. The previous banding arrangements had been perceived by many employers as making flexible trainees too expensive to employ and, effectively, this had limited the number of flexible training placements available.

Basic salary under the new system is determined by the trainee's actual hours of work, and there is an additional banding

supplement paid as a proportion of basic salary according to the intensity and anti-social nature of the trainee's out of hours work.

Flexible trainees' hours of actual work are divided into five discrete time categories and labelled F5-F9. Each category attracts a proportion of the full-time basic salary, as below:

- F5 is 20 or more and less than 24 hours of actual work a week and attracts 0.5
- F6 is 24 or more and less than 28 hours of actual work a week and attracts 0.6
- F7 is 28 or more and less than 32 hours of actual work a week and attracts 0.7 of the full
- F8 is 32 or more and less than 36 hours of actual work a week and attracts 0.8 time basic salary
- F9 is 36 or more and less than 40 hours of actual work a week and attracts 0.9

The banding supplement is calculated as a proportion of the calculated basic salary as below:

FA	50%
FB	40%
FC	20%

Total salary therefore is calculated as follows:

$$\text{Total salary} = \text{salary}^* + \text{salary}^* \left(\text{x} \begin{matrix} 0.5 \\ 0.4 \\ 0.2 \end{matrix} \right)$$

* salary = F5 to F9 calculated as above.

The supplement for a post that is not compliant with the New Deal is applied at a rate of 100% of the calculated basic salary. This is Band F3.

Pay protection applies to those already training flexibly at 1 June 2005 whose pay under the new system would otherwise be reduced.

[Insert reference to new AL which includes the FT deal]

PRHOs in general practice

PRHOs in general practice are paid an out-of hours supplement of 65 per cent of basic salary. This applies irrespective of their out-of-hours commitment, although they cannot be contracted to work hours in excess of New Deal limits.

Banding criteria: definitions used

The following definitions are under the New Deal. It is important to remember however that the EWTD has different definitions of work and rest.

Definition of work and rest

Actual work: the definition of hours of actual work will be that definition used in the New Deal (ie includes all time carrying out tasks for the employer, including periods of formal study/teaching, but does not include rest while on-call. For the purposes of defining work after 7pm, work begins when a doctor is disturbed from rest and ends when that rest is resumed. This includes, for example, time spent waiting to perform a clinical duty* and time spent giving advice on the telephone.

Rest: All time on duty when not performing or waiting to perform* a clinical or administrative task, and not undertaking a formal educational activity; but including time spent sleeping.

Natural breaks do not count as rest.

* For example, a doctor waiting for the operating theatre to be prepared; not a doctor on duty who has been notified of a need to return to the hospital or unit, but not immediately.

Information
Terms and conditions of service, paragraph 22

Definition of weekend

A weekend worked is one which involves the doctors being on duty at any time during the period from 7pm Friday to 7am Monday.

Information
Terms and conditions of service, paragraph 19

Definition of working patterns

Whilst the following definitions apply under the New Deal, it is important to remember that the EWTD imposes other limits on the number of hours of continuous work and stipulates further rest periods in between (or requires compensatory rest to be given where prescribed rest is not achieved). Where there is

conflict, the shorter of the duty hours and longer of the periods between duty periods will prevail.

On-call rota: doctors on on-call rotas usually work a set working day on weekdays, from Monday to Friday. The out-of-hours duty period is covered by doctors working 'on call' in rotation. **Juniors are rostered for duty periods of more than 24 hours**.

Partial shift: on most weekdays doctors on partial shifts work a normal day. But, at intervals, one or more doctors will work a different duty for a fixed period of time, eg evening or night shifts. Doctors can expect to work for a substantial proportion of the out-of-hours duty period, during which time they will expect to achieve some rest in addition to natural breaks. **Juniors will be rostered for duty periods of not more than 16 hours**.

24-hour partial shift: weekdays are usually worked as normal days. In rotation, a duty period is rostered, not exceeding 24 hours including handovers, for the weekend and out-of-hours cover. **Juniors will be rostered for duty periods of more than 16 hours, but less than or equal to 24 hours**.

Full shift: a full shift will divide the total working week into definitive time blocks with doctors rotating around the shift pattern. Doctors can expect to be working for the whole duty period, except for natural breaks. **Juniors will be rostered for duty periods that do not exceed 14 hours**.

Hybrid working arrangement: a hybrid working pattern involves a combination of two or more of the above patterns (refer HSC 1998/240 Annex D). **Each component duty pattern must conform to its appropriate definition and hours' controls as above**.

Definition of prospective cover

When the doctor is contracted to provide internal cover for colleagues when they are on annual and/or study leave, ie if no locums are provided. Prospective cover is also in operation when on-calls are required to be swapped when taking leave or when leave is fixed in advance. When a doctor on the rota acts as a 'floater', ie covering any doctors on the rota who are away on holiday, prospective cover is not in operation.

Information

Terms and conditions of service, paragraph 22

Banding criteria: formal criteria for each of the pay bands

To find out which band you are in log on to the BMA website at http://www.bma.org.uk/ap.nsf/Content/Junior+doctors+banding+calculator. A flow chart for working out bands is attached at appendix VI.

Calculating hours of actual work

Mechanism for the allocation of banding and the appeals process

All junior doctors sharing the same rota, shift or partial shift should be assigned the same banding. Where junior doctors do not have identical duties and responsibilities to the others on the rota or shift system they should be assessed separately.

At this first phase, regional improving junior doctors working lives action teams, or equivalent, could be involved to help resolve difficulties and to ensure consistency.

Juniors who knowingly and intentionally allocate themselves to a wrong band could face serious consequences. If juniors intentionally complete monitoring forms inaccurately (for example, to avoid change to a partial shift) they are denying all members of the rota, and their successors, the correct pay according to the banding allocation for their post. They are also letting their employer leave non-compliant working patterns unresolved, and acting fraudulently.

Where agreement is reached on banding, the employer should notify the outcome in writing to the junior doctors concerned and any relevant consultants and clinical directors. Copies of all documentation should be available to the regional improving junior doctors working lives action team (or equivalent) which will give its opinion in any case where there is a dispute or in other cases at its discretion. Where agreement cannot be reached during the initial phase, the parties will record the issues to be resolved. **Members who are failing to reach agreement with their trust on their banding should seek advice from *ask*BMA (see page 175) at an early stage.**

Appeals process

Information
Terms and conditions of service, paragraph 22

AL(MD)1/2001

If either party does not accept the regional action team's (or equivalent) opinion, there will be a right of appeal which will be the responsibility of the employer to operate fairly and transparently. Appeals will be heard by a local trust committee which should be convened as soon as possible and trusts are expected to do so while the doctors remain in post. The decision of the committee is final. The effect of the decision will be backdated to the date of the change, or to 1 December 2000, whichever is applicable. It is essential that members who are considering making an appeal contact *ask*BMA (see page 175) for advice and support.

Clinical academics and other junior doctors who work for more than one employer

Information
AL(MD)1/2001

Academics and other junior doctors who work for more than one employer will normally receive their base salary from their main employer. They previously received ADHs for out-of-hours work, either paid directly or recharged by the main employer. Under the new pay arrangements, where an academic or other junior doctor is working the same frequency of rota and/or length of hours as other junior doctors in the rota, the same system will operate and these academic or other staff will receive the pay band supplement applicable to the rota or specialty in which they perform their out-of-hours duties. Where such doctors do not have identical duties and responsibilities to the rest of the doctors on the rota/shift system, they should be assessed separately taking into account the overall number of hours worked per week.

Pay protection arrangements for compliant posts

Information
Terms and conditions of service, paragraph 21

AL(MD)1/2001

For compliant posts/placements which are rebanded to a lower band, postholders shall have their salary* protected at the rate applicable at the time of rebanding for so long as it remains favourable and for the duration of the post/placement.

For rotations, future posts/placements which have been accepted by the appointee at a compliant band that are rebanded to a lower band shall have the salary* protected at the rate applicable at the time of rebanding as above.

* Salaries will be increased only to take account of increments in the base salary.

Information

Terms and conditions of service, paragraph 21

AL(MD)1/2001

Pay protection arrangements for non-compliant posts

All posts which are non-compliant with the New Deal will be paid at the Band 3 rates applicable at the time.

For posts/placements which became compliant before 1 December 2002 postholders shall have their salary* protected at the Band 3 rate applicable at the time of rebanding for so long as it remains favourable and for the duration of the post/placement.

For posts/placements which became compliant on or after 1 December 2002 postholders shall have the salary* protected at the Band 2A rate applicable at the time of rebanding as above.

For rotations, future posts/placements which had been accepted by the appointee at Band 3 that became compliant before 1 December 2002 shall have their salary* protected at the Band 3 rate applicable at the time of rebanding as above.

For rotations, future posts/placements which had been accepted by the appointee at Band 3 that became compliant on or after 1 December 2002 shall have the salary* protected at the Band 2A rate applicable at the time of rebanding as above.

* Salaries will be increased only to take account of increments in the base salary.

Mechanism for reallocating posts to lower pay bands

To re-band a post a protocol, agreed between the Department of Health and the JDC, must be followed. The protocol is replicated in the flow chart at appendix VI, which must be completed by the trust before a post is formally rebanded. A specimen of the protocol is attached at appendix VII.

Backdating of pay on rebanding after monitoring

Where monitoring after a change of house shows that a higher banding is appropriate, pay at the higher band will be backdated to the start of the post.

Where routine monitoring shows that a higher banding is appropriate, even though there has been no formal change to the working pattern, pay at the higher band will be backdated to the point 3 months after the first day of the previous successful monitoring round except:

- Where this is the first monitoring round of the post, in which case pay is backdated to the first day in post; or
- Where there have been intervening attempts by the trust to monitor but which have not been successful, in which case pay is backdated to the first day of the monitoring period that first showed a higher band was appropriate; or
- Where valid monitoring at the request of the postholders showed a higher band, in which case pay is backdated to the date of the request to monitor if this is less than 3 months from the first day of the previous successful monitoring round.
- Where a previously non-compliant rota is shown on valid monitoring to fall into a compliant pay band, the trust must write to the doctors to inform them of the change, and pay at the protected level of Band 2A must be paid from the first day of the following month.

Prospective cover for annual and study leave of colleagues

Many charged with implementing the New Deal have struggled with the concept of prospective cover and the prospective cover allowance (PCA) calculation. Although there is no nationally agreed means of calculating prospective cover, the JDC guidance is widely accepted. Below is a new, improved formula for calculating hours of work which has replaced the old prospective cover calculation.

Prospective cover

Employers may contract juniors in advance to cover the full annual (including public holidays) and study leave entitlement of all colleagues on that roster. This is known as prospective cover. The juniors on that roster are 'prospectively covering' the annual and/or study leave of their colleagues.

In practice, this means that a junior can normally only take annual or study leave on a day when he/she is rostered to work normal days, or the junior would be required to swap on-calls or shifts with a colleague on that rota in order to take leave. This practice is based on the assumption that only the proportion of work outside of the normal working day requires to be covered. This assumption does not hold for many shift-working patterns.

When does prospective cover apply?

Prospective cover applies in all cases, except on those rotas where:

- locums are obtained to cover annual and study leave
- a junior can take annual or study leave at any time on the rota, including when rostered to be working out of hours (eg a late shift, over night or an on call) and no junior on that rota is required to cover that shift.

Fixed annual leave

If annual leave is fixed, prospective cover applies.

Introduction of prospective cover

Prospective cover cannot be introduced into a junior doctor's existing contract without consent, or if the hours limits set out previously would be breached by doing so.

If an employer wishes to introduce prospective cover (or any other change) into the contract of an incoming junior, it must consult with both the incoming and outgoing doctors. Any unilateral change without proper consultation must be resisted and reported to *ask*BMA (see page 175).

Principle of the prospective cover allowance (PCA)

Consider a worker who works 20 hours per week. They will be paid for 20 hours for each week of their holiday entitlement. Likewise, an individual working 40 hours per week will be paid for 40 hours for each week of holiday. Junior doctors usually work more than 40 hours per week.

Example:
A simple 1 in 5 on-call rota is shown below.

Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Hours	1
On-call	Day	Day	Day	On-Call	–	–	72	**2**
Day	Day	On-Call	Day	Day	–	–	56	**3**
Day	On-Call	Day	Day	Day	On-Call	On-Call	104	**4**
Day	Day	Day	On-Call	Day	–	–	56	**5**
Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40	
	Day = 9am to 5pm = 8 hours On-Call = 9am to 9am = 24 hours						328	

For illustrative purposes, it is assumed in this example that each doctor is entitled to 10.4 weeks of leave each year. This equates to one week of leave in each five week rota cycle. Week 5 contains no on call commitments. The juniors on this rota are expected to take annual leave when they have no on call commitment (ie they are prospectively covering their annual leave). Week 5 also contains less hours than any of the other four weeks.
On average, in the first four weeks, the juniors work:

$$\frac{72 + 56 + 104 + 56}{4} = 72 \text{ hours}$$

The juniors in this example are therefore being paid for 40 hours for each week of their holiday entitlement, rather than the 72 hours that they work on average. A method was therefore required to account for this difference. Previously, the method used was the prospective cover allowance (PCA). This method will not be described here as it has now been superseded.

Prospective cover allowance and shift working

The previous method of calculating the PCA works well for some on call rotas. Implementation of the New Deal has resulted in an increase in shift working patterns. Practical difficulties are encountered when applying the PCA calculation to these rotas. Therefore, a new method is required to calculate how many hours a doctor works on average per week when he/she is not on leave for all shift types.

The Riddell formula for hours calculation©

Introduction

The principle of the Riddell formula for hours calculation is outlined below. However, an understanding of this principle is not required to analyse a rota.

Principle of the Riddell formula

The Riddell formula identifies how many hours a doctor is working on average per week by dividing the number of hours a doctor works when not on leave by the number of weeks worked when not on leave, or:

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}} \quad [1]$$

If we again consider our one in five on call rota:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Hours
1	On-Call	Day	Day	Day	On-Call	–	–	72
2	Day	Day	On-Call	Day	Day	–	–	56
3	Day	On-Call	Day	Day	Day	On-Call	On-Call	104
4	Day	Day	Day	On-Call	Day	–	–	56
5	Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40
								328

The total hours worked when not on leave is the sum of hours total for weeks 1 to 4, thus:

= 72 + 56 + 104 + 56
= 288

The number of weeks worked in rota cycle when not on leave is 4, thus:

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}}$$

$$\text{Average hours per week} = \frac{288}{4}$$

$$= 72 \text{ hours}$$

This is the same answer we derived in the previous calculation. We can therefore see that Equation **(1)*** allows accurate determination of average hours per week for the above example. A formula is required to allow application to any rota type. It can be expressed mathematically as:

$$\text{Average hours per week} = \frac{D - (E \times C)}{B - E}$$

A = total leave entitlement for the year (in weeks)
B = number of weeks in the rota cycle (often equal to the number of doctors)
C = number of hours in a leave week (0 if all rostered shifts must be covered, irrespective of who is on leave)
D = total hours worked in the rota cycle if no leave is taken
E = (A/52 x B)

Use of the Riddell formula

As described, the Riddell formula identifies the number of hours a junior doctor is available for work on a given rota, ie the 'available hours'*. Therefore, the formula derives the available hours for a given rota, which can then be assessed against New Deal limits.

* The terms 'available hours' and 'duty hours' are often used interchangeably under the New Deal.

Determination of theoretical actual hours using the Riddell formula

The major reason to calculate theoretical actual hours of a rota is to determine the potential banding. Calculation of theoretical actual hours is not routinely required to determine New Deal compliance of a rota on paper. True actual hours will be determined on monitoring, and must not exceed the New Deal limit of 56 hours.

The Riddell formula above derives the average 'available hours' per week for a given rota. 'Actual hours' may be determined either by substituting total actual hours worked in the rota cycle for variable D, or by subtracting rest from the total hours worked in the rota cycle (variable D). This latter approach allows identification of a formula, shown below, that will calculate actual hours for all rotas, including hybrid rota patterns.

$$\text{Average actual hours per week} = \frac{(D - \text{Rest}) - (E \times C)}{(B - E)}$$

A = total leave entitlement for the year (in weeks)
B = number of weeks in the rota cycle (often equal to the number of doctors)
C = number of hours in a leave week (0 if all rostered shifts must be covered, irrespective of who is on leave)
D = total hours worked in the rota cycle if no leave is taken
E = (A/52 x B)
F = number of partial shift out of hours (or total partial shift hours if no normal working week day is identifiable)
G = number of on-call out of hours (or total on-call shift hours if no normal working week day is identifiable)
H = the number of 24-hour partial shifts

Rest is defined as partial shift rest requirements + on-call rest requirements + the number of 24-hour partial shifts x 6 hours (the rest requirement for a 24 hour partial shift)

Thus;

$$\text{Rest} = \frac{F}{4} + \frac{G}{2} + [H \times 6]$$

For our previous example rota, this would give:

Rest
= Total on-call hours / 2
= 128/2
= 64

$$\text{Average actual hours} = \frac{(328 - 64) - \{(10.4/52 \times 5) \times 40\}}{5 - (10.4/52 \times 5)}$$
= 56 hours

Determining a normal working weekday day

A normal working weekday can be identified in many rotas. This is the normal daytime shift that is worked Monday to Friday. In most rotas this is clear. If a normal working weekday day is not identifiable, it may be possible to determine times during which the juniors are expected to be working at full shift intensity during the week. This defines the 'in hours' period. If this is not identifiable then it may not be necessary to define a normal working day. In this case, total partial shift or on-call hours should be used for F and G respectively.

Example of a rota without a normal working day

In this A&E rota, there is no normal working day. Nights are worked at partial shift intensity with all other duty periods being at full shift intensity. The week marked as clinic/AL is a supernumerary week where the individual is either on leave or receiving specialty training. Annual leave and public holidays are covered prospectively with all study leave covered by external locums. Therefore, there are 6.5 weeks of leave to cover per junior per year.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail
1	Early 9-16	Night 21-9	Night 21-9	Night 21-9	Night 21-9	Night 21-9	Night 21-9	79
2	Night 21-9	Teaching 9-10.30	Off	Off	Off	W/E Late 11-23	W/E Late 11-23	37.5
3	Off	Tue Early 9-21	Late 16-23	Middle 11-21 Fri	Early 9-21	Off	Off	43
4	Middle 11-21	Tue Late 9-22.30	Early 9-16	Late 16-23	Off	W/E Early 9-21	W/E Early 9-21	63.5
5	Late 16-23	Teaching 9-10.30	Middle 11-21	Early 9-16 Fri	Late 11-23	–	–	39.5
6	Clinic/AL 9-17	Clinic/AL 9-17	Clinic/AL 9-17	Clinic/AL 9-17	Clinic/AL 9-17	–	–	40
								302.5

Applying the Riddell formula:

$$\text{Average available hours} = \frac{302.5 - \{(6.5/52 \times 6) \times 40\}}{6 - (6.5/52 \times 6)}$$
$$= 51.9 \text{ hours}$$

To determine the 'actual hours' for the rota, we first determine the rest entitlement. The full shift component of the rota requires natural breaks, which do not count towards rest, the partial shift component accrues one quarter of the duty period as rest. Therefore, the total rest for this rota is equal to:

$$\text{Rest} = \text{Total partial shift hours} / 4$$
$$= (7 \times 12) / 4$$
$$= 21\text{hrs}$$

$$\text{Average actual hours} = \frac{(302.5 - 21) - \{(6.5/52 \times 6) \times 40\}}{6 - (6.5/52 \times 6)}$$
$$= 47.9 \text{ hours}$$

Hours monitoring using the Riddell formula

How to determine the theoretical 'available' and 'actual' hours of a rota on paper has been described above. For banding purposes, the true average available and actual hours for a given rota must be determined by monitoring.

Analysis of monitoring forms is often complicated by lack of data. This occurs for two main reasons:

- the doctor is on annual leave
- the doctor has not completed a monitoring form.

It is essential to address this lack of data as outlined below. Failure to do so will result in an inaccurate result and may result in a post being inappropriately banded.

How to address annual leave in monitoring

Two problems arise when monitoring a rota. Firstly, it is unusual that a monitoring period with contain an absolutely representative amount of leave that would be expected on average to occur in a two-week period. Secondly, as discussed above, a worker is entitled to an average week as leave. However, many rotas allocate shifts to the annual leave week that may be worked if a junior is not on leave. These rarely equate to an average week. Therefore, we require a method that will standardise these two variable factors.

Firstly, a 'leave adjustment' is calculated from the rota template using the following formula;

$$\text{Leave adjustment} = \frac{(\text{average hours worked} - \text{allocated leave week in hours}) \times \text{leave entitlement}}{52}$$

This should be calculated twice, once for actual hours and once for available hours.

Example:

If we look at our example five-week rolling on-call rota again we can see how the formula should be applied to monitoring data.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	On-Call	Day	Day	Day	On-Call	–	–	72	56
2	Day	Day	On-Call	Day	Day	–	–	56	48
3	Day	On-Call	Day	Day	Day	On-Call	On-Call	104	72
4	Day	Day	Day	On-Call	Day	–	–	56	48
5	Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40	40
								328	264

Day: 9am – 5pm = 8 hours
On-call: 9am to 9am = 24 available hours, 16 actual hours
(Weekend 12 actual hours)

From the calculations above we know that on paper this rota requires the juniors to be available for an average of 72 hours per week and to be actually working for an average of 56 hours per week. This calculation uses the figures from the theoretical Riddle formula, so junior doctors need to use the average and adjustment from the template to make this calculation.

This is on the basis that the doctors cover all their leave internally and achieve the minimum rest requirements under the New Deal. To adjust for leave during the monitoring period we can apply the following formula:

$$\text{Leave adjustment} = \frac{(\text{average week in hours} - \text{allocated leave week in hours}) \times \text{leave entitlement}}{52}$$

'Available hours' leave adjustment $= \frac{(72 - 40) \times 10.4}{52}$

$= 6.4$

'Actual hours' leave adjustment $= \frac{(56 - 40) \times 10.4}{52}$

$= 3.2$

Thus by providing internal cover, each doctor works on average an additional 6.4 available and 3.2 actual hours per week. These values must be added to the average hours determined during the monitoring exercise.

The leave adjustment must be added in all cases of monitoring, regardless of whether the monitoring included multiple or no doctors on leave.

In our example, we now monitor the post. When a doctor is on leave, we substitute in the rostered hours for the annual leave week, in this example 5 x 8 hours = 40 hours.

For each of the five doctors working this rota, their individual rotas for the 2 week period will be as follows:

Doctor 1

Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	On-Call	Day	Day	Day	On-Call	–	–	72	56
2	Day	Day	On-Call	Day	Day	–	–	56	48

Doctor 2

Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day	Day	On Call	Day	Day	–	–	56	48
2	Day	On Call	Day	Day	Day	On Call	On Call	104	72

Doctor 3

Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day	On Call	Day	Day	Day	On Call	On Call	104	72
2	Day	Day	Day	On Call	Day	–	–	56	48

Doctor 4

Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day	Day	Day	On Call	Day	–	–	56	48
2	Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40	40

Doctor 5

Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Avail	Actual
1	Day/AL	Day/AL	Day/AL	Day/AL	Day/AL	–	–	40	40
2	On Call	Day	Day	Day	On Call	–	–	72	56

If for the monitoring exercise we obtained 100 per cent returns of monitoring forms, the individual juniors adhere to start and finish times and achieve exactly the rest required under the New Deal, then their monitored and paper hours would be identical. Thus the total available hours on the basis of monitoring for this rota would be:

72 + 56 + 56 + 104 + 104 + 56 + 56 + 40 + 40 + 72 = 656

We now divide this number by the two weeks of monitoring and the five doctors to give an average of 65.6 available hours per week. However, this does not reflect the additional duties worked by providing internal cover. By adding the leave adjustment derived above we obtain the true average available hours for this rota:

65.6 + 6.4 = 72 hours

By applying the same principal to the actual hours totals we get:

56 + 48 + 48 + 72 + 72 + 48 + 48 + 40 + 40 + 56 = 528

We now divide this number by the two weeks of monitoring and the five doctors to give an average of 52.8 actual hours per week. Adding the leave adjustment as above we obtain the true average actual hours for this rota:

52.8 + 3.2 = 56 hours

This worked example demonstrates not only how to accurately account for annual leave in a monitoring period, but also that addition of the leave adjustment is required for accurate determination of monitored hours.

Non- returned forms

Junior doctors are contractually required to comply with monitoring. Trusts are required to ensure that robust monitoring systems are in place. The New Contract states that a 'minimum return rate for monitoring is 75 per cent of all doctors in training on each rota… and 75 per cent of all duty periods'. If this is met, the hours not accounted for by non- returned forms must be accounted for in the assessment of monitoring data to ensure an

accurate assessment of hours for banding. The missing data cannot be ignored because we may ignore a particularly quiet week, say 36 hours, which would artificially increase hours on monitoring and result in an inappropriately high band, and vice versa.

Therefore, providing the minimum return rate is met, any shifts unaccounted for should be added to the monitoring data as per the rostered hours.

Derivation of the Riddell formula

Starting from this equation:

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}} \quad \textbf{(1)}$$

we must identify the variables that can be extracted from a rota to allow us to identify the numerator, total hours worked when not on leave, and the denominator, weeks worked in the rota cycle.

Total hours worked when not on leave

To determine total hours worked when not on leave (that is the numerator for our equation) we can take the total hours worked in the entire rota cycle (328 in our example) and subtract the week of annual leave (40 in our example). This is fine for rotas for which leave occurs in convenient multiples. In the case of our example, one week leave in every five equates to leave requirement of:

$$\frac{52}{5} = 10.4 \text{ weeks per year.}$$

For rotas in which leave does not occur in such convenient multiples, we must first determine the proportion of leave which a junior is entitled to in each rota cycle. This is expressed as:

$$\frac{\text{Leave}}{52} \times \text{number of weeks in rota cycle} \quad \textbf{(2)}$$

By multiplying this equation **(2)** by the number of hours in the leave week we now have a figure (in hours) for the amount of annual leave the junior is entitled to in each rota cycle of a specific rota. If we subtract this figure from the total hours worked in the entire rota cycle, we determine the 'total hours worked when not on leave', which is our numerator.

Thus, total hours worked when not on leave

$$= \text{Total hours in rota} - \left[\text{hours in leave week} \times \frac{\text{leave entitlement} \times \text{weeks in rota cycle}}{52} \right] \quad \textbf{(3)}$$

Weeks worked in rota cycle when not on leave

This is the denominator for our equation. In our example, to determine the number of weeks worked in the rota cycle when not on leave we need to take the five rostered weeks and subtract the one week leave, giving four weeks.

To apply this to all rota types, we must take the number of weeks in the rota cycle and subtract the proportion of leave which to each junior is entitled. This last figure we determined in equation **(2)**.

Thus:

$$\text{Weeks worked in rota cycle when not on leave} = \text{Weeks in rota cycle} - \frac{\text{leave entitlement} \times \text{weeks in rota cycle}}{52} \quad \textbf{(4)}$$

The Riddell formula

Therefore, taking equation **(1)**

$$\text{Average hours per week} = \frac{\text{total hours worked when not on leave}}{\text{weeks worked in rota cycle when not on leave}} \quad \textbf{(1)}$$

we can substitute in equations **(3)** and **(4)** to give:

$$= \frac{\text{total hours in rota} - [\text{hours in leave week} \times \frac{\text{leave entitlement}}{52}] \times \text{weeks in rota cycle}}{\text{weeks in rota cycle} - \frac{\text{leave entitlement}}{52} \times \text{weeks in rota cycle}}$$

If;

A = total leave entitlement for the year (in weeks)
B = number of weeks in the rota cycle
C = number of hours in a leave week
D = total hours worked in the rota cycle if no leave is taken
E = (A/52 X B)

Then;

$$\text{Average hours per week} = \frac{D - (E \times C)}{B - E}$$

Salaries

Junior doctors are paid on national pay scales, determined each year by the Doctors and Dentists Review Body (DDRB) after receiving evidence from the BMA and the Department of Health. The DDRB reports to the Secretary of State for Health and Secretaries of State for Scotland and Wales. The report is later made public, with the government's decision, for implementation on 1 April each year.

Each grade has its own pay scale. There are currently three points on the house officer scale, seven on the senior house officer scale, nine on the specialist registrar scale with five on the registrar scale and six on the senior registrar scale.

The top two points of the SHO scale and top two points of the SpR scale are in theory 'discretionary'. In practice the award of the two points should be automatic unless, for example, an employer is already taking action in respect of unsatisfactory performance. Advice should be sought from *ask*BMA (see page 175) if problems occur in this area.

Information

AL(MD)1/98 Pay and conditions of service of hospital medical and dental staff

AL(MD)7/98

DDRB report 2005

Starting salaries and retention of higher grade salaries

Junior doctors are normally paid at the minimum of the salary scale on appointment to a grade. However, if junior doctors have previous service, employers should appoint them to a salary level beyond the minimum of the scale and sometimes even to the maximum point where previous service allows. They cannot, however, appoint to an incremental point of a grade which is different to the grade being entered unless protected salary arrangements apply.

Information

PM(81)30 Annex A, paragraph 20

Terms and conditions of service, paragraph 121

NHS circular 1981(PCS)35(Scot)

HSS(TC8)13/82(NI)

New pay circular ref

Incremental dates

Except where previous service is counted, or where a practitioner has been paid on one of points 1 to 5 of the senior house officer scale for a period of five months or more in their last appointment prior to promotion to specialist registrar, the incremental date will be the date of taking up the post in a new grade. Where previous service is counted, the number of completed months service will determine the incremental date. The incremental date for existing higher specialist trainees who transferred to the specialist registrar (SpR) grade during the

specialties' transition period remained the same (ie was not reset to the date on which they entered the SpR grade).

Information
Terms and conditions of service, paragraphs 122 to 125, and 133c

Counting of previous service

Regular appointments

AL(MD)2/96

AL (MD) 6/2002

Where a junior doctor is appointed to a post in a grade having already given regular service in one or more posts in that grade, or in a higher grade, all such service will be counted in full in determining starting salary and incremental credit.

Locum posts

Where a junior doctor has held a regular appointment in a grade or higher grade, all subsequent locum service in that grade (or higher grade) will count towards incremental credit as though it had been service in a regular post.

All other locum service counts towards incremental credit as though it had been service in a regular post but only at half rate. However, only service of three or more continuous months duration will be considered. Service by agency locums counts in the same way as that by NHS locums. Service in an LAT post counts in full for incremental credit, even if this is the trainee's first appointment in the specialist registrar grade.

Counting of service while on annual leave

Absence on annual leave counts for incremental purposes.

Counting of service while on maternity leave

Absence on maternity leave counts for incremental purposes.

Service outside NHS hospitals

Information
PM(81)30

1981(PCS)35(Scot)

HSS(TC8)13/82(NI)

Terms and conditions of service, paragraphs 81(a)

AL (MD) 3/02

Equivalent service or service in a higher grade outside NHS hospitals including overseas service, other than locum service, may be considered for incremental purposes. Details are available to members from *ask*BMA (see page 175).

Hospital service in Northern Ireland, the Isle of Man, and the Channel Islands, should be counted for the purposes of incremental credit and protection of salary as though it were service in the NHS.

Practitioners in the grades of SR, SpR, R, SHO, HO and PRHO who are required as part of their approved training programme to

work in non-NHS organisations shall be guaranteed continuity of service for employment purposes.

Promotion increase

Where a junior doctor has been paid in their previous regular appointment at a rate of salary higher than or equal to the rate which they would be paid at the bottom of the scale on taking up their new appointment, then the starting salary in the new appointment should be fixed at the point in the scale next above that previous rate, or at the maximum of the scale if the previous rate had been higher. A junior doctor's basic salary (excluding salary supplement) should not decrease on promotion to a higher grade, ie should always be equal and normally higher.

Rate of salary paid in previous appointments only includes basic pay for these purposes.

If, prior to taking up a regular appointment as a specialist registrar, a doctor has undertaken a locum appointment in this grade, the incremental date will be brought forward, counting completed service at half rate or in full.

Information

Terms and conditions of service, paragraph 133

Terms and conditions of service, paragraphs 129 and 130

Increments on first appointment to a grade

Specialist registrar/registrar

On first appointment as a specialist registrar or registrar, one increment and one only should be given for any more than two years service spent previously in the SHO grade.

Senior registrar

On first appointment as a senior registrar, one increment should be given for each year in excess of three spent as a registrar, up to a maximum of two increments.

Protection of higher grade salary

Information

Terms and conditions of service, paragraph 132

Additional guidance in circular PM(81)30

1981(PCS)35(Scot)

HSS(TC8)13/82(NI)

Where a practitioner takes an appointment in a lower grade for the purpose of obtaining approved training (which could include training to enable the junior doctor to follow a career in another specialty), the doctor, while in the lower grade, should continue to be paid on the incremental point they reached in their previous appointment. Salary supplements are paid as a proportion of the protected salary, even if the protected salary is that of a career grade, eg staff grade. A doctor in this position working an on-call rota would thus be paid a salary supplement according to the post in the lower grade calculated as a proportion of the protected staff grade salary. On re-appointment to the higher grade, the starting salary should be assessed as if the period spent in the approved training grade had been continuous service in the previous higher grade. A junior doctor seeking to retain their higher grade salary should make an application to do so to the new employer prior to taking up the new post.

It is important to note that retrospective claims for retention of higher grade salary are normally acceptable though it is better by far to arrange this in advance.

Junior doctors will need to prove to their new employer that the appointment in the lower grade has been taken in order to further a postgraduate training programme. Therefore written evidence to this effect should be obtained from the former employer and/or regional postgraduate tutor or dean.

If a junior doctor takes a lower graded post in order to fulfil examination criteria, the employer is under no obligation to grant retention of the higher salary automatically. The Department of Health advises that such applications should be considered on their individual merits.

Overpayment or underpayment of salary

Information

FDL(98)02

In cases of overpayment of salary, it would be unreasonable for the employer to take back the full amount in a lump sum; instead, to avoid hardship, the money should be deducted gradually from the monthly pay, with the doctor's consent. No interest should be charged. In some circumstances, repayment may be waived. Because some overpayments are not recoverable in law, junior doctors should seek advice from *ask*BMA (see page 175) before agreeing to any repayment.

In cases of underpayment of salary, the employer should pay the sum owing as soon as possible; the doctor should not be required to wait until the next pay day.

Information
Pay Circular (M&D) 1/2005

In both situations, members are advised to contact *ask*BMA (see page 175).

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 *ask*BMA (see page 175). 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 which 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.

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.

Information

BMA guidance note: Fees for part-time medical services, and relevant fees guidance schedules.

Private and category 2 fees for junior doctors

Junior hospital doctors can earn fees for their services to private patients in some circumstances. Where junior doctors attend private patients outside their contracted hours they are entitled to receive payment. In carrying out private work, junior doctors' total hours of work should not exceed New Deal 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.

Fees are payable for other services, such as completion of cremation certificates, court and legal fees and unsupervised family planning work: these are regarded as category 2 fees. These fees are taxable and should be declared on an annual tax return or the junior doctor risks Inland Revenue investigation. Local tax inspectors take a close interest in returns from funeral directors.

The specialist registrar (SpR) grade*

* Please note that, in most instances, references to the grade of specialist registrar also refer to the pre-Calman (see below) registrar and senior registrar grades.

The Calman Report

In 1992, a working group under the chairmanship of the then Chief Medical Officer, Sir Kenneth Calman, was set up to advise the Secretary of State for Health on any action needed to bring the UK into line with the EC directives on medical training. The working group's report (the 'Calman Report') was published in April 1993 and included the following important recommendations:

- the introduction of improved training programmes, which should be shorter, more structured and better organised
- the establishment of a single training grade to replace the career registrar and senior registrar grades
- the introduction of the certificate of completion of specialist training (CCST).

In 1995, the specialist registrar (SpR) grade replaced the registrar and senior registrar grades, with no new appointments being made to the old grades.

References

Hospital doctors: training for the future: the report of the working group on specialist medical training (April 1993)

A guide to specialist registrar training: NHS Executive (February 1998)

AL(MD)2/96 Terms and conditions of service for the specialist registrar grade

Modernising medical careers

Information

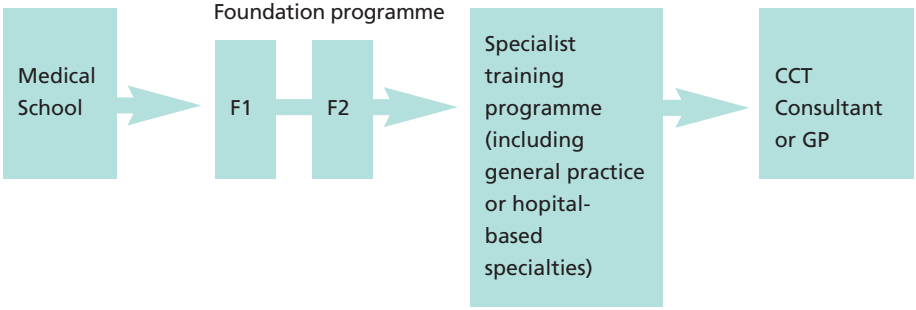
CMO. A paper for consultation. Unfinished business: proposals for the reform of the SHO grade. August 2002.

UK Departments of Health. Modernising medical careers: the response of the four UK health ministers to the consultation on 'Unfinished business: proposals for reform of the senior house officer grade'. February 2003.

The Department of Health's Modernising Medical Careers (MMC) initiative represents a radical change to postgraduate training and medical career structures. JDC has been working closely with the MMC team inputting the views of junior doctors and offering both support and constructive criticism. Much of MMC is still at the planning stage and what follows is an outline of those plans as they stand at present (April 2005).

The main difference between the old system and MMC will be that progress through training will no longer be determined by experience and knowledge but by evidence of the outcomes of training demonstrated through competency-based assessment. The aim is to implement focused, streamlined training for all grades. This should reduce bottlenecks in the SHO grade and other barriers to career progression fostered by the present system.

The current model of training, ie one-year PRHO, two to five years SHO and five years SpR training, is likely to be replaced by a model similar to the following:



NHS Modernising Medical Careers. Operational framework for foundation training. April 2005.

Foundation programmes

Final-year medical students will apply for a place on a foundation programme via an annual matching scheme to new foundation schools under the auspices of postgraduate deans. The opening date for the **submission** of applications is likely to be October for a start date in the following August. Interviews are not likely to be part of the matching process. Candidates will need to apply to their first choice of foundation school (or unit

of application only. Those who do not gain a place at the first choice of foundation school will have their documentation automatically forwarded to their next ranked choice of school. This process may be repeated until all available places are filled. Graduates will then be matched to two-year foundation programmes, attracting a two-year contract of employment.

Medical schools with graduation dates that are out of phase will gradually be brought into line with a national application deadline and August start date. In the meantime, deaneries/foundation schools in these areas should have special arrangements in place to accommodate affected graduates. Others needing out of phase start dates because of either personal reasons or failing exams etc, should inform their deanery/foundation school as soon as possible so that their date can be deferred. These graduates should not normally lose their place in the deanery/foundation school.

Foundation year one (F1) programmes will be implemented from August 2005. They will correspond with the existing PRHO year except that in many cases trainees may complete three, four-month placements, instead of two posts of six months' duration. The GMC, along with the postgraduate deanery, will continue to be responsible for this stage of training and F1 trainees will need to demonstrate areas of competence outlined in the GMC's *The new doctor* in order to be recommended for full registration at the end of the first year.

Foundation year two (F2) programmes will begin in earnest in August 2006. The F2 year will equate with SHO year 1 but, again, the year is likely to consist of three, four-month placements. The Postgraduate Medical Education and Training Board (PMETB), along with the deanery, has responsibility for postgraduate training from this year onwards. The competencies to be achieved over the course of F2 are those outlined in the joint MMC/Academy of Medical Royal Colleges curriculum.

Foundation programmes (FPs) should, within a structured programme, deliver training in the broad, generic, competencies that every doctor will need during his/her career. They are designed to give trainees the opportunity to experience a range of clinical settings. It is not thought that any specialty-

GMC. The new doctor: guidance on PRHO training. January 2005.

F2 Curriculum Committee of the Academy of Medical Royal Colleges, MMC Implementation Group in the Department of Health. Curriculum for the foundation years in postgraduate education and training. April 2005.

UK Departments of Health. Modernising Medical Careers. The next steps: the future shape of foundation, specialist and general practice training programmes. April 2004.

BMA Medical Students Committee. Application to foundation programmes – a proposal. February 2005

BMA Junior Doctors Committee. The shape of specialist training – aspirations for seamless progression. February 2005.

BMA Junior Doctors Committee. Supplement to 'The shape of specialist training' – Informing selection to specialist training from foundation programmes. February 2005.

BMA Junior Doctors Committee. Discussion paper on an integrated training system for junior doctors. January 2001.

specific training will take place during FPs but the chance to explore career choices and potential should be offered in the form of taster experiences and opportunities to develop personal development portfolios.

F2 trainees will need to provide evidence that the competencies outlined in the curriculum have been achieved, through new in-work assessment tools and a summative assessment process at the end of F2.

Trainees be expected to keep and develop a training portfolio to support foundation training and help to inform the educational appraisal process.

Doctors wishing to undertake F2 training in a different foundation school to that of their F1 appointment will need to apply either for an inter-deanery or a competitive transfer. It is likely that inter-deanery transfers will only be granted if there are well-founded reasons, such as health issues, carer responsibilities or research opportunities and will depend on whether places are available in the receiving deanery.

Further information about the application process and detailed information about how the foundation programme will work can be found in the MMC document *Operational framework for foundation training*, available on the MMC website www.mmc.nhs.uk. A rough guide to foundation training will also be sent to final year medical students before they begin the application process.

Specialist training

Post-foundation specialist training (general practice or hospital-based specialities) will involve a new integrated and streamlined training programme combining SHO level basic specialist training and SpR level higher specialist training. The original aim of the new 'run-through grade' was to provide the same kind of organised, structured programmes with clear curricula for SHO level as currently exists for SpR level training, but within a seamless training programme incorporating both grades with progress monitored through competency-based assessment.
PMETB and the medical royal colleges together have been charged with developing the new programmes and with reviewing

the length of training programmes. This will done on a specialty-by-specialty basis. Proposals should be finalised by September 2005 and the new programmes should be ready for implementation in August 2007.

The JDC hopes that specialist training programmes will include the following characteristics:

- seamless progression from foundation programmes to specialist training
- broadly-based specialty training at first, progressing to greater specialisation
- flexibility if career aspirations change, with recognition of previous experience
- rigorous in-training assessment
- flexibility to allow the pursuit of academia, out-of-programme experience and the opportunity to train less-than-full-time
- good career counselling and efficient manpower planning.

The JDC has outlined its aspirations for reform of postgraduate training in a number of documents, including *The shape of specialist training: aspirations for seamless progression* (February 2005). These are all available on the junior doctors' pages of the BMA website www.bma.org.uk .

There is concern in some specialties that new training programmes will not deliver the same type of consultant as represented by the current certificate of completion of specialist training (CCST). Some MMC proposals include the need for 'deep specialisation' to occur at a post-CCT* stage. Any such post-CCT training may depend on local service demand. Since these plans emerged, JDC has been continually campaigning against the danger of undermining the quality of training of consultants and the creation of a two-tier consultant service.

* Under the auspices of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003, from 30 September 2005 PMETB will issue certificates of completion of training (CCTs) rather than CCSTs. CCT-holders will still be eligible for inclusion on the specialist register and for consultant posts.

MMC timelines

April 1993	Department of Health publishes *Hospital doctors: training for the future (the report of the working group on specialist medical training).*
January 2001	BMA Junior Doctors Committee publishes *JDC discussion paper on an integrated training system for junior doctors.*
August 2002	CMO publishes a paper for consultation: *Unfinished business: proposals for the reform of the SHO grade.*
February 2003	UK Departments of Health publish *Modernising medical careers: the response of the four UK health ministers to the consultation on 'Unfinished business: proposals for reform of the senior house officer grade'.*
July 2003	Department of Health publishes *Choice and opportunity: MMC for non-consultant career grade doctors.*
April 2004	UK Departments of Health publish *The next steps: the future shape of foundation, specialist and general practice training programmes.* April 2004.
April 2005	F2 Curriculum Committee of the Academy of Medical Royal Colleges, MMC Implementation Group in the Department of Health. *Curriculum for the foundation years in postgraduate education and training.*

Forthcoming

May 2005	NHS MMC *Operational framework for foundation training* due for publication.
June 2005	*Rough guide to the foundation programme* due for publication (for medical students) Selection methods for specialist training to be agreed in principle.
August 2005	First year of the foundation programme begins.
September 2005	Specialty training review conclusions. September 2005.
October 2005	Workforce transition management arrangements to be agreed.
August 2006	Application process for specialty selection to be agreed.
August 2007	First MMC cohort enters specialist training.

Contract information

At the time of writing the terms and conditions of service (including salary scales, leave etc) for F1 and F2 trainees should be commensurate with the PRHO and SHO year 1 grades respectively. We expect negotiations with the JDC on terms and conditions of service to cover the new system to be underway shortly**.** Please see the junior doctors' section of the BMA website www.bma.org.uk for current information and contact *ask*BMA on **0870 60 60 828** for advice and assistance on offers and contracts of employment.

Appointments to the SpR grade

Until the regulations governing new specialist training programmes have been developed, and new terms and conditions of service have been agreed, the existing principles as outlined below will apply (please see contract information above).

Open competition

A competitive entry process for selection to specialty training programmes should be finalised by August 2006. Currently, entry to the SpR grade is through open competition, following an agreed appointments procedure. As with all appointments processes, the procedure must conform to employment law and good practice, including equal opportunities in selection and recruitment.

Advertising posts

Vacancies in training programmes must be advertised in a national medical journal. Advertisements are required to include a statement on equal opportunities and also the words: 'The postgraduate dean confirms that this placement and/or programme has the required educational and dean's approval.' It is advisable to check that a post is formally recognised and has been approved by the postgraduate dean to avoid the grave problems associated with non-standard posts.

A training programme description, the training and service requirements, person specifications and a standard application form should be available on request.

References

HSC 1998/229

MEL (1999)36 (Scot)

Terms and conditions of service, paragraph 313

A guide to specialist registrar training: NHS Executive February 1998

Pre-interview and pre-application visits

To find out more about the post, it is a good idea to make a pre-interview or pre-application visit. Such visits should be for the benefit of **candidates** not the employer, and they should not be seen as part of the selection process. With prior agreement from the prospective employer, specialist registrars may claim travelling expenses for such visits.

Appointment committees

In England and Wales appointment committees' membership should be:

- lay chair
- college representative
- postgraduate dean or his/her deputy
- a minimum of two and a maximum of four representatives of consultant staff from the trusts in the rotation
- university nominee
- programme director or chair of the regional specialty training committee
- trust senior management representative.

The membership may be slightly different occasionally to take account of a particular discipline, placement or rotation.

In Scotland the appointment committee will comprise at least five members including:

- a chair selected from a panel drawn up by the regional postgraduate dean in consultation with employers
- a member from the appropriate section of the National Panel of Specialists
- a member of the regional Postgraduate Medical Education Committee (usually the postgraduate dean or a deputy)
- a senior medical representative of the services principally involved in the training programme for the post in question (eg clinical director or consultant); and
- a consultant appointed by the relevant university.

Unsuccessful candidates

Unsuccessful candidates may obtain feedback on request from the chair or other members of the appointments committee. This should be linked to some careers counselling.

Successful candidates

Successful candidates will receive an offer of employment in the specialist registrar grade.

Once the offer is accepted, the candidate will be given a national training number (NTN).

(See the websites of the MMC, www.mmc.nhs.uk, PMETB, www.pmetb.org.uk, and the relevant medical royal colleges for up-to-date information on new MMC training programmes and pilots.)

National training numbers (NTNs)

Currently an NTN (Scottish training number (STN) in Scotland) is given to UK citizens and those who hold an indefinite right of residence entering the SpR grade on a substantive basis. The NTN is a unique, individual training number held so long as the doctor is in the SpR grade and also while out-of-programme activity agreed with the dean is being pursued. Although the NTN is mainly used for administrative purposes, it is extremely important in that it acts as a 'passport' for trainees, guaranteeing a continued place in a CCT training programme.

Visiting training numbers (VTNs)

A is given to overseas doctors who do not hold a right of indefinite residence in the UK and who have been appointed to a Type 1 training programme (ie, leading to the award of a CCT).

Fixed term training appointment numbers (FTNs)

FTNs are awarded in the following circumstances:

- to overseas doctors on fixed term training appointments (FTTAs)
- to doctors from other EEA countries who wish to pursue a specific training goal in the UK, and
- rarely to CCT holders undertaking post CCT sub-specialty training.

Education and training in the SpR grade

The information below was correct at the time of writing (April 2005). It should not noted that discussions regarding the structure and implementation of modernising medical careers (MMC) are ongoing and significant changes to this information may occur (see page 72 for further information on MMC).

Training agreements

All SpRs should have a training agreement setting out, in terms of education and training, the relationship and duties and obligations of all the main parties involved in SpR training. The agreement is between the SpR and the postgraduate dean, and may also involve the employing trust and the training programme director. It should set out not only what is expected of the SpR, but also what SpRs should expect to be provided, for example regular tuition by consultants and appropriate levels of protected study time.

Reference

UK Departments of Health. A guide to specialist registrar training. February 1998.

Assessment of progress

Assessment is designed to measure progress against defined criteria to meet an agreed standard. The procedure for assessment varies between specialties and deaneries but there should be regular informal discussions, as part of an appraisal process, to inform SpRs about progress. Each SpR will also have an annual review, conducted by a small specialty-based panel under the aegis of the deanery specialty training committee. At this review, decisions will be made about the individual's progress and training needs. Trainees should participate in their review and be provided with copies of all the documents taken into account in assessing progress. The Record of In-Training Assessment (RITA) is a record of the annual review and of the SpR's progress through the grade and is normally completed by the SpR and the postgraduate dean or their staff. If the result of the annual review is that progress is not judged satisfactory, there are three stages of action which may follow:

- stage one, a recommendation for targeted training
- stage two, a recommendation for intensified supervision or repeat experience; and
- stage three, withdrawal from the programme.

SpRs may ask for a review of the panel's recommendations under stage one. There is a right of appeal through the postgraduate dean against a stage two or stage three recommendation. SpRs who are experiencing problems because of unsatisfactory progress should seek advice from *ask*BMA (see page 175).

Appraisal

Appraisal is an organised series of meetings between trainee and trainer (educational supervisor) which focuses on the trainee and their personal and professional needs. It is not an assessment, or a series of ad hoc meetings, and should be properly planned during the course of a job.

The first meeting should occur soon after a junior starts a new post to establish previous experience, aspirations, training opportunities and expected standards. This should culminate in an educational plan that sets realistic objectives for the forthcoming period.

It is likely that the appraisal process will play an important role in the revalidation of junior doctors.

Breaks in SpR training programmes to work abroad

Trainees may retain their NTN whilst spending time abroad gaining further experience as long as the time out from the training programme has been agreed with the postgraduate dean, taking account of the advice of the relevant medical royal college. It is possible for some or all of the experience abroad to be accredited for training. More information on this issue is available in section 14 of *A guide to specialist registrar training*.

Sub-specialty training

Sub-specialty training should normally occur in the training period for the CCT. However, exceptionally, it may be possible to pursue sub-specialty training after the award of the CCT, for which a fixed training number (FTN) will be awarded. Currently, such post-CCT training is very exceptional and is carefully monitored to ascertain that it is appropriate.

(Please check with the websites of the MMC, www.mmc.nhs.uk, PMETB, www.pmetb.org.uk, and the relevant medical royal colleges for up-to-date information on any new arrangements for post-CCT training.)

References

SI 1995 No. 3208. The European Specialist Medical Qualifications Order 1995.

SI 2003 No. 1250. The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003.

SI 2004 No. 3365. The National Health Service (Appointment of Consultants) Amendment Regulations 2004 (accompanying guidance).

Award of the certificate of completion of training (CCT)

From 30 September 2005 the PMETB will take over the statutory responsibilities of both the Specialist Training Association (STA) and the Joint Committee for Postgraduate Training for General Practitioners (JCPTGP). Under its governing legislation it will issue certificates of completion of training to both hospital specialists and general practitioners. Thus from September 2005 CCTs rather than certificates of completion of specialist training (CCSTs) will be issued to those who have completed specialty training.

PMETB has given assurances that the award of a CCT will continue to indicate that a doctor has reached a standard compatible with independent practice, will grant entry to the Specialist Register and eligibility for a consultant appointment.

Once an SpR has successfully completed their training programme they may apply to the PMETB for a CCT (applications made before 30 September 2005 should be made to the STA). PMETB will charge doctors £250 as a one-off payment for awarding the certificate. Colleges should notify the PMETB of doctors successfully completing the training programme.

The PMETB is legally responsible for safeguarding standards of postgraduate medical training and ensuring that training requirements comply with European law. The GMC maintains and publishes the Specialist Register and, once the CCT has been awarded, doctors should apply to the GMC for inclusion on the Specialist Register. It is now a legal requirement for all doctors to be on the Specialist Register before they can take up a consultant appointment.

(Please see the PMETB website for further information on its function **www.pmetb.org.uk**.)

Appeals against a decision of PMETB

There will be an appeals mechanism which means that if the PMETB refuses to award a CCT, the doctor will be informed of the reasons why his or her application was turned down. In these circumstances there is a right of appeal to an independent review panel. Doctors are advised to review their case with the relevant medical royal college or faculty in the first instance, but

appeals can also be made directly to the PMETB.

It is important to note that PMETB will charge a fee of £1,000 for a written appeal and £1,500 for an oral appeal. The JDC opposes such high charges.

Leaving the SpR grade

Although the award of the CCT is an indication that training is complete and a doctor is eligible for a place on the Specialist Register and consultant appointment, it may take some time to be appointed as a consultant. Under current regulations, therefore, employment as an SpR does not formally come to an end until six months after the later of the following dates:

- the date of completion of training, or
- the date on which the SpR is notified formally by the postgraduate dean that training is complete and he or she is eligible for the award of a CCT.

All SpRs are eligible for this six month 'period of grace'.

If, at the end of the six month period, the SpR has not been appointed as a consultant, postgraduate deans may offer a further time-limited contract in the SpR grade. In order to do this, the postgraduate dean should be satisfied that the SpR has taken all reasonable steps to secure a consultant post. This new employment contract is for a single limited period and is not renewable or open to further extension. The length of time of the extension will be decided by the postgraduate dean in the light of predicted consultant opportunities in the specialty. In specialties in which there is a shortage of consultant opportunities, the postgraduate deans may decide to give all SpRs in the specialty the same period for the further contract. Before seeking or accepting such a further time-limited contract, advice should be sought from *ask*BMA (see page 175).

For either the six month period of grace or the period of a further employment contract, the postgraduate dean may ask the SpR to move to another post in the grade to maintain and develop skills, rather than remaining in the final placement.

Applying for consultant jobs

It is advisable to start exploring consultant opportunities in good time before the expected date of the award of a CCT. Specialist registrars are now able to apply for consultant appointments before gaining their CCT, on the understanding that the interview is no longer than six months before their CCT date and admission to the GMC's Specialist Register.

Members should contact *ask*BMA on 0870 60 60 820 for information about becoming a consultant and to obtain a copy of the BMA *Consultant handbook* at an early stage. BMA Regional Services also runs seminars on becoming a consultant.

Doctors who apply for consultant jobs which do not conform to national agreements should seek advice from *ask*BMA at the earliest opportunity and certainly before signing a contract.

Locums in the SpR grade

It is usually only permissible for locums to be appointed when a previously occupied SpR placement falls vacant or the post holder is away on leave. Locums may be appointed to one of two types of appointment:

- locum appointment – service (LAS): the appointment is to cover service elements only
- locum appointment – training (LAT): the appointment covers service elements and offers a training opportunity.

Locum appointments — service (LASs)

LAS posts should be short-term and limited to a maximum of three months. They are service based and, although they offer valuable experience of working as an SpR, there is little training benefit to be derived from such appointments. This should be made clear in advertisements. An NTN is not given for LAS appointments and no credit can be given against future CCT training programmes.

Locum appointments — training (LATs)

LAT posts do provide CCT training experience, and where possible the college should give **prospective** recognition to the applicant confirming that the LAT could count towards a particular training programme. LATs are designed principally for those who wish to enter the SpR grade and have reached the standard required to do so, but who have not yet been appointed to a substantive post. It is important to note, however, that it is not possible to obtain a CCT without a substantive placement in the SpR grade. LATs usually last for a duration of between three months and a year. An NTN is not given for LAT appointments.

Slightly different terms of service apply to LATs from those which apply to other locum appointments. Doctors in LATs are paid at the incremental point to which they are entitled because of previous experience, not the mid-point. Service in a LAT appointment counts in full towards incremental credit, even if it is the trainee's first appointment in the SpR grade. LATs may also claim removal or travel expenses in the same way as other SpRs.

Fixed-term training appointments (FTTAs)

FTTAs enable those appointed to undertake some elements of SpR training to acquire specific experience or to achieve a particular qualification. They are designed for overseas doctors without right of permanent residence in the UK who do not wish to, or cannot, pursue a CCT training programme. EEA non-UK doctors may also be appointed to an FTTA to undertake a specific training goal not leading to a CCT. Also, exceptionally, CCT holders may be appointed to an FTTA to obtain some post-CCT sub-specialty experience. FTTAs usually last for a period of between six months and two years. FTTA holders will be given an FTTA training number (FTN). Although appointment will not in itself lead to the award of a CCT, relevant training undertaken during the course of an FTTA may be counted retrospectively towards a CCT training programme.

Overseas doctors

The provisions for overseas doctors entering the SpR grade depend upon whether the doctor holds a right of indefinite residence in the UK. Those who hold a right of indefinite residence are entitled to hold a national training number and are, in general, regarded in the same way as EEA nationals.

Information

EC Directive 93/16/EEC

A guide to specialist registrar training: NHS Executive (February 1998), section 6

HSS (TC8) 15/98 (NI)

The provisions covering those who do not hold a right of indefinite residence are more complex. Such doctors may apply in open competition to be appointed to a Type I programme which will, if completed satisfactorily, lead to the award of a CCT. In such circumstances an overseas doctor will be awarded a visiting training number. Alternatively, doctors may either apply for or be placed by the postgraduate dean in a Type II fixed-term training appointment (see above) which will not lead to the award of a CCT. In such circumstances the overseas doctor will be awarded a fixed-term training appointment number). Further advice and information should be obtained from the postgraduate dean or *ask*BMA (see page 175).

Overseas doctors may also apply for locum appointments for training and locum appointments for service for which they do not receive a training number.

Further information

The above information refers to existing arrangements for the SpR grade only. Detailed information about all aspects of the specialist registrar grade is given in the UK Departments of Health document *A guide to specialist registrar training* (also known as the 'orange guide'). Copies are available in trust and postgraduate libraries and postgraduate deans' offices and on the Department of Health website: www.dh.gov.uk.

For information about new modernising medical careers specialist training programmes due to be implemented in 2007, or pilot schemes, please see the websites of the MMC, www.mmc.nhs.uk, PMETB, www.pmetb.org.uk, and the relevant medical royal colleges.

BMA members may obtain advice on individual queries from *ask*BMA (see page 175). Non-members should consult the local postgraduate dean.

Flexible training

Flexible (part-time) training allows doctors and dentists to work less than full-time in posts that are fully recognised for training, and have the educational approval of the postgraduate dean and the royal colleges. In some specialties it is possible to work flexibly for the whole of postgraduate training, whereas others require some of this training to be full-time.

Junior doctors are able to train on a flexible (part-time) basis if they have 'well-founded individual reasons' (EC Directive 93/16/EEC) such as domestic commitments, disability or ill health which prevent them from working full-time. It is the postgraduate dean, or associate dean with responsibility for flexible training, who confirms that an application by a junior doctor to train flexibly is well founded. The flexible training scheme for specialist trainees is outlined below.

A new deal to improve access to flexible training will be implemented from June 2005. The new deal has been agreed by the JDC, NHS Employers, UK health departments and the Conference of Postgraduate Medical Deans.

Information

EC Directive 93/16/EEC

A Guide to Specialist Registrar Training: NHS Executive (February 1998), Section 6

HSS (TC8) 15/98 (NI)

Pay Circular from NHS Employers

Application process

The following stages will normally be included in the application process for flexible training:

1. Advice and eligibility for flexible training sought in a meeting with the Postgraduate Deans representative.
2. Appointment through open competition in accordance with equal opportunities principles.
3. Agreement of training programme with deanery.
4. Approval of training programme by Regional Specialty Education Committee/Programme Director on behalf of Postgraduate Dean and Royal College.
5. Funding approval by deanery and employing trust.

Trainees should remember that the application process may take up to three months to complete and they should give as much notice as possible to facilitate the process.

It is not part of an appointment committee's job to consider whether a candidate wishes to train flexibly on taking up a post

or in the future and candidates do not need to state at interview that they wish to train flexibly. However, it is suggested that potential applicants discuss with the postgraduate deanery their intention to train flexibly at the earliest opportunity.

Deaneries now offer a number of different ways of incorporating flexible training into rotas. There are three types of ways in which doctors can train flexibly, these are slot-sharing, supernumerary posts and job sharing

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 flexible 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. This arrangement is not to be confused with a 'job-share'.

Supernumerary posts

Supernumerary posts can be offered when flexible trainees can not be placed in a slot-share because there is not a suitable partner or where flexible training is needed at short notice. Supernumerary posts are additional to a normal complement of trainees.

Job-shares

The JDC does not support job-share arrangements where two trainees apply and are appointed to a full time post together. In job-share arrangements it is usual for two trainees to share a full time salary, work half the hours and receive 50% of the training opportunities. Job shares can sometimes be confused with slot shares which are different.

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

Flexible Careers Scheme

The Department of Health launched the 'Flexible Careers Scheme' in 2002 as part of the improving Working Lives initiative. The Scheme, run by NHS Professionals, provides doctors with an opportunity to work flexibly with in the NHS while being supported in maintaining their careers. However the posts are not recognised for training purposes as trainees are only up able to work upto 50% of a full time commitment. Doctors can work from two to four sessions per week with no on-call or weekend commitments. Further information can be obtained from NHS Professionals on 0845 60 60 345 or from the Department of Health website: http://www.dh.gov.uk

Pensions for flexible trainees

It should be noted that any part-time working is scaled down to its whole time equivalent in calculating the pension payable, although some out-of-hours work may be taken into account. For instance, if a doctor worked half time for 40 years, the pension would not be 40/80ths of final salary, but half of 40/80ths. Full details of how the NHS pension is calculated can be found in the BMA guidance note Salaried Doctors.

For flexible trainees contracted to work fewer than 40 hours of duty per week, pensionable pay for contributions purposes will be the appropriate proportion of actual whole-time basic pay (1.0). However, contributions must also be paid on any additional hours of duty a doctor works between their contracted hours and a maximum of 40 hours per week. **Employers must make arrangements to track and record these additional hours for pension purposes**.

Pensioning of overtime pay under the ADH system

Although over-time pay for junior doctors is not usually superannuable, under the contract used until 01 December 2000, flexible trainees should have been pensioned on any pay they received up to 40 hours, including additional duty hours (ADHs). However, for many years, trusts failed to do this because of an administrative error.

Agreement was reached with the NHS Pensions Agency in November 2000 on repayment of pension contributions where flexible trainees had not been pensioned on their ADHs.

Employers will have to make up the payments which they should have paid and should also notify the flexible trainees who did not pay the correct pension contributions. Those doctors will have the option to:

- make a single payment
- pay back their contributions within three years, interest free; or
- pay back their contributions as a lump sum on retirement accruing interest at 5% per annum prior to retirement.

There will be a reduction of 25% from the amount the doctors have to repay in recognition of the fact that if they had paid the contributions when they should, they would not have been taxable. The Pensions Agency will inform employers of this arrangement and it will be the employer's responsibility to contact those affected.

It is important that those who worked flexibly under the ADH system have their previous pension contributions corrected so that correct pension credit is accrued and final calculation of pension can be made. For example, for each year that was worked where 40 hours should have been pensioned but were not, only six months' pension credit will have been accrued. When corrected, a full year's pension credit will be given.

Further guidance on this issue is available from *ask*BMA (see page 175).

Locum work in the NHS

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. **This section explains the terms and conditions of service for locum doctors employed by the NHS**. 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.

Unless prospective cover arrangements are in place employers are obliged to obtain a locum to cover a junior doctor's annual and/or study leave. Employers are also obliged to obtain a locum to cover sick leave and maternity leave, which can never be covered prospectively. Trusts 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, they should be paid according to the locum rates under the pay banding system.

Responsibility for arranging locum cover

Information

Terms and conditions of service, paragraph 110e

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.

Locums and the New Deal

Junior doctors may only be employed on a locum basis by their own employers provided that such employment does not cause their average weekly hours to exceed the limits in the New Deal, except in circumstances where they are acting up as a consultant.

It is a contractual term that junior doctors should not undertake locum medical or dental work for any other employer where such work would cause their contracted hours to breach the New Deal limits.

External locums

Information

EL(94)32 – Hospital medical and dental staff: locum tenens engaged through private agencies

External locums engaged through an agency are paid according to the rate negotiated by the agency. This rate was previously capped but now employers are allowed to negotiate locally the best arrangements for their particular circumstances.

MEL(1994)41 (Scot)

AL(MD)1/2001

External locums engaged directly by employers for a week or less are paid in accordance with the locum rates agreed under the pay banding system.

In all cases, the rate is that appropriate to the grade of the doctor being covered (not the locum's own grade).

Internal locums

Information

Terms and conditions of service, paragraphs 111a-e

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.*

AL(MD)1/2001

Under internal locum arrangements, employers pay junior doctors providing locum cover in their own hospitals, or associated hospitals identified in the job description, at locum rates agreed for the pay banding system for the whole time they are on duty, provided that such work is undertaken when the doctor would otherwise have been off duty. If cover is being provided outside the doctor's main hospital, external locum arrangements apply.

Internal locum arrangements, unlike prospective cover arrangements, allow doctors to be paid at the locum rate of the grade of the doctor being covered. The hours can be claimed at the locum rate, or if the doctor wishes, leave may be taken in lieu.

When a junior doctor performs work on a locum basis for their employer, and the agreement of the employer is not secured in advance, the junior should claim payment at locum rates, using the retrospective claim form. Employers should designate a person responsible for authorising retrospective payments and ensure that the doctor is paid as quickly as possible.

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

Under the pay banding system, locums are paid on the following basis:

Band LA

For locums employed to cover a shift working pattern, hours outside Monday to Friday, 9am to 5pm, are paid at the following rate: 1.8 x basic hourly rate*

Band LB

For locums employed to cover an on-call rota, hours outside Monday to Friday, 9am to 5pm, are paid at the following rate: 1.5 x basic hourly rate*

Band LC

For locums employed on any working pattern, all hours within Monday to Friday, 9am to 5pm, are paid at the following rate: 1.4 x basic hourly rate*

Band LL

For locums employed to cover a post for one week or more are paid at the following rate: 1.2 x total salary (basic salary* + banding supplement) of the post being covered.

* Mid-point of the grade salary scale (for SHOs this is the average between the third and fourth points given that there are currently six points on the SHO incremental scale).

Locum appointments training (LATs)

Information
AL(MD)1/2001

AL(MD)1/2003

Junior doctors in locum appointments for training (LAT) 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

Information
Terms and conditions of service, paragraph 117

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 leave at the rate of five or six weeks per 12 months' continuous locum service, depending on the grade being covered. 'Continuous locum service' means service as a locum in the employment of one or more employing trusts 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.

Information
Terms and conditions of service, paragraph 211-213

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

Information
Terms and conditions of service, paragraph 241

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.

Travelling expenses

Information
Terms and conditions of service, paragraph 289

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.

Specialist registrar grade

When vacancies arise in the specialist registrar grade, three types of appointment can be made to cover these:

- 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)
- a fixed term training appointment (FTTA) which offers an individual training programme as well as service cover.

Further details of all of these can be found in the Department of Health's publication *A guide to specialist registrar training*. Advice is available to members from *ask*BMA (see page 175).

Information

A guide to specialist registrar training: NHS Executive February 1998, Section 5

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 on liability between the doctor and the employer.

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

References

HSG(96)48 Indemnity arrangements for clinical negligence claims in the NHS

1998(PCS)32 (Scot)

MEL (2000) 18

HSS(TC8)12/90 (NI)

BMA guidance note: Medical indemnity in the NHS

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)
- PRHO 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 trust
- 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
- clinical trials not covered under legislation
- work for other agencies on a contractual basis or work 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, DSS etc and making court appearances. As a general rule, category 2 work is that which is not principally to do with the prevention, diagnosis and treatment of illness, and a fee can usually be requested from a body outside the NHS. 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 New Deal and EWTD, would be covered by NHS indemnity and defence union cover.

Changing defence union

Doctors who are thinking of changing defence union should consider the wider implications of such a transfer, for example which union will provide cover for past events.

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 www.informationcommissioner.gov.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.

Please consult your medical royal college if you feel you are placed in breach of the Act.

Career guidance

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. Personal choice involves a number of factors, for example job satisfaction, desire for direct patient contact, research opportunities, variety, freedom, and so on. Personality plays an important part in the final choice; some graduates may prefer to work in specialties such as pathology or public health medicine rather than the clinical disciplines which involve direct contact with patients.

Under the new modernising medical careers (MMC) structure, career choices will need to be made early on within the first few, foundation, years after graduation. At the end of foundation year 2 most trainees should immediately compete for entry to a specialist or general practice training programme etc, and so will need to make important career decisions about half way through the F2 year. Placements within foundation programmes (FPs) should provide trainees with tasters of a range of different specialties and areas of medicine. Time spent in different specialties is good experience and provides an opportunity to obtain first hand knowledge of fields about which people may be unfamiliar or even unaware. However, although it is expected that FPs will allow an element of choice of which specialties are undertaken, the training itself is designed to develop generic, rather than specialty-specific skills. The chance to explore career choices and potential should, however, be offered in the form of taster experiences and opportunities to develop personal development portfolios. Good career information and advice will nevertheless be essential to trainees at this stage.

The MMC reforms should replace the current inconsistent and ad hoc arrangements for careers advice with an integral, structured and appropriate career management service with support for all medical students, doctors in training and established doctors throughout their careers. Postgraduate deaneries will continue to have ultimate responsibility for the career management of doctors in training. Further information about the new arrangements should be available from the deanery.

References

BMA guidance note: Medical careers – a general guide

BMA Board of Medical Education. Sign-posting medical careers for doctors. June 2003.

BMA Board of Medical Education. Medical specialties: the way forward. February 2005.

NHS Modernising Medical Careers. Operational framework for foundation training. April 2005.

Modernising Medical Careers. Career blueprint for doctors – a blueprint for delivery. (DRAFT). February 2005

BMA Consultant handbook. 2005.

Department of Health. The NHS improvement plan: putting people at the heart of public services. June 2004.

JDC looks forward to the current inconsistent, informal and ad hoc arrangements being replaced with an improved and established career support system for junior doctors. However, there is still concern about the need for independent, impartial and wider career advice. JDC has therefore proposed that the BMA establishes its own careers advice services. A business plan for this is currently being developed in conjunction with BMJ Careers.

British Medical Journal (*BMJ*) careers advice zone

The *BMJ* Careers Advice Zone helps doctors and medical students in their quest for accessible, impartial careers advice. The Advice Zone can be used to submit a question to a panel of over 200 experienced advisers, search the database of existing questions and advice, and to share careers advice with other users. It can be reached at **www.bmjcareersadvicezone.synergynewmedia.co.uk**.

Choosing a specialty

The most obvious way of getting to know about a particular specialty is to talk to someone who is already practising in that discipline. Further guidance can be sought from regional postgraduate deans or clinical tutors in trusts, the councils for postgraduate medical education in Scotland and in Northern Ireland or from regional advisers in general practice. Each medical royal college has regional advisers from whom information is also available. The BMA and other organisations hold careers fairs from time to time to disseminate information on the various specialties and expert advice is available at these fairs. Details can be obtained from *ask*BMA on 0870 60 60 828.

Choosing a career — top five tips

Research options carefully and use all sources of career advice available

- speak to a practitioner in the field
- consult postgraduate deaneries for advice
- contact the appropriate medical royal college
- read the BMA's Board of Medical Education publication *Medical specialties: the way forward* * (available on the BMA website www.bma.org.uk).

Think about options that will suit your personality and skills

- consider taking a psychometric test
- think about life experiences and ambitions and where these might lead.

Think about options that will suit your lifestyle

- use flexible training and working options
- consider the on-call commitment for different specialties.

Don't rush into making a decision

- consider taking flexible training pathways that keep options open.

When considering posts ensure that the contract and the conditions of service are fully understood

- BMA members can contact *ask*BMA for employment advice and information on 0870 60 60 828.

* Box reproduced from this report with gratitude.

It should be noted that competition in some specialties is immense. Some thought should be given to staffing numbers: the supply and demand of doctors and the resulting career opportunities. For many years too many doctors have wanted careers in some hospital specialties such as general medicine, general surgery and obstetrics and gynaecology, and fewer in, for example, radiology, geriatrics and psychiatry.

The *NHS Improvement plan* in 2004 proposed a move away from the centrally prescribed national targets on the number of doctors needed to support service delivery. Consequently, several new bodies have been established to provide workforce planning advice to make certain that the NHS has sufficient staff to meet patient demand and meet NHS targets. Of these the National Workforce Development Board (NWDB) is responsible for delivering the required numbers of training commissions that underpin the future development of the medical workforce. It is supported by the Workforce Numbers Advisory Board (WoNAB) which continues to oversee workforce planning at a national level. WoNAB brings together experts on workforce planning on a multi-disciplinary basis to advise on numbers of future training

References

BMA Consultant handbook. 2005.

BMA Board of Medical Education. Sign-posting medical careers for doctors. June 2003.

BMA Board of Medical Education. Medical specialties: the way forward. February 2005.

NHS Modernising Medical Careers. Operational framework for foundation training. April 2005.

Modernising Medical Careers. Career blueprint for doctors – a blueprint for delivery. DRAFT. February 2005

BMA Consultant handbook 2005.

Department of Health. The NHS improvement plan: putting people at the heart of public services. June 2004.

places that should be made available and works in collaboration with workforce development confederations (WDCs) and care group workforce teams (CGWTs).

Medical royal colleges should hold information on the number of training posts and the number of consultant posts likely to be available in each specialty in future years.

Careers outside the NHS

Junior doctors may also wish to consider other career options outside the National Health Service. These include: clinical academic medicine, full-time research, the civil service, armed forces medicine, pharmaceutical medicine and occupational medicine.

General practice or a hospital career?

Doctors who choose general practice will probably achieve their career posts (ie become principals or non-principals in general practice) at an earlier age than their hospital consultant colleagues who have a longer training period, even after implementation of the MMC reforms. One of the attractions may also be to have a settled home and a higher income at an earlier age, perhaps by age 28 or 30, than in the hospital service.

Another difference between a career in general practice and hospital medicine is the pay structure. Whereas GPs may expect to have fairly uniform pay throughout their careers, hospital doctors will earn less during their training years, but their final pay at retirement is likely to be higher than that of their GP colleagues.

Thinking of working abroad?

The BMA's International Department also publishes *Working abroad: a guide for BMA members* and *Opportunities for doctors in the EEA*. These are available on the website www.bma.org.uk. The first report gives specific advice on some of the developed countries in which junior doctors are likely to work as well as on working in developing countries; and the latter on legislation which enables doctors to live and work in other member states of the European Economic Area as well as information on the different health care systems and registration.

Working with BMA Regional Services, the BMA's International Department also arranges evening seminars on the subject of working abroad. The seminars are held at locations around the country and aim to give a general introduction to those who are interested in temporary employment in developed or developing countries, at a postgraduate level. Expert speakers cover issues such as integration with an NHS career, registration and immigration procedures and working for agencies. For further information on the seminar dates and locations, please contact the BMA's International Department on 020 7383 6491.

Annual leave

Basic entitlement

The basic annual leave entitlements for junior doctors are as follows:

Specialist registrar (third or higher incremental point)	6 weeks
Specialist registrar (minimum, first or second incremental point)	5 weeks
Senior registrar	6 weeks
Registrar	5 weeks
Senior house officer	5 weeks
House officer	5 weeks

Calculating annual leave entitlement

As junior doctors work more than a standard working week, there has always been confusion as to what constitutes a week's leave in terms of number of days off. This has led to employers adopting different ways of calculating annual leave entitlements; for instance, some employers calculate annual leave on the basis of a five, six or seven day working week.

Information

Terms and conditions of service, paragraphs 205-217

GWC handbook, section 1

Leave taken in complete weeks

When annual leave is taken in complete weeks, one week should be any period of seven consecutive days. This would include weekends, whether or not there is an on-call commitment.

HC(PC) (77)6

HSS(TC8) 16/77 (NI)

Leave taken in odd days

When annual leave is taken in periods of one or more days which do not correspond to complete weeks, the entitlement needs to be expressed in days. The recommended standard formula is as follows:

Weeks' leave x week length

where the weeks' leave are five or six depending on grade, and the week length is the average number of days of the week on which there is a contractual commitment irrespective of the duration or type of commitment on any particular day.

Examples

1. An SHO is entitled to five weeks' annual leave. An SHO on a 1 in 4 rota would have a weekly commitment of five days (Monday-Friday) plus two weekend days divided by the number on the rota (ie 2 ÷ 4 = 0.5 days).

   This SHO's average weekly contractual commitment is therefore 5.5 days.

   The SHO's annual leave entitlement is therefore:

   5 x 5.5 days = 27.5 days pa

Information
GWC handbook, section 2

2. A specialist registrar is entitled to six weeks' annual leave. A specialist registrar on a 1 in 4 rota would therefore have an annual leave entitlement of:

   6 x 5.5 days = 33 days pa

   The formula can also be applied to junior doctors working on a partial or full shift system.

Information
Terms and conditions of service, paragraph 214

GWC handbook, section 2

However, there are several other methods found in different hospitals, each of which has its advantages and disadvantages.

- The five day week. A complete week counts as five days, making the annual leave entitlement 25 or 30 days; weekdays including Fridays count as one day. Taking less than full weeks in this system may sometimes give a lower allowance than the recommended formula and should be brought to the attention of *ask*BMA (see page 175).

- The six or seven day week. A complete week counts as six or seven days, making the annual leave entitlement between 30 and 42 days depending on grade. This is usually achieved by counting Fridays as two or three days, the rationale being that this prevents the potential abuse of taking a large number of Fridays combined with requesting not to be on-call at the weekend.

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 *ask*BMA(see page 175).

Leave year

The leave year for specialist registrars, registrars and senior house officers runs from each doctor's incremental date. This is a recent change; prior to 2004, SpRs' and SHOs' leave years ran from 1 November to 31 October each year.

For house officers the leave period corresponds to the period of tenure of the post, and not more than four days' leave may be carried forward from one post to subsequent appointments.

Untaken leave

Where a junior doctor has been unable to take the full allowance of annual leave before the end of the 'leave year' they are allowed to carry over up to five days, subject to the exigencies of the service. Authorisation is required from the employer and payment in lieu of leave not taken cannot normally be made. Employers often restrict leave such that only one doctor per rota can be on leave at any one time. If junior doctors wait until the end of the post to take leave, they may not get it. Provided employers inform junior doctors of this at the start of the post, they can refuse to pay in lieu for leave not taken. 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.

The arrangements for house officers are given above under 'Leave year'.

Carry over of leave from one post to another is often contentious, and if possible should be agreed in advance with the new employer/consultant.

Information

Terms and conditions of service, paragraphs 250-254

HC(79)10 Hospital medical and dental staff: study leave

HP(PC)(77)12

1985(PCS)20 (Scot)

WPM(80)21 (Wales)

HSS(TM)3/75 (NI)

Transferring leave from post to post

Where a junior doctor transfers from one post to another in the NHS, they are permitted to transfer the balance of leave remaining in the leave year. House officers may only transfer up to four days' leave. The previous employer is responsible for notifying the next employer about the outstanding leave.

Notification of leave

Junior doctors are required to notify their employer when they wish to take leave, and the granting of such leave is subject to approved arrangements having been made for cover. It is usual for employers to ask for a minimum period of six weeks' notice of intention to take leave. Some employers have introduced planned leave arrangements in order to make it easier for them to provide locum or prospective cover. These arrangements can be to the advantage of all junior doctors on a rota or shift; however, such schemes must be applied in a reasonable manner and command the support of the junior doctors locally.

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 10 paid statutory and 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, and two additional days which may either be specified by the employer or be converted into annual leave. In Scotland, the statutory days consist of three public holidays at Christmas/New Year, with the remainder as determined by the employer in the light of local practice.

Part-time junior doctors are entitled to statutory and public holidays on the above days if they are normally working those days.

Information

GWC Handbook, Section 2

AL(MD) 4/2003

Working on public holidays

If a junior doctor is required to be on duty at any time, including between midnight and 9am on a statutory or public holiday they should receive a day off in lieu. If the junior doctor is required to continue working the normal day it may be possible to negotiate an additional day off in lieu. If it is not feasible to take these days in lieu, then pay in lieu can be given.

Prospective cover

See page 50.

Information

Terms and Conditions of Service, paragraphs 250-254

HC(79)10 Hospital Medical and Dental Staff: Study leave

HP(PC)(77)12

1985(PCS)20 (Scot)

WPM(80)21 (Wales)

HSS(TM)3/75 (NI)

HM(67)27

COPMeD. Guidelines for study leave. September 1998.

A position paper of the BMA's JDC and the Trainees Committee of the Academy of Medical Royal Colleges. Valuing learning: funding individualised study and professional development for today's doctor in training. May 2004.

NHS Modernising Medical Careers. Operational framework for foundation training. April 2005.

Study and professional leave

Definition

Study or professional leave is granted for postgraduate education or teaching purposes, and includes study (usually, but not exclusively or necessarily, on a course), research, teaching, examining or taking examinations, visiting clinics and attending professional conferences.

JDC has long been calling for a thorough review of existing study leave arrangements which it views as inadequate and widely variable. In May 2004 a position paper was produced in conjunction with the Trainees Committee of the Academy of Medical Royal Colleges, *Valuing learning: funding individualised study and professional development for today's doctor in training* (accessible on the BMA website www.bma.org.uk). This makes recommendations about the need to develop a more appropriate system of study leave to accommodate the new and changing circumstances of doctors in training in the UK.

The Conference of Postgraduate Medical Deans (COPMeD) is undertaking a review of study leave provision with JDC's recommendations in mind and this is welcomed. The information given below may also be subject to change with the implementation of new modernising medical careers training programmes. (Please see the MMC website, www.mmc.nhs.uk, and the COPMeD website, www.copmed.org.uk, for up-to-date information.)

Recommended periods

Although study leave is discretionary the terms and conditions of service state that it should normally be granted to the maximum extent consistent with maintaining essential services and within the recommended standards.

The terms and conditions of service recommend the following standards:

Pre-registration house officers/foundation year 1*

PRHOs should be granted reasonable time within working hours for attending, within the hospital, clinical/pathological conferences and ward rounds with other firms.

Post-registration house officers/foundation year 2* and other SHOs

Either
Day release for the equivalent of one day per week during university terms
Or
Up to a maximum of 30 days in a year. For this purpose the year is calculated from 1 October
And
Study leave to sit an examination for a higher qualification.

Specialist registrars

Either
Day release for the equivalent of one day per week during university terms
Or
Up to a maximum of 30 days in a year (for this purpose the year is calculated from 1 October)
And
Study leave to sit an examination for a higher qualification where it is necessary as part of a structured training programme (up to two occasions)
And
Study leave to sit other examinations for a higher qualification.

Senior registrars

One day per week for individual study and specified research projects, or its accumulated equivalent
And
Professional leave for up to 10 days per year cumulative over a three-year period.

Locums

Can claim study leave in the same way as substantive post holders.

Less than full-time trainees

Less than full-time trainees are eligible for study leave calculated pro rata based on their training commitments. They are entitled to the fully study leave funding allocation.

Foundation programmes

The exact arrangements for study leave during the new foundation programme have yet to be confirmed although F1 PRHOS will continue to be eligible for the allocation stipulated above. The initial draft guidance from the MMC team suggests that study leave during foundation training will not be used for the purposes of supporting specialist examinations. JDC welcomes this along with the introduction of formal study leave arrangements for PRHOs/F1 trainees.

The draft operational framework suggests that three hours bleep-free time may be set aside out of each week for F1 trainees. This may be aggregated to allow whole day-release for generic training (to a total of six days using one hour per week).

The draft operational framework also suggests that about 10 days of F1 and F2 trainees' study leave may be used to support the learning objectives of formal education programme. The BMA does believes that study leave should rather be used to provide the basis for supporting the doctors' wider professional development as well as to support learning about different specialties through taster experiences.

Applications

Regional postgraduate deans (in Scotland the Scottish Council for Postgraduate Medical and Dental Education) have overall responsibility for managing study leave budgets. Currently however, in most regions budgets have been devolved to district clinical tutors (postgraduate deans in Scotland and Northern Ireland and postgraduate organisers in Wales) or the appropriate NHS trust. 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. 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 trust.

Expenses

Employers should accept the natural consequences of granting study leave, so that all reasonable expenses associated with periods of approved study leave are paid. 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 practitioner 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 should be paid. Examination fees are not paid.

Some deaneries 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.

Professional leave for overseas conferences etc

Employers may at their discretion grant professional or study leave outside the United Kingdom with or without pay and with or without expenses or with any proportion thereof.

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 other arrangements will be in place to facilitate appeals. Further details of the local study leave policy may be obtained from the postgraduate dean. It is important that junior doctors do appeal because referral of refused applications will not otherwise occur.

(ii) **small claims court**. 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.

In Scotland, each postgraduate dean has an appeals procedure for study leave applications.

BMA members should seek advice from *ask*BMA on 0870 60 60 828 before embarking on an appeal.

Study leave for GP registrars

The GP Registrars Subcommittee of the General Practitioners Committee (GPC) has agreed policy on study leave for GP registrars. The guidance note *Study leave for GP registrars* is available on the BMA website www.bma.org.uk.

Sick leave

References are made throughout this section to paragraphs in the General Whitley Council handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the General Whitley Council has been replaced by a NHS Staff Council. At the time of writing, the GWC handbook was still in use for medical staff, but is likely to be replaced by an updated handbook in the near future.

Scale of allowance

Junior doctors absent from duty owing to illness, injury or other disability receive the following sick leave allowances:

- during the first year of service:
  one month's full pay and (after completing four months' service) two months' half pay.
- during the second year of service:
  two months' full pay and two months' half pay.
- during the third year of service:
  four months' full pay and four months' half pay.
- during the fourth and fifth years of service:
  five months' full pay and five months' half pay.
- after completing five years service:
  six months' full pay and six months' half pay.

Pay includes salary supplement.

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. In aggregating periods of absence, no account is taken of any absence on unpaid sick leave. Specific conditions apply to absence due to injury resulting from a violent crime. For the purposes of calculation of the allowance, 26 working days are equivalent to 'one month'.

Information

Terms and conditions of service, paragraphs 225-244

GWC handbook, Section 57

Previous qualifying service

All previous NHS service, (including locum service), 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, or on an appointment which is considered by the postgraduate dean or College or Faculty adviser in the specialty concerned (if necessary, with the advice of the consultant) to be part of a suitable programme of training, or to undertake voluntary service, their previous NHS or other approved service should be taken fully into account in assessing entitlement to sick leave allowance, provided that:

- the junior doctor has not undertaken any other work outside the NHS during the break in service, apart from limited or incidental work during the period of the training appointment or voluntary service; and

- the employer considers that there has been no unreasonable delay between the training or voluntary service abroad ending and the commencement of the 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.

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.

Statutory sick pay (SSP)

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 statutory sick pay, the occupational sick pay allowance is increased by an amount equivalent to the amount of statutory sick pay due, except that the sum of the occupational sick pay allowance and statutory sick pay payable should not exceed the doctor's normal pay for the period.

It should be noted that employees with contracts of less than three months are excluded from SSP, but there are special rules affecting employees who have more than one contract with the same employer separated by eight weeks or less. Locums may need to obtain form SSP1(e) from their employer so that they may claim sickness benefit from the state. Further information on the special rules is available from trust human resources departments or local social security offices.

Special leave

References are made throughout this section to paragraphs in the General Whitley Council handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the General Whitley Council has been replaced by a NHS Staff Council. At the time of writing, the GWC handbook was still in use for medical staff, but is likely to be replaced by an updated handbook in the near future.

Parental leave

After 12 months' continuous service within the NHS, each parent has the right to take at least 13 weeks' unpaid leave in respect of children under 14 years, and 18 weeks for disabled children or adopted children under 18 years.

Notice periods for taking such leave should not be unnecessarily lengthy. Parental leave can be added to periods of paternity or maternity leave.

Special leave for domestic, personal and family reasons

Employers are required to provide clear guidelines on the length of special leave for domestic reasons and whether it should be paid or unpaid.

All employees, regardless of service length, have the right to reasonable time off work to deal with emergencies involving a dependant. Payment may be made by local agreement, but the expectation is that relatively short periods of leave for emergencies will be paid. Circumstances when employees can take time off include:

- if a dependant falls ill or has been injured or assaulted
- where a partner is having a baby
- to make care arrangements for a dependant who is ill or injured
- to make funeral arrangements or attend a funeral of a dependant
- to deal with an unexpected disruption or breakdown in care arrangements for a dependant, eg when a childminder fails to turn up
- to deal with an incident involving the employee's child during school hours, eg if a child has been involved in a fight or suspended from school.

Information

Employment Relations Act 1999

Maternity and Parental Leave Regulations 1999 ammended by Maternity and parental leave (Amendment) regulations 2002 and 2001

NHSE AL(GC)1/2000, sections 7 to 13 of the GWC handbook: equal opportunities agreement

Advance Letter (GC) 1/2003

Information

Employment Relations Act 1999

Information

NHSE AL(GC)1/2000, sections 7 to 13 of the GWC handbook: equal opportunities agreement

Section 7, sub-section F amended by AL(GC) 1/2003

Employment break scheme

The General Whitley Council and hospital doctors terms and conditions of service recommends that NHS employers agree local schemes with trade union representatives to provide for people to take a longer period away from work than provided for by parental leave or other leave arrangements. The main reasons for such breaks include childcare, care for another dependant, training, study leave or work abroad; other reasons should be considered on their merits. The minimum length of the break should be three months and the maximum five years.

Information

GWC handbook, section 3

Other special leave

Special leave with pay is also available in certain circumstances, eg attendance at court as a witness, or training with the reserve and cadet forces.

Information

Trade Union and Labour Relations (Consolidation) Act 1992

ACAS Code of Practice on Time Off for Trade Union Duties and Activities (2003)

Leave for trade union duties and activities

Employers are obliged to allow officials of recognised trade unions, which includes BMA junior doctor representatives, to take reasonable time off with pay to undertake trade union duties and approved training in working hours. Employees are allowed to take reasonable time off, not necessarily with pay, for the purpose of taking part in trade union activity.

GWC handbook, section 38

Professional leave

Reasonable paid leave should be granted to enable doctors to attend meetings of their College or professional body eg BMA. In case of difficulty, members should contact *ask*BMA (see page 175).

J Cross and T Pickersgill: Representing your colleagues: BMJ 1999; 319:2

Leave for candidates for appointments

Paid leave for attending interviews is at the discretion of the employer, but is good practice and is referred to as such in A Guide to Specialist Registrar Training .

Maternity leave

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 twelve months continuous service with one or more NHS employers at the beginning of the eleventh week before the 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.

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 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.

Information

GWC handbook, section 6 amended by Advance letter (GC)1/2003

Employment Rights Act 1996

Maternity Allowance and Statutory Maternity Pay Regulations 1994

Social Security Maternity Benefits and Statutory Sick Pay (Amendment) Regulations 1994

Employment Rights Order (1996) (NI) ammended by Employment Relations (Northern Ireland) Order 1999

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 in touch with any developments that may affect her intended date of return.

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 Statutory Maternity Pay or Maternity Allowance (including any dependants allowances) receivable;
- for the next 18 weeks, the employee will receive half of full pay plus any Statutory Maternity Pay or Maternity Allowance (including any dependants allowances) receivable providing the total receivable does not exceed full pay.

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 Statutory Maternity Pay entitlements, subject to the following qualifications:

- in the event of a pay award or annual increment being implemented before the paid maternity leave period begins, the maternity pay should be calculated as though the pay award or annual increment had effect throughout the entire Statutory Maternity Pay calculation period. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated on the same basis.
- in the event of a pay award or annual increment being

implemented during the paid maternity leave period, the maternity pay due from the date of the pay award or annual increment should be increased accordingly. If such a pay award was agreed retrospectively, the maternity pay should be re-calculated
- 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 Statutory Maternity Pay purposes, average weekly earnings for the period of sick absence shall be calculated on the basis of notional full sick pay.

Unpaid Contractual Maternity Leave

Employees will also be entitled to 26 weeks unpaid leave.

Commencement and Duration of Leave

An employee may begin her maternity leave at any time between the eleventh 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.

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

Premature Birth

Where an employee's baby is born alive 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 eleventh 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 eleventh 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 at the beginning of the actual week of childbirth.

Where an employee's baby is born before the eleventh 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 born dead after the 24th week of pregnancy the employee will be entitled to the same amount of maternity leave and pay as if her baby was born alive.

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 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 employees 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 Statutory Maternity Pay, received. 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.

Fixed-Term Contracts or Training Contracts

Employees subject to fixed-term or training contracts which expire after the eleventh week before the expected week of childbirth, and who satisfy the conditions, shall have their contracts extended so as to allow them to receive the 26 weeks paid contractual maternity leave above.

Absence on maternity leave (paid and unpaid) up to 52 weeks before a further NHS appointment shall not constitute a break in service.

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.

Employees on fixed-term contracts who do not meet the twelve months continuous service condition set out above may still be entitled to Statutory Maternity Pay.

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 practitioner 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.

Increments

Maternity leave, whether paid or unpaid, shall count as service for annual increments and for the purposes of any service qualification period for additional annual leave.

Accrual of Annual Leave

Annual leave will continue to 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.

Pensions

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

Antenatal Care

Pregnant employees have the right to paid time off for antenatal care. Antenatal care may include relaxation and parentcraft classes as well as appointments for antenatal care.

Employees Not Returning to NHS Employment or with Less Than Twelve Months Continuous Service

An employee who satisfies above conditions, except that she does not intend 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 Statutory Maternity Pay, which is paid at 90% of her average weekly earnings for the first 6 weeks of her maternity leave and to a flat rate sum for the following 20 weeks.

If an employee does not satisfy the conditions for contractual maternity pay she may still be entitled to Statutory Maternity Pay. Statutory Maternity Pay will be paid regardless of whether she satisfies the conditions above. If her earnings are too low for her to qualify for Statutory Maternity Pay, or she does not qualify for another reason, she should be advised to claim Maternity Allowance from her local Job Centre Plus or social security office.

Employees who fall into the category set out in paragraph 42 will also qualify for twenty six weeks unpaid maternity leave.

Continuous Service

For the purposes of calculating whether the employee meets the twelve 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 Trusts 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 general practitioner for a period not exceeding twelve months;
- a period of up to twelve months spent abroad as part of a definite programme of postgraduate training on the advice of the Postgraduate Dean or College or Faculty Advisor in the speciality concerned;
- a period of voluntary service overseas with a recognised international relief organisation for a period of twelve months which may exceptionally be extended for twelve months at the discretion of the employer which recruits the employee on her return;
- absence on a employment break scheme in accordance with the provisions of Section 7 of the General Council Handbook;
- absence on maternity leave (paid or unpaid) as provided for above.

Employers may at their discretion extend the period.

Employment as a trainee with a General Medical Practitioner in accordance with the provisions of the Trainee Practitioner Scheme shall similarly be disregarded and count as service.

Employers have the discretion to count other previous NHS service or service with
other employers.

Information about Maternity Rights and Statutory Maternity Pay

Information about all maternity rights is contained in the following Department of Trade and Industry (DTI) booklet:–
Maternity Rights: a guide for employers and employees (URN 99/1191)
Copies of the booklet can be obtained by telephoning 0870 1502 500.
It is also available from the DTI web site at www.dti.gov.uk/er/individual/maternity.pdf

Information on Statutory Maternity Pay and Maternity Allowance entitlements is contained in the following Department for Work and Pensions (DWP) booklet:–
A Guide to Maternity Benefits (NI 17A)
Copies of the booklet can be obtained from local benefits offices.
Further information on Statutory Maternity Pay and Maternity Allowance entitlements is also available on the DWP website at www.dwp.gov.uk/lifeevent/famchild/index.htm

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. This protection applies up to the end of the statutory maternity leave period or during the four weeks following the end of that period if she has since then been incapable of work due to a medically certified illness.

If you feel that you are being denied your employment rights contact *ask*BMA in the first instance. *ask*BMA will asses 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 may apply.

Paternity leave and pay

Paternity leave and pay is available to employees following the birth or placement of a child for adoption.

Following the birth of a child, the new rights to paternity leave and pay give eligible employees the right to take paid leave to care for the child or support the mother.

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, husband or partner of the mother
- have worked continuously for their employer for 26 weeks ending with the 15th week before the baby is due.

Employers can ask their employees to provide a self-certificate as evidence that they meet these eligibility conditions.

Length of paternity leave

Eligible employees can choose to take either one week or two consecutive weeks 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.

Statutory paternity pay is paid by employers for either one or two consecutive weeks as the employee has chosen. The rate of statutory paternity pay is the same as the standard rate of statutory maternity pay in 2005, £10,280.

Notice of intention to take 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 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 DTI 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 statutory paternity pay (SPP) they pay out in the same way as they can claim back statutory maternity pay. 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.

Further information

More detailed information on statutory maternity rights is given in the Employment Department Group's booklet *Maternity rights: a guide for employers and employees* (PL 958), which members who come only within the scope of employment legislation might find helpful. Copies are obtainable free from Employment Centres (see phone book) and the DTI Publications order line (0870 1502500).

Further information about the statutory maternity pay scheme can be found in a wide range of social security leaflets, in particular *Maternity Benefits* (NI 17A) and *Babies and benefits* (FB8), which include information on the maternity allowance. These are available free from social security offices. There is also a guide for employers about SMP (CA 29). This is available free from the employers' order line (0845 7646646).

Accommodation and catering

Information
HC(91)9 and Memorandum of guidance on NHS residential staff accommodation

HSG(91)1 The NHS staff residential estate

Junior doctors – the New Deal, (NHSME 1991)

NHS employers should provide accommodation for certain groups of staff including those in training, those whose duties require them to be resident and staff who, for good reason, cannot obtain other suitable accommodation and whose recruitment and retention would otherwise prove difficult. Both single and married accommodation may be provided in all cases, although the provision of married accommodation will be subject to its availability.

Compulsorily resident practitioners

A doctor who is required, whether as a condition of their appointment, or statutorily, to reside in a hospital shall be provided with free accommodation. For example, pre-registration house officers are required by statute to be resident and are therefore entitled to free accommodation. Employers should not charge for such accommodation. However, the doctor may decide to occupy alternative accommodation for which a rent is payable, rather than the accommodation which the employer would otherwise provide. If a doctor does decide to do this, the rent for the accommodation is abated up to the cost of the accommodation which would otherwise have been provided.

Information
Terms and conditions of service, paragraph 173

Voluntary resident practitioners

The lodging charges for voluntarily resident junior doctors are a matter for local negotiation within each trust. There is no longer an upper limit for lodging charges negotiated with the Department of Health, the rate being agreed instead within each trust.

The lodging charges for voluntarily resident junior doctors are a matter for local negotiation within each trust. There is no longer an upper limit for lodging charges negotiated with the Department of Health, the rate being agreed instead within each trust.

Lodging charges for existing accommodation should be increased at the same time, and by the same percentage, as increases in junior doctors' pay. Lodging charges may not be without agreement following local negotiation. Further increases must be by reasonable amounts in order to move towards charges which reflect the standard of accommodation provided and the local market value.

NHS employers are advised to seek a professional assessment of the rent their accommodation would be likely to command in the open market. Trusts should also be aware of rent levels generally for comparable accommodation in their area and should consider recruitment and retention as well as cost issues.

Lodging charges for new accommodation will be determined by local negotiation and agreement to reflect the standard of accommodation provided and notional market value.

Information

Terms and conditions of service, paragraphs 173-174

AL(MD)4/95 Lodging charges for voluntarily resident practitioners

HSS (TC8) 15/95 (NI)

The NHS Executive advance letter on lodging charges for voluntary resident practitioners specifies that the 'level of lodging charges set locally must be agreed with local junior doctors' representatives… eg the BMA's local negotiating committee where one exists'. It is extremely important that junior doctor representatives are involved in negotiations to increase or set lodging charges and this will usually be through the local negotiating committee (LNC) (see page 6). Advice should be sought from *ask*BMA if there has not been junior doctor involvement in the negotiations or if there is not a junior doctor representative on the LNC.

It is for employers to decide when to implement increases in rent, although they must comply with relevant legislation, including the Housing Act of 1998.

Overnight accommodation when on-call

No charge should be made for on-call accommodation for junior doctors required to stay overnight in the hospital as part of an on-call rota or shift system.

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. If a doctor is required to stay overnight as part of an on-call or partial shift pattern one night in seven or more then they are required to pay a proportion of accommodation charges if they are not eligible for free accommodation.

On-call/rest rooms should be available for all junior doctors and should be free of charge.

Accommodation for doctors on full shifts

Even with the New Deal and EWTD provisions in place, a junior doctor could still be working 13 consecutive days consisting of 14-hour shifts. In addition to this, travel time to and from trusts following a 14-hour shift results in severely depleted opportunity to sleep, potentially exacerbated by lengthy journeys for doctors in rotations that cover large geographical areas. The provision of accommodation during or outside duty periods would allow doctors to take anchor sleeps of 10 - 40 minutes, which are well researched as being effective in reducing fatigue. This would hopefully address the fact that junior doctors who are seriously fatigued whilst on duty increase the risk of making clinical errors, turning routine procedures into high-risk procedures which is clearly unacceptable for the patient.

A substantial body of research has been carried out into the negative effects of working long hours, for example, the JDC is aware of several cases where junior doctors have had road traffic accidents on their way home from long shift periods. Trusts need to extend their concern for their employees beyond the confines of the hospital, particularly as some full shift rotas have late finish times, eg midnight or later, that the Department for Transport Local Government and the Region (DTLR) has specifically advised against.

A recent judgement in the European Court of Justice (ECJ), 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 whilst on duty on the hospital site. The JDC recognises that accommodation facilities are frequently inconducive to restful sleep and also that with cross cover arrangements within a full shift arrangement there is less likelihood of sleep being possible whilst 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.

Accommodation between duty periods

In circumstances where intervals between duty periods make it unreasonable for the junior doctor to return to their normal accommodation, for example between shift duties, employers as best practice should provide free accommodation at their discretion.

Information

Terms and conditions of service/model contract guidance (NHSME January 1993) (August 1993 in Scotland)

Abatement of voluntary lodging charges

Abatements are given to compensate a doctor for being away from their accommodation for work purposes. Junior doctors who are required to stay overnight in hospital as part of an on-call rota or partial shift system one night in seven or more often, but who are not eligible for free accommodation, shall pay the following proportion of the lodging charge:

Required to stay overnight	Proportion
One night in three	0%
One night in four	35%
One night in five	55%
One night in six or seven	75%

Due to the increasing tendency for trusts to hand over responsibility for their rented accommodation to housing associations, junior doctors may find difficulty in claiming these abatements. If a housing association just manages the accommodation the abatements should still apply. If a separate body owns the accommodation the position is less clear. In such cases, advice should be sought from the *ask*BMA.

Information

Terms and conditions of service, paragraph 175

Letter (2 3 98) from C Sheriff NHSE to BMA

Inadequate standard of accommodation

Charges made for accommodation should reflect the standard and amenities provided. Should standards fall below the minimum stated in Annex A of HSC 2000/036 employers must provide the accommodation free of charge until improvements have been completed. Should the accommodation fall below the HIMOR standards (Annex A) Trusts should provide alternative accommodation until the HIMOR notice has been lifted or the juniors contract comes to an end. Should trusts provide sub standard accommodation the following penalties will apply.

Information

HC(91)9 and Memorandum of guidance on NHS residential staff accommodation

Standards falling below the minimum safety standards – accommodation must be closed immediately and alternative arrangements made by the trust.

Standards falling below the minimum stipulated in HSC 2000/036 *Living and working conditions for hospital doctors in training* – accommodation must be free until improvements are completed (within an agreed timescale) and training posts should be advertised accordingly.

Standards still falling below the minimum stipulated in HSC 2000/036 after an agreed date for improvement – no training posts can be advertised until the trust has reached minimum standards. Trusts would also be required to find alternative accommodation for any trainees in post, and to provide transport to and from hospital if necessary.

Information

HSC 2000/036 Living and working conditions for hospital doctors in training

HDL (2001)50

Self-contained accommodation

The provision of self-contained and married accommodation varies from hospital to hospital. All accommodation must meet the minimum standards set out in HSC 2000/036. There is no requirement for employers to provide this accommodation and where such accommodation is provided the quality tends to vary. Junior doctors requiring married accommodation should check that such accommodation is available from the trust before taking up the post.

Information

HSC 1998/135 PRHOs undertaking placements in general practice

PRHOs in general practice

PRHOs in general practice should be provided with free accommodation, either in a conveniently near hospital or in the area served by the practice or within easy reach of the practice.

Rent rebates

Information

HC(91)9 and Memorandum of Guidance on NHS Residential Staff Accommodation

Married junior doctors who occupy NHS accommodation on a rental basis because they are required to be resident are eligible to receive abatements of up to 25 per cent of assessed rent and up to 50 per cent if both husband and wife are compulsorily resident. This includes a further abatement of 10 per cent over and above what is offered to other staff in recognition of the fact that no charge is made for lodging in the case of a doctor occupying single hospital accommodation where residence is a condition of appointment. In exceptional cases, for example, where a doctor is

required to occupy a house far in excess of their normal needs or at a rent out of all proportion to what they might normally pay, an abatement of over 25 per cent may be permitted.

The rent of a house or flat occupied by a doctor who is appointed for one year or less should not be revised during the term of the appointment and any revision of the rent following a review should be deferred until the end of the tenure in such cases.

Tenancy agreements

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

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

A licence 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 which 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 *ask*BMA.

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 local 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.

Council tax

The BMA has a fact sheet: *The council tax: implications for junior doctors.* This is available from the BMA website.

Standards of accommodation

HSC 2000/036 *Living and working Conditions for hospital doctors in training* sets out the minimum standards of accommodation and catering for junior doctors. These agreed minimum standards are the result of discussions between junior doctors' representatives, regional New Deal task force officers, representatives from postgraduate deaneries, NHS managers, NHS Estates staff and other interested parties. The agreement stipulates the following minimum standards:

On-call rooms

Trusts need to have sufficient numbers of rooms for all on-call or partial shift junior doctors, whether this be during all or part of any particular night on duty. In addition to this all on-call rooms should be of the same standard as residential accommodation.

The on-call rooms should be a separate unit away from clinical areas, though at a maximum of between five and 10 minutes walking distance from the relevant wards. The rooms must not be built next to power plants or goods delivery areas, or other areas that could disturb occupants' rest.

Access to and from the on-call rooms, doctors' mess and clinical areas should be safe and without risk to health or welfare, for example, well lit.

Bedrooms

Each bedroom (one per occupant) should have the following: Adequate light and sound proofing, ventilation, temperature adjustment, and security; suitable floor covering; lined curtains; bed (3ft) (double [4ft 6in minimum] for married accommodation); weekly linen change and twice weekly towel change (for on-call rooms, change of bedlinen and towels between occupants); desk and chair; wardrobe, drawers and bookcase/shelves; easy chair; reading light by bed and desk; room cleaned three times a week; smoke alarm in the room; a standard BT or cable socket to the internal hospital telephone system; access to the facility for making external calls at no higher than relevant BT rates; and a wash basin with hot and cold running water.

Bathrooms

Each bathroom (one between three, working towards one between two occupants by August 2003) should have the following:

shower which is fed by both hot and cold water and fitted with a device such as a thermostatic mixer valve to prevent users being scalded; bath; toilet.

Kitchens

Each kitchen (one between four occupants) should have the following:

cooker (4 rings and oven); microwave; fridge-freezer; utensils for cooking and eating; kettle; toaster; steam iron and ironing board; smoke alarm in the kitchen.

Dining areas

Dining area (one between four occupants) should have the following:

table; at least one chair per occupant.

Living rooms

Living room (one between four occupants):

sufficient seating for all occupants using sofas and comfortable chairs; and a coffee table.

Star rating system

Only once all the minimum living and working conditions stated above have been achieved, may employing authorities improve the facilities offered to junior doctors by including extra facilities. The trust will then receive a star rating from one to three depending on the number of additional facilities they provide.

Incorporating five of the following items = one star
Incorporating 10 of the following items = two star
Incorporating 15 of the following items = three star

This will encourage trusts, for just a small extra investment, to attract junior doctors to their hospital by providing accommodation and other facilities of a high standard.

Bedroom

Double bed
En suite shower
Daily towel and linen change
Duvet (minimum 12 togs)
Radio/alarm clock
Tea/coffee making facilities
Facilities for IT/Internet access
TV aerial connection.

Kitchen

Filter coffee machine
Automatic washing machine
Tumble dryer
Dishwasher.

Living room

TV and video recorder
IT/Internet access.

Miscellaneous

Indoor and locked communal cycle store
Car parking on site
Double glazing
Security – internal voice communication with front door and camera link with main door.

Catering

Junior doctors on duty must be able to get good quality hot and cold food at any time. If the canteen is closed, this should be through a supply of microwave meals, cold cabinet or a similar arrangement. Supplies should be sufficient for all staff on duty, and readily accessible to doctors in training. Supplies should be regularly restocked, with swipe cards or change machines provided where necessary.

Bread, cereals and drinks should be available at all times.

In small trusts (where there are fewer than 10 junior doctors on-call at any one time) canteen opening hours can be reduced from the minimum standard set out below. However, the minimum standard (availability of good quality hot and cold food round the clock) must be observed.

Where catering facilities exist, they must be open 365 days a year.

Meals provided must be adequate, varied, attractively and efficiently served and freshly prepared.

Canteen must be open and serving hot food for extended meal times for breakfast, lunch and dinner, wherever possible with a minimum late opening until 11pm and a further two hour period after 11pm and before 7am.

Canteen must always provide healthy eating options and a vegetarian option, and should provide for a range of cultural and dietary requirements.

Serving and dining areas must be situated away from facilities provided for patients, relatives and other non-employees.

Information

HSC 2000/036 Living and working conditions for hospital doctors in training

Monitoring and complaints

There should be a designated named trust officer to whom junior doctors can address complaints and concerns about facilities.

An independent facilities inspection officer will inspect trust facilities on a regular basis, and work with and ensure that trusts improve any sub standard facilities.

Regional action teams, or their equivalent, must also take accommodation and catering standards into account when deciding whether to agree New Deal accreditation for trusts.

Recreational and other facilities

There should be a doctors' mess easily accessible from wards and departments. In large hospitals this may require more than one mess. In small trusts a joint mess for all clinical staff may be acceptable.

Resident or on-call junior doctors should have access to a parking space near their accommodation where on-site car parking is available. Where this is not available, employers should attempt to ensure that alternative secure parking arrangements are in place.

Secure, communal cycle store.

Laundry with an adequate number of washing machines and dryers (reasonably priced and well maintained).

Exercise/sporting facilities for all staff – where this is not possible, employers should make arrangements with local sports centres and swimming pools and should inform juniors of these facilities.

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.

Removal expenses

The scheme for reimbursement of removal expenses gives employers discretion on the scope and level of removal expenses which 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. 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 trust human resources department before the interview stage. 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 within the trust. The BMA has issued guidance to its local negotiating committees 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 trusts in the region and this will often include setting a limit on expenses, usually of about £8,000.

Information

GWC handbook, section 26

AL(GC)1/93

AL(MD)7/93 – Removal expenses: hospital medical and dental staff and doctors in community medicine and the community health service

PCS (GC) 93/1 (Scot)

PCS (DD) 1994/1 (Scot)

AL(MD)1/94 (Wales)

HSS(TC1)7/93 (NI)

HSS (TC8) 6/95 (NI)

GWC handbook, section 26, paragraph 3

Information

Terms and conditions of service, paragraph 315

AL(MD)2/01

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 paragraph 315 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.

Flexible training

Nothing in the scheme precludes full reimbursement of removal expenses to those moving into flexible training. This is a matter for negotiation with the new employer.

GP registrars

Doctors who move from posts in the NHS to take up appointments as registrars in general practice, or move from one training practice to another and out of necessity change their accommodation are entitled to removal expenses.

The scheme for payment of removal expenses for GP registrars in the GP part of their training is broadly similar to the old scheme for hospital doctors but reimbursement is made to the registrars by the health authority (health board in Scotland). Members are advised to consult paragraphs 38.7 – 38.22 (38.4 – 38.20 in Scotland) of the Statement of fees and allowances or *ask*BMA (see page 175).

Honorary contract holders

A doctor moving from a post with a university, the Medical Research Council (MRC) 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.

Responsibility for payment

The doctor's **new** employer is responsible for the payment of expenses. There is no longer any need for doctors to demonstrate that their move is from one 'approved' authority to another as in previous schemes.

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. *ask*BMA (see page 175) can advise on the best course of action if this occurs.

Information

GWC handbook, section 26, paragraphs 5 and 9

Level of expenses payable

Under the GWC agreement 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 dependants
- 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.

Making a claim

Step 1: the agreement

- Contact the human resources department of the prospective employer and find out in detail how they plan to calculate and pay removal expenses.
- Contact the *ask*BMA office (see page 175) to check that the offer is in line with any local agreement on removal expenses, and that it is reasonable.
- Use the list as a guide to the possible costs which should be covered in the offer.
- Do not accept an appointment until agreement is reached on the range and level of expenses.
- Get the employer's agreement in writing and check whether there is a time limit on submitting a claim.
- Keep all receipts, and check whether those are needed for all expenses or whether miscellaneous expenses can be claimed without them.

Step 2: what to claim

- The GWC scheme states that any reasonable costs incurred in relocation may be met, including those incurred in:
- the search for accommodation in the new area

- the purchase and sale of property
- removal of furniture and effects
- continuing commitments in the old area
- general/miscellaneous removal costs
- additional housing costs in the new area
- other expenses, at the employer's discretion.

Step 3: what to avoid

- loans, offered as an alternative to removal expenses
- undertakings to repay if moving within a fixed period
- lump sum settlements: new tax rules mean that tax may be payable
- overall ceilings on expenses: the BMA is opposed to these.

Tax

Removal expenses can be paid tax-free up to a 'qualifying limit', which is revised annually. Currently, the limit stands at £8,000. Further information can be obtained in a guidance note from *ask*BMA (see page 175). Your local tax office will also be able to help.

Information

Finance Act, 1993, section 76, schedule 3

Removal expenses: what to claim

The following are offered as example only and are neither inclusive or exclusive.

Expenses during search for accommodation

- preliminary visits to new area (paid leave and expenses, including immediate family)
- subsistence allowance for a maximum of 4 nights away while seeking accommodation
- return travel expenses (including immediate family)
- travel expenses for weekly visits home or by the immediate family to the practitioner until new accommodation has been found (for a maximum of 12 months)
- allowance for retention of accommodation in new area while absent (for a maximum of 12 months).

Expenses of house purchase and sale

- advance of salary for house purchase (make sure repayment terms are clear)
- legal and other expenses (eg stamp duty, legal fees, surveys, wiring/drains test)
- house sale (eg solicitors' fees, agents' fees, costs relating to a purchase which falls through).

Expenses of moving house

- journey from old to new home, with immediate family
- one return visit to superintend removal
- storage and/or removal of furniture/effects (three quotes must be sought)
- tenancy agreements
- miscellaneous (eg plumbing, telephones, replacement of school uniform, TV aerial, etc).

Continuing expenses in old area

The employing may reimburse any reasonable continuing commitments in the old area, eg:

- child's lodging costs (where they remain behind)
- rent and rates payable on the old property concurrently with the new one.

Additional expenditure in new area

The employer may make allowances towards additional housing costs where the cost of accommodation is higher than in the old area, eg:

- increased expenditure in new area compared with similar expenditure in old area for:
- rent/rates
- property insurance
- other (covering rent or imputed equivalent, council tax, water rates, etc).

Travelling and other expenses

References are made throughout this section to paragraphs in the General Whitley Council handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the General Whitley Council has been replaced by a NHS Staff Council. At the time of writing, the GWC handbook was still in use for medical staff, but is likely to be replaced by an updated handbook in the near future.

Junior doctors who are required to travel on NHS business are entitled to receive certain mileage allowances or may be offered a Crown car.

Payment of mileage allowances

The circumstances under which juniors may receive mileage allowances are set out in paragraphs 277-289 of the *Terms and Conditions of Service*. The following is a brief summary of the provisions. Further advice should be sought from the *ask*BMA (see page 175).

Full-timers

Full-time 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.

PRHOs in general practice may also claim for excess fares from residence to place of work or visiting patients (if needing to travel separately).

Information

BMA guidance note: NHS official travel

Terms and conditions of service, paragraphs 277-303

AL(MD)2/2001

PCS(DD)2001/14

Information

Terms and conditions of service, paragraph 286

Part-timers

For part-time junior doctors, the following journeys are classified as official business:

- principal hospital to any destination on official business
- home to any destination other than the principal hospital, on official business
- home to principal hospital, normally subject to a maximum of 10 miles in each direction, when there is a subsequent official journey
- home to principal hospital, when the junior doctor is called out in an emergency.

Information

Terms and conditions of service, paragraph 298

Terms and conditions of service, paragraph 290

PCS (DD) 2001/4

Rates of mileage allowances

Junior doctors, including PRHOs in general practice, who use their own car on NHS business are entitled to allowances at the standard rate unless they are classified as regular users. Standard and regular user mileage rates vary according to engine capacity.

Regular users

Regular users are junior doctors who fulfil any of the following criteria:

- travel an average of more than 3,500 miles a year on NHS business; or
- travel an average of at least 1,250 miles a year; and
  - necessarily use their cars an average of three days a week; or
  - spend an average of at least 50 per cent of their time on such travel including the duties performed during the visits.

Regular users receive a lump sum which is paid in monthly installments in addition to any mileage allowances due. Regular users may opt to be paid at the standard rates instead. The point at which standard rates are more advantageous than regular user rates varies according to the junior doctor's tax position.

Insurance

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

Public transport rate

The standard or regular user rates will not apply if a junior doctor uses a private vehicle in circumstances where travel by a public service (eg rail or bus) would be appropriate. For such journeys an allowance at public transport rate will be paid unless this is higher than the rate that would be payable under standard or regular user rates. **It is important to note that public transport rate should only be paid where the use of public transport is not unreasonable ie, it is convenient and would not prolong the journey excessively.** If it is not possible, or reasonable, to use public transport, standard or regular user rates should be paid.

In all other circumstances, the standard or regular user rates apply. Employers should use the following criteria in deciding whether the public transport rate should apply:

- the nature of the practitioner's duties
- the length and complexity of journeys (including the number of changes and likely waiting times)
- the availability of public transport
- personal safety
- the time of day
- relative journey times (public transport compared with private vehicle)
- any other relevant factors, for example, equipment or luggage to be carried.

In particular, employers should take into account the variable times at which practitioners start and finish work when public transport may not be a viable way of travelling.

If a practitioner needs to use private transport because public transport does not provide a reliable or reasonable way to get to or from work (or is in some other way inappropriate) or because they are travelling on an official journey, the standard or regular user mileage rates should apply.

Mileage paid at the public transport rate does not count towards the number of miles for which payment is made at higher rates under the standard and regular users mileage schemes. For example, a doctor who had to drive 3,000 miles and was paid at the appropriate standard rate for 2,000 miles and public transport

Information

Terms and conditions of service, paragraphs 290, 298-299

AL(MD)2/2001

rate for 1,000 miles would still be entitled to a further 1,500 miles at standard rate (ie the higher level paid up to 3,500 miles).

Information
Terms and conditions of service, paragraph 300

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 given in the previous table.

Information
Terms and conditions of service, paragraph 296

Car out of use

Regular users unable to use their car because of illness or because their car has a mechanical defect will have the lump sum abated as follows:

- full payment will continue for the remainder of the month in which the car was originally not used, and for a further three months
- 50 per cent of the lump sum will be paid for the succeeding three months.

If the car is still out of use after this period, the lump sum payments will cease until the car is available again.

During the time a car is off the road for repairs, the employer will pay reasonable expenses incurred in travelling for all classes of user.

Information
Terms and conditions of service, paragraph 302

Loans for car purchase

Junior doctors are entitled to a loan at 2.5 per cent flat rate when they are first classed as 'regular users' provided they apply within three months of classification or appointment, whichever is the later. This entitlement does not normally apply to junior doctors offered a Crown car (see below).

The maximum amount of the loan cannot exceed the cost of the car less the net amount realised by the sale or part exchange of a vehicle used on NHS business within the preceding 12 months. The loan is repayable over a maximum of five years or the estimated life of the car, if shorter. If a junior doctor changes employer while repaying a loan the new employer will purchase the loan from the former employer.

Garage expenses, tolls and ferries

Information
Terms and conditions of service, paragraph 301

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 vouchers wherever possible. Overnight parking charges will only be reimbursed if the junior doctor is receiving night subsistence allowance for overnight absence or is receiving mileage expenses paid at public transport rates.

Pedal cycles

Information
Terms and conditions of service, paragraph 303

Official journeys undertaken by pedal cycle attract expenses at the rate in the earlier table.

Railway fares

Information
GWC handbook, section 23

Junior doctors are expected to take the fullest possible advantage of any cheap fares available, and should check in advance whether they are entitled to first class fares.

Air fares

Payment for travel by air may not exceed the cost of travel by appropriate alternative means of transport, together with an allowance equivalent to the amount of any saving in subsistence expenses consequent on travel by air, provided that where the employer decides that the saving in time is so substantial as to justify payment of the fare for travel by air, they may pay an amount not exceeding:

- the ordinary, or any available cheap fare for travel by regular air service; or
- where no such service is available or in case of urgency, the fare actually paid by the doctor.

Information
BMA guidance note: NHS official travel

AL(MD)2/90

1990(PCS)27 (Scot)

HSS(TC8)9/90 (NI)

The Crown car scheme

A Crown car is any vehicle owned or contract-hired by an employer. The Crown 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 trusts.

Eligibility

Terms and conditions of service, paragraphs 304-38

Junior doctors are not automatically entitled to a Crown car, but will be offered one if the employer considers it economic or in the interest of the service to do so.

Types of car

For junior doctors, a base vehicle of at least 1100cc and no more than 1800cc can be provided. A larger vehicle may be chosen but any excess costs compared with the use of the base vehicle are met by the individual junior doctor.

Petrol costs

Junior doctors who have been allocated Crown cars are responsible for purchasing all petrol, whether for business or private mileage. Reimbursement for NHS business mileage should be claimed by submitting a signed claim form. The rate per mile is determined according to the following formula:

$$\frac{\text{Cost of one gallon of LRP}}{\text{Base vehicle's mileage on urban cycle}}$$

The price of petrol is as notified from time to time by the Department of Health based on the price of lead replacement petrol as published in Petroleum Times. The mileage on the urban cycle is as quoted by manufacturers from officially approved tests under the Passenger Car Fuel Consumption Order 1983

Private charges

A Crown car user will be required to reimburse the employer for the private use element of the car. This will take the form of a composite annual charge to cover payment for the road fund licence, insurance for private use, a handling charge, VAT and a fixed amount per 1,000 miles of estimated private driving. Further details are given in the BMA guidance note NHS Official Travel – available from the BMA website.

Implications of declining a Crown car

A junior doctor may be requested to have a Crown car by an employer as it is more economical for them to provide a car rather than reimburse travelling expenses at standard or regular user rate. If the request is declined the junior doctor will be reimbursed at a 'special rate' equivalent to the current 9,001 to 15,000 miles rate for over 2000cc for regular and standard users, regardless of the vehicle's engine size. There is no entitlement to claim standard or regular user lump sum payments and allowances.

Taxation

As far as the Inland Revenue is concerned, private use of Crown 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 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 *ask*BMA (see page 175) and/or their accountant.

Subsistence allowances

Information

Terms and conditions of service, paragraph 311

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, interview expenses, or in connection with removal expenses during a search for suitable permanent accommodation in a new area, subject to the terms of the removal expenses policy.

The following allowances are payable:

Night subsistence – commercial accommodation

When a junior doctor stays overnight in a hotel or other commercial accommodation, 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 and relatives or in caravan accommodation, a flat rate of £25 is payable. This includes an allowance for meals. No receipts are required.

Information
GWC handbook, section 22

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 £20.00.

Terms and conditions of service, paragraphs 275-6 and 311

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 national insurance 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 – £5.00
(more than five hours away from base including the lunchtime between 12 noon and 2pm)

Evening meal allowance – £15.00
(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 General Whitley Council agreement 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.

Information

HSC 2000/036 Living and working conditions for hospital doctors in training

HC(PC)(79)3 Provision of telephones for medical and dental staff

HM(58)68 Provision of telephones for resident medical staff

SHM4/1971 (Scot)

1979 (PCS)32 (Scot)

WHC(PC)(79)3 (Wales)

HSS(TC8)11/79 (NI)

HSC 2000/036

Telephone expenses

Resident medical staff

Under HSC 2000/036 *Living and working conditions for hospital doctors in training*, resident junior doctors should be provided with a telephone connected, using a standard BT or cable socket, to the internal hospital telephone system and for there to be access to the facility for making external calls at no higher than relevant BT rates. It is BMA policy that junior doctors should not be charged more than the actual charge of the call made by the telephone company.

Official business calls

Junior doctors may claim the cost incurred of outgoing calls made on official business.

Telephone installation and rental costs

It is sometimes a contractual requirement for specialist registrars to possess a telephone. Employers should pay for the cost of installation and rental of telephones where they are satisfied that the following conditions apply:

- it is essential for the efficiency of the service that the junior doctor should be on-call outside normal working hours; and
- the telephone is the only practicable method of communication with the junior doctor; and
- the possession of a telephone is a contractual requirement. However, contract holders are also entitled to reimbursement of the cost of calls by the employer.

The payment of installation and rental costs is usually taxable.

Interview expenses

Where an employer invites a junior doctor to appear before a selection board or invites a shortlisted junior doctor to attend in connection with an application for appointment, reimbursement of eligible expenses is made by the prospective employer. The applicant is entitled to travelling expenses and subsistence allowances at the appropriate rates. A candidate will not be reimbursed for more than two attendances, except that a candidate for a consultant appointment may be reimbursed up to three attendances. If an employer invites such a candidate to attend prior to shortlisting, it may reimburse the expenses provided that the candidate is subsequently shortlisted.

A junior doctor who is requested to appear before a selection board while on holiday is reimbursed for:

- travelling expenses from the holiday address, but limited to travelling expenses from the port of entry if the junior doctor is abroad, and provided they return to the holiday address after the interview. Travel from Northern Ireland, the Isle of Man and the Channel Islands is not regarded as travel from abroad, and therefore travelling expenses should be met in full
- subsistence allowances at the appropriate rate, unless the junior doctor is able to stay at home and it is reasonable to expect them to do so.

Information

Terms and conditions of service, paragraph 313

AL(MD)4/98

PCS(DD) 1999/2

HSS (TCS) S/99

Expenses may be reimbursed for pre-interview or pre-application visits for specialist registrar appointments. The prior agreement of the prospective employer should be obtained.

Reimbursement is not made to a junior doctor who refuses the offer of an appointment as advertised on grounds which the employer considers inadequate.

Postage

Any expenditure incurred by a junior doctor in postage in the service of an employer is reimbursed by the employer.

Information

Terms and conditions of service, paragraph 312

Information

BMA factsheet:
A general guide to the NHS pension scheme

NHS pension scheme

The NHS pension scheme compares well with other occupational pension schemes in the public and private sectors and can provide a good standard of living in retirement. In addition to the basic pension and lump sum entitlement, there are a number of other valuable benefits including insurance and family benefits.

Why be a member of the scheme?

In the past, a number of people have been persuaded to opt out of their occupational pension schemes and to take out personal pension plans (PPPs) instead. Fortunately, very few doctors have chosen to do so. The BMA has taken actuarial advice on this question and it is clear that for the vast majority of doctors opting out of the NHS pension scheme would be financially unwise.

Contributions

The employee contribution rate is 6 per cent of superannuable income. This attracts tax relief. Scheme members also pay a reduced rate of national insurance contribution (because the NHSPS is contracted out of the state earnings related pension scheme, SERPS). The real cost is considerably less than 6 per cent as the following example of an SHO on the third point of the scale in 2003 shows:

	Non member £	Scheme member £	Saving £
Basic salary	27,150	27,150	–
Banding supplement (assumed band 2A [80%])	21,720	21,720	–
Total salary	48,870	48,870	–
Tax	11,977	11,325	652
NI	3,075	2,654	421
Net salary	33,818	34,891	1,073
Employee's contribution (6% of £27,150)		1,629	-1,629
Saving on tax and NI			1,073
Real cost			-556
Real cost as% of basic salary			2.05

NB Based on salary, tax and national insurance rates applicable from April 2003

The employer contribution is 14 per cent of salary in England, Wales, and Scotland and 7 per cent in Northern Ireland.

Pensionable income

This includes basic salary, London weighting allowance and domiciliary consultation fees. It does not include pay supplements beyond whole time basic salary (1.0), temporary additional NHDs or income above the earnings cap (£105,600) for doctors who joined the NHS after 1 June 1989.

On retirement, pensionable salary will be the notional whole time salary rate for the position (part-time working is ignored) during the best of the last three years. In most cases this will mean the salary rate applicable during the last 12 months of service.

Pensionable service

The period actually worked in the NHS will count as reckonable service, irrespective of whether it was whole time or part-time. Reckonable service is used for a number of calculations, including the following:

- maximum service limits (40 years at age 60; 45 years at age 65 and in total)
- number of added years which can be purchased (see below).

In calculating pension, any part-time working must be scaled down to its whole time equivalent, eg 10 years working an 8/10 contract would result in 8 years' scaled service.

Information

BMA guidance note: Salaried doctors

Calculation of pension

The two essential elements in calculating pension are pensionable salary and scaled service.

The formula used is as follows:

Pension = scaled service /80 x pensionable salary

A consultant retiring with 35 years scaled service would have pension calculated as follows:
Pension = 35/80 x £78,097 = £34,166

The method of calculating a general practitioner's pension is different. Details can be found in the BMA factsheet entitled *General practitioners.*

Index linked pensions

NHS pensions in payment are increased in April each year in line with the Retail Prices Index

Lump sum

The lump sum is tax free. It is usually three times pension. In the example above, the lump sum would be as follows:

£34,166 x 3 = £102,498

For married male doctors with service before 25 March 1972, and for female doctors who opted for a bigger widower's pension, the lump sum will be less than three times pension. The BMA's *General guide to the NHS pension scheme* gives details.

Retirement age

Normal retirement age in the NHSPS is age 60 and at that age any doctor may retire and claim the pension. However, it is possible to stay in the scheme up to age 65 and even beyond then, up to age 70, if a contract is extended (subject to a maximum of 45 years in total in the scheme).

Early retirement

A number of options are available.

- Voluntary early retirement
  Doctors may retire from age 50 with an actuarially reduced pension and lump sum. Voluntary early retirement without actuarial reduction is possible if the employer is willing to pay for the extra cost involved.
- Redundancy or organisational change
  Early retirement with an enhanced pension may be possible in these circumstances from age 50 onwards
- Ill health retirement
  For doctors permanently incapable of carrying out their duties as a result of ill health, an enhanced ill health pension and lump sum may be payable.
- Mental health officers.

Information

BMA factsheets:
Redundancy,
Voluntary early retirement,
Ill health retirement

Breaks in service

Doctors who work or study abroad for a period or have a break in service for any other reason will need to consider their pension position. If they have been in the NHS scheme for less than two years, and have a break of more than one year, then a refund of contributions is normally payable. This should be avoided if at all possible because pension entitlement accrued to date will be lost and the refund will be significantly reduced by taxation and the need to repay national insurance contributions. There are a number of possible ways of avoiding a refund.

Doctors with more than two years in the NHS scheme cannot take a refund and will have a preserved benefit in the scheme. They may therefore wish to consider buying additional service in the scheme to make up for time lost as a result of a break in service (see below).

Information

BMA factsheet: Leaving the NHS

Additional benefits

There are a number of methods available to increase the benefits payable under the NHS pension scheme.

Information

BMA guidance note: Improving benefits

Added years

By paying extra contributions it is possible to buy added years in the NHS scheme so that the maximum service entitlement has been achieved by age 60 (or age 65). This is particularly useful for doctors because they do not qualify until at least age 23 and therefore cannot achieve 40 years at age 60 without buying extra years.

Added years produce benefits in exactly the same format as the scheme generally, ie an extra index linked pension and a tax free lump sum of three times that extra pension.

Additional voluntary contributions (AVCs)/Free standing additional voluntary contributions (FSAVCs)

AVCs/FSAVCs are money purchase arrangements. This means that the extra contributions paid are invested and, at retirement, will produce a sum of money which is used to purchase extra pension (in the form of an annuity). The benefits will depend upon the success of the investment and the interest rates prevailing at retirement (which affect the cost of an annuity).

AVCs are an in-house scheme organised by the NHSPS with Equitable life, Prudential and Standard Life (however Prudential is not available to doctors in Scotland or Northern Ireland). Because this is an in-house arrangement, administrative charges are likely to be lower than for an FSAVC as no commission is payable.

However, Equitable Life has been in difficulty, and any doctor investing in AVCs is urged to seek independent financial advice. Further information is available from the previous pages of the BMA website, or the pensions department.

FSAVCs may be purchased from a company of your choice. The BMA has concerns about the way in which FSAVCs are marketed, particularly to junior doctors. Please take care and contact the BMA pensions department if you are concerned that you may have been mis-sold an FSAVC.

Unreduced lump sum

Any doctors who would not otherwise receive the full lump sum (eg married male doctors with service before 1972) may pay extra contributions in order to purchase the unreduced lump sum and thereby ensure that their lump sum is three times pension.

Contribution limits

In addition to the basic NHS scheme contribution of 6 per cent of salary, it is possible to pay up to 9 per cent in extra contributions to purchase additional benefits, making 15 per cent of salary in total. Tax relief is provided on the full 15 per cent.

Personal pensions/stakeholder pensions

Any private income can be pensioned separately in the form of a personal pension plan.

Choice of additional benefits

The BMA factsheet Improving benefits provides additional details on the choices available. Having read that, if still in doubt, doctors may wish to seek independent financial advice.

Mental health officer (MHO) status

Prior to 6 March 1995 (1 April 1995 in Scotland and Northern Ireland), MHO status was granted to whole-time or maximum part-time doctors who spent the whole or substantially the whole of their time caring for mentally disturbed people.

After 20 years as an MHO, each year thereafter counts as double for pension purposes and it is possible to retire at age 55.

Following legal action by the BMA, MHO status was extended to part-time doctors, backdated to 1976, provided they met the usual criteria. The BMA factsheet *Salaried doctors* provides details.

MHO status was withdrawn on 6 March 1995, but is retained by doctors who had it at that time.

Pensions green paper/taxation paper

The government is preparing major changes to pension and taxation arrangements. Some of these are welcome, especially increasing the scope to invest in pensions. However, the BMA has some major concerns, particularly the proposal to increase the NHS pension scheme normal retirement age for new entrants and for the future service of existing staff. There is also concern that the new lifetime pensions savings limit has been set to low. These matters are being addressed by the BMA and further information can be obtained from the Pensions department.

Further advice

Further advice on the NHS pension scheme can be obtained from the following bodies which are responsible for administering the scheme:

England and Wales

NHS Pensions Agency
Hesketh House
200-220 Broadway
Fleetwood, Lancashire
FY7 8LG
Tel: 01253 774774

Scotland

Scottish Public Pensions Agency
7 Tweeside Park
Galashiels
TD1 3TE
Tel: 01896 893100

Northern Ireland

Health and Personal Social Services
Superannuation Branch
Waterside House
75 Duke Street
Waterside, Londonderry
BT47 6FP
Tel: 01504 319000

Easy to read leaflets on the scheme are available from these authorities or the employer or health authority/board.

Occupational pension schemes, such as the NHS scheme, are required to provide members with benefit statements upon request (no more than once a year).

Doctors who wish to obtain an estimate of their pension should write to their in the first instance, or direct to the NHS Pensions Agency or equivalent in Scotland or Northern Ireland (see above). Members should give details of their date of birth and national insurance number. They should also ask for a full service record (and dynamising sheet for general practitioners) and check it carefully upon receipt.

If there are any problems or difficulties with the estimate provided, members should contact the Pensions Department at BMA House (see page 177).

The BMA produces a number of factsheets on the NHS Pension Scheme in addition to those mentioned above, which are available from *ask*BMA (some are also on the BMA web site). Individual advice on occupational pension schemes can be obtained from the Pensions Department (see page 177) at BMA House.

The BMA is not registered under the Financial Services Act and therefore cannot provide financial advice.

Tax for junior doctors

The following fact sheet are available from the BMA and on the BMA website:

Tax for the newly qualified doctor
Income tax and the employed doctor
Income tax and partnerships
Income tax for general practitioners
Income tax for consultants
Capital gains tax
Personal pension policies
National insurance contributions

NHS injury benefits scheme

All doctors working in the NHS, including hospital call-out teams and general practitioners, are covered under the NHS Injury Benefits Scheme whilst on NHS duties, from the moment they take up their appointment. Staff employed by agencies are not covered.

The scheme is non-contributory and is separate from the NHS pension scheme.

Grounds for entitlement

Injury benefits become payable when doctors are injured in the course of their duties, or contract a disease because of exposure to it by nature of their work, if:

- earning ability is permanently reduced by more than 10 per cent; or
- as a result of the injury or disease, they are on sick leave with reduced pay (or paid leave has been exhausted); or
- they die as a result of injury or disease.

Types of benefit

A minimum income is guaranteed to the doctor and to the widow/widower and certain dependants. In addition, a lump sum is payable where earning ability is permanently reduced and employment has to cease, or on death. Benefits are based on pensionable pay. Detailed information is contained in the BMA factsheet 'Injury benefits', available from *ask*BMA (see page 175).

Enhancement of final pay for junior hospital doctors

When the BMA negotiated injury benefits for junior doctors it argued that these doctors could have received higher remuneration (and have a higher level of injury benefits) had they been able to take up a career in general practice at the earliest opportunity.

It was therefore agreed that pay for injury benefit purposes would be a percentage of GP net average remuneration, which it was considered the junior would be likely to receive had he or she opted for a career in general practice instead of an extended training in hospital.

Information

BMA fact sheet: Injury benefits scheme

The following table shows maximum benefits under the scheme. The BMA factsheet should be consulted for more detailed information.

Junior doctor salary (as from 1/4/05)	% of deemed GP net remuneration (100% = £76,390 as from 1/4/05) £	Maximum benefit (ie 85% of previous column) £
House officer scale maximum £22,907	53% = 40,487	34,414
Senior house officer scale maximum £35,511	65% = 49,654	42,206
Specialist registrar scale maximum £42,985	100% = 76,390	64,932

BMA website – www.bma.org.uk

The BMA website provides all the latest information on professional issues, with continually updated news summaries and BMA press releases. It can be used generally as a comprehensive source of information and also provides specific services to all BMA members.

www.bma.org.uk/juniordoctors

The dedicated junior doctors' section of the website includes feedback on the latest developments in JDC issues and activity. JDC reports, including this handbook, and are posted along with guidance on pay and conditions and useful tools such as an interactive calculator to determine which pay band junior doctors' posts should be allocated to, and advice about what to do if your post is banded or re-banded incorrectly. The website also provides a base for JDC's ongoing information campaigns.

There is a simple on line registration process to gain a password which will give you access to all areas of the website. Register today and get the most from the BMA.

www.bma.org.uk

The BMA website also provides links to sites such as major medical organisations and satellite sites such as the *BMJ, BMJ Careers* and the national BMA websites of Scotland, Wales and Northern Ireland. The junior doctors' section of the Department of Health website is also a useful location to access official documents such as the terms and conditions of service for hospital doctors, health circulars outlining the regulations on living and working conditions for junior doctors, and the protocol for the rebanding of training grade posts.

Other pages

Other pages of the BMA website include:

- latest information on all professional issues
- career guidance
- BMA's policy and reports on major issues
- details of BMA work, for instance in science and in ethics
- membership information
- virtual access to the BMA library.

Sources of further information for junior doctors

Terms and conditions of service

Hospital and medical and dental staff (England and Wales): terms and conditions of service; Department of Health/Welsh Office (July 1994).

This is available for reference in trust medical staffing offices, together with related documentation.

'Orange guide'

A guide to specialist registrar training; NHS Executive (February 1998).

This is available in trust libraries and postgraduate centres or by telephoning the NHS Responseline on 08701 555 455. The most recent version of the orange guide was published in February 1998.

BMA guidance available to members

All BMA guidance is updated regularly and is available to members only, free of charge, from *ask*BMA and the BMA website (www.bma.org.uk). A list of available guidance notes is set out below.

General

Doctors' pay
Doctors' pay supplement: current pay levels
Medical careers – a general guide

Junior Doctors

JDC guidance on the new contract for junior doctors
Junior doctors' contracts
Flexible training
Private practice
Retention of higher grade salaries (for hospital juniors)
Retrospective claim form

Medical Students

Electives for medical students
Finance for medical students
How to study medicine
Medical students in hospitals
First house job
Medicine in the 21st century
The Insiders' guide to medical schools (can be purchased from booksellers)

NHS Employment

Maternity leave (for NHS medical staff)
Mileage rates for NHS employed doctors
NHS indemnity
NHS official travel
Removal and associated expenses
Associate specialist grade
The staff grade

General Practice

General guidance
GP registrars
Vocational training for general practice
Job-sharing for GP principals
For assistants in general practice:
- Framework for a written contract of employment
For GP practice staff:
- Framework for a written contract of employment
- Specimen handbook of terms and conditions of service
Medical partnerships under the NHS

Fees for part-time medical services

A general guide with 15 schedules giving up-to-date information on negotiated and statutory fees.

Pensions

A general guide
Pensions for the newly qualified
Why doctors should not opt out
Improving pension and lump sum benefits
Injury benefits scheme
Salaried doctors
Early retirement (including redundancy)
General practitioners
Leaving the NHS and pension transfers

Tax

Tax for the newly qualified doctor
Income tax and the employed doctor
Income tax and partnerships
Income tax for general practitioners
Income tax for consultants
Capital gains tax
Personal pension policies
National insurance contributions

Members should take advice on individual problems from *ask*BMA (see page 175). There may have been changes since publication of the guidance notes and in Scotland and Northern Ireland circumstances may differ and the guidance notes may not apply.

askBMA and local services

BMA members needing employment advice and information or members who feel they need representation should contact *ask*BMA on 0870 6060 825, askbma@bma.org.uk *ask*BMA advisors are trained in doctors employment issues and will mostly be able to deal with an enquiry immediately. However, advisors are also able to assess whether or not individual members need direct representation from the BMA's advisory staff working from one of five BMA centres (England) or from a national office (Northern Ireland, Scotland and Wales).

So, no matter whether you need a guidance note or have a serious problem at work you should contact *ask*BMA first.

As well as providing individual representation BMA centres and national offices support local junior doctors representatives and Local Negotiating Committees.

You must log on to the BMA website before accessing the *ask*BMA page.

The BMA is unable to help non-members or assist members if their problem predates membership of the association.

When contacting the *ask*BMA, members should quote their current membership number. **Members seeking advice on individual or local problems should contact *ask*BMA in the first instance**.

The BMA website has easy links to *ask*BMA, but if you wish to go there directly, the address is www.bma.org.uk/ap.nsg/hubaskbma

Department of Health guidance

Copies of Department of Health publications are available online at www.dh.gov.uk/publicationsand statistics/fs/en

National BMA offices

BMA head office

British Medical Association, BMA House, Tavistock Square,
London, WC1H 9JP
Tel: 020 7387 4499

JDC Secretariat

Tel: 020 7383 6613
Fax: 020 7383 6360
Email: info.jdc@bma.org.uk

General enquiries	020 7387 4499
Armed forces	020 7383 6158
BMA news	020 7383 6122
BMA library	020 7383 6625
BMJ bookshop	020 7383 6244
General practitioners	020 7383 6375
Hospital seniors	020 7383 6156
International department	020 7383 6491
Medical ethics department	020 7383 6286
Medical students	020 7383 6262
Membership enquiries	020 7383 6680
Members' dining room	020 7383 6311
Occupational health	020 7383 6166
Public health division	020 7383 6140
Science and education	020 7383 6164
Staff and associate specialists	020 7383 6310
Pensions department	020 7383 6166

The Medical Royal Colleges

- Faculty of Accident and Emergency Medicine www.faem.org.uk
- Royal College of Anaesthetists www.rcoa.ac.uk
- Faculty of Dental Surgery www.rcseng.ac.uk
- Royal College of General Practitioners www.rcgp.org.uk
- Royal College of Obstetricians and Gynaecologists www.rcog.org.uk
- Faculty of Occupational Medicine www.facoccmed.ac.uk
- Royal College of Opthalmologists www.rcophth.ac.uk
- Royal College of Pathologists www.rcpath.org www.rcpch.ac.uk
- Faculty for Pharmaceutical Medicine www.fpm.org.uk
- Royal College of Physicians of Edinburgh www.rcpe.ac.uk
- Royal College of Physicians of Ireland www.rcpi.ac.uk
- Royal College of Physicians of London www.rcplondon.ac.uk
- Royal College of Physicians and Surgeons of Glasgow www.rcpsglasg.ac.uk
- Royal College of Psychiatrists www.rcpsych.ac.uk
- Faculty of Public Health www.fphm.org.uk
- Royal College of Roadiologists www.rcr.ac.uk
- Royal College of Surgeons of Edinburgh www.rcsed.ac.uk
- Royal College of Surgeons of England www.rcseng.ac.uk
- Royal College of Surgeons of Ireland www.rcsi.ac.uk
- Academy of Medical Royal Colleges www.aomrc.org.uk

Appendix I

Form of offer and acceptance of contract for hospital medical and dental staff in the grades of senior registrar, registrar, senior house officer, house officer and pre-registration house officer and doctors in public health medicine and the community health service

[Insert: Name and address of employing authority/trust

Date……]

Dear ……..

Offer of appointment

1. (a) I am instructed by the [insert name of employing authority/trust] to [offer you]* [confirm the offer of]* an appointment as [insert job title and grade] at [insert name of hospital(s)] commencing on ……. [for a period of ……. terminating on …….].*

(b) The date of the start of your period of continuous employment is ……. For these purposes, your employment with [insert name of previous employer] [is]* [is not]* included in the period of continuous employment.

Applicable collective agreement

2. Your appointment will be subject to the *Terms and conditions of service of hospital medical and dental staff* (England and Wales) as amended from time to time [and any reference in those Terms and conditions to an employing authority shall be construed as if it were to include a reference to an employing trust].*

Duties

3. (a) Your hours and duties are as defined in the attached job description (For rotations, the job description may differ for each individual post/placement). You will be available for duty hours which in total will not exceed the duty hours set out for your working pattern in paragraph 20 of the *Terms and conditions of service.*

Your working pattern is described as [full shift]* [partial shift]* [24 hour partial shift]* [on-call rota]* [hybrid comprising [full shift]* [partial shift]* 24 hour partial shift]* [on-call rota]*]* with controls on hours as defined in the *Terms and conditions of service* paragraph 20.

You will receive a base salary (for practitioners in posts allocated to payband FA, you will receive a pro-rata base salary) as detailed in table 1, appendix 1 of the Terms and conditions of service.

A non pensionable supplement at payband ……. will be payable in accordance with paragraph 22 of the T*erms and conditions of service* (For rotations, banding supplements may differ for each individual post/placement).

Banding supplements may be altered (in accordance with paragraphs 6(e) and 7(c) below) in the light of changes in working patterns in order to make posts compliant with the New Deal. If the payband changes, you will be issued with a letter of variation (in accordance with paragraph 7 below). Pay protection will apply in accordance with paragraph 21 of the *Terms and conditions of service.*

Pay

4. (a) Your base salary will be £…….. per annum, paid monthly [and will progress by annual increments of £……. to £……. per annum]* in accordance with the current national agreed salary scale for your grade. (These rates are subject to amendment from time to time by national agreement.) See note 1.

[(b) Your incremental date will be …….]*

[(c) You will receive, in addition to your base salary a supplement at the rate of …….per cent of your base salary for duty contracted at [Band 1 A/B/C]* [Band 2 A/B]* [Band 3]* [Band FA]* [Band FB]* as set out in paragraph 3(d) above, which will be payable monthly. [(These rates may be amended from time to time by national agreement).]*

[(d) In addition, you will be paid the following allowances:

*eg peripheral allowances, London weighting]**

Pension

5. (a) Your appointment will be pensionable and your base salary will be subject to deduction of superannuation contributions in accordance with the NHS Pension Regulations 1995 unless you opt out of the scheme. (Any supplement payable to you is not pensionable.) Details of the NHS scheme are given in the scheme guide, which is enclosed.

(b) There [is]* [is not]* a contracting out certificate in force for the purposes of section 3(5) of the Employment Rights Act 1996.

(c) Pay supplements over and above base salary are non-pensionable.
For practitioners contracted to work 40 or more hours of duty per week:

Your pensionable pay for contributions purposes must be based on your actual whole-time basic pay (1.0) only.

For practitioners contracted to work less than 40 hours of duty per week:

Your pensionable pay for contributions purposes will be the appropriate proportion of actual whole-time basic pay (1.0). However, your contributions must also be paid on any additional hours of duty you work between your contracted hours and a maximum of 40 hours per week.

Your employer must make arrangements to track and record these additional hours (see paragraph 5(e) above) for pension purposes.

Monitoring of working patterns

6. (a) The trust is contractually obliged to monitor junior doctors' New Deal compliance and the application of the banding system, through robust local monitoring arrangements supported by national guidance. You are contractually obliged to cooperate with those monitoring arrangements.

(b) These arrangements will be subject to:
- review by the regional improving junior doctors working lives action team (or equivalent); and
- for the trust, the performance management systems.

(c) The trust must collect and analyse data sufficient to assess hours' compliance and/or to resolve pay or contractual disputes. Therefore, when the trust reasonably requests you to do so, you must record data on hours worked and forward that data to the trust.

(d) The trust is required to ensure that practitioners in the HO and PRHO grades from 1 August 2001 and practitioners in the SR, SpR, R and SHO grades from 1 August 2003, comply with the controls on hours of actual work and rest detailed in sub-paragraph 22.a of the Terms and conditions of service.

(e) You are required to work with your employer to identify appropriate working arrangements or other organisational changes in working practice which move non-compliant posts to compliant posts and to comply with reasonable changes following such discussion.

Revision to pay banding

7. (a) The trust will notify you in writing of its decision on banding.

(b) Full details of the procedure for appealing against banding decisions are in the *Terms and conditions of service* sub-paragraph 22.l.

(c) Full details of the procedure for rebanding posts are in the *Terms and conditions of service* sub-paragraph 22.m.

Notice

8. You are entitled to receive ……. notice of termination of employment and are required to give [insert name of employing authority/Trust] …… notice. See also note 2.

Registration and insurance

9. (a) You are required to be registered with the [General Medical Council]* [and]* [General Dental Council]* throughout the duration of your employment.

(b) You are normally covered by the NHS Hospital and Community Health Services indemnity against claims of medical negligence. However, in certain circumstances (especially in services for which you receive a separate fee) you may not be covered by the indemnity. The Health Departments therefore advise that you maintain membership of your medical defence organisation. See also note 3.

Additional work

10. You agree not to undertake locum medical or dental work for this or any other employer where such work would cause your contracted hours (or actual hours of work) to breach the controls set out in paragraph 20 of the Terms and Conditions of Service.

Residence

11. [The appointment requires you to be resident at [insert name of hospital]. No charge will be made for lodgings, in accordance with the *Terms and conditions of service.*

[See also note 4]*

[The appointment requires you to be resident in [insert name of hospital house or flat]. The terms of your occupation are set out in the enclosed tenancy agreement/licence.

[See also note 4]*

[The appointment does not require you to reside in hospital, but you have chosen to do so; and a deduction from salary for lodgings will accordingly be made, in accordance with the Terms and conditions of service.

[See also note 4]*

[The appointment does not require you to reside in hospital, but you have chosen to do so; and the terms of your occupation of [insert address of hospital house or flat] are set out in the enclosed tenancy agreement/ licence.

[See also note 4]*

[It is your responsibility to ensure that when on-call you will be available by telephone and able to reach your hospital in time to meet your clinical commitments]*

Leave

12. (a) You will be entitled to ……. weeks' annual leave with full pay each year. The trust's leave year runs from ……..

(b) In the current leave period [insert dates] your entitlement will be …… weeks.

(c) Full details of both annual leave and sick leave allowances and the conditions governing those allowances and study leave, are set out in the *Terms and conditions of service.*

Property

13. (a) [Insert name of employing authority/trust] accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.

(b) Notwithstanding (a) above, [insert name of employing authority/trust] undertakes, so far as is reasonably possible, to ensure that lodgings are maintained in a secure condition.

(c) You should, through the exercise of normal diligence, also seek to maintain the security of your lodgings.

Deductions

14. The [insert name of employing authority/trust] will not make deductions from or variations to your salary other than those required by law without your express written consent.

Sickness absence

15. The provisions relating to absence by you because of sickness appear in paragraph 225-244 of the *Terms and conditions of service*.

Grievance procedure

16. (a) Should you have any grievance relating to your employment you are entitled to discuss the matter in the first instance with the consultant (or consultants) to whom you are responsible, and where appropriate to consult, either personally or in writing, with [insert name of the appropriate personnel officer], at [insert address of personnel officer].

(b) The agreed procedure for settling differences between you and [insert name of employing authority/trust] where the difference relates to a matter affecting your *conditions of service* is set out in Section 42 of the *General Whitley Council conditions of service* (or in any replacement provision which may come into force from time to time).

Disciplinary procedure

17. The provisions relating to disciplinary procedure appear in section 42 of the *General Whitley Council conditions of service* as incorporated by paragraph 189 of the *Terms and conditions of service*.

Acceptance

18. If you agree to accept the appointment on the terms specified above, please sign the form of acceptance on the following page and return it to me. A second signed copy of this is attached, which you should also sign, and retain for your future reference.

Yours faithfully

Signature .....

On behalf of .....

NOTES

[ ]*: A square bracket followed by an asterisk indicates 'delete as necessary'.

1. Your salary gives ..... years' incremental credit for previous service. If you have any enquiry about how this has been calculated, please contact [insert name and address of personnel officer].

2. (a) The Departments and the profession have agreed that minimum periods of notice should be applied as follows, unless there is agreement by both parties to a contract that a different period should apply:

House officer	2 weeks
Senior house office	1 month
Registrar	2 months
Specialist registrar	3 months
Senior registrar	3 months

(b) The Employment Rights Act 1996 provides entitlement to minimum periods of notice, dependent upon an employee's length of continuous employment, as follows:

Period of continuous employment	**Notice entitlement**
1 month or more but less than 2 years	Not less than 1 week
2 years or more but less than 12 years	Not less than 1 week for each year of continuous employment
12 years or more	Not less than 12 weeks

3. Copies of HC(89)34 and the leaflet on indemnity arrangements issued in December 1989 (are enclosed)* [may be obtained on request]*.

4. Copies of the enclosure to EL(91)82 relating to standards of residential accommodation [are enclosed]* [may be obtained on request]*.

5. Copies of HSC 2000/031 – *Modernising pay and contracts for hospital doctors and dentists in training*, [are enclosed]* [may be obtained on request]*.

PLEASE DO NOT DETACH

I hereby [accept]* [confirm my acceptance of]* the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it.

Signature .....

Date .....

This offer, and acceptance of it, shall together constitute a contract between the parties.

Appendix II

Form of offer and acceptance of contract for a fixed-term training appointment (Type II contract) in the grade of specialist registrar for overseas doctors who do not have right of residence in the UK or EEA doctors pursuing a non-UK Type I equivalent programme

[Insert: Name and address of employing authority/trust
Date……]

Dear [insert name of specialist registrar]……..

Offer of appointment

1. I have been informed by [insert name of postgraduate dean] that your application for a fixed-term training appointment (FTTA) in the grade of specialist registrar has been successful. I understand that you have been issued, by the postgraduate dean, with a fixed-term training number (FTN) for the duration of your participation in fixed-term [Type II*/non-UK EEA SpR placement* delete as appropriate] training programme which will end on [insert date when training programme will end as notified by the postgraduate dean].

2. I am instructed by the [insert name of employing authority/trust] to [offer you]* [confirm the offer of]* a placement as a visiting specialist registrar at [insert name of hospital(s)] starting on [insert date]* for a period of [insert period] ending on [insert date].

3. A UK certificate of completion of specialist training (CCST) is only available to trainees who have successfully completed a Type I training programme in the UK. The appointment you are being offered now is not on a Type I programme.

   [delete as appropriate]

   * Your training is in a Type II programme and, as such, does not have the award of a CCST in the UK as its training goal, although should you at a later date be accepted into a Type I programme, your Type II training may count towards some of the requirements of the Type I programme.

   * [Non-UK EEA doctor who intends to complete a training placement in the UK as part of a non-UK Type I equivalent programme.] * Your training is intended to count towards the higher specialist training programme which

you will complete in [specify country]. It will not lead to the award of a CCST in the UK. Should you at a later date be accepted into a Type I programme, your Type II training may count towards some of the requirements of the Type I programme.

Your employment is subject to your continuing to hold an FTN [*and your UK residential status permitting you to pursue the agreed training programme] [*delete for non-UK EEA doctors].

4. The date of the start of your period of continuous employment is [insert date]. For these purposes, your employment with [insert name of previous employer(s)] [is]* [is not]* included in the period of continuous employment. The continuity of your employment in the specialist registrar grade is protected upon moving between trust employers by the Employment Protection (Continuity of Employment of NHS employees) (Modification) Order 1996 (SI 1996/1023).

Applicable collective agreement

5. Your appointment will be subject to the Terms and conditions of service of hospital medical and dental staff (England and Wales) (Scotland) as amended from time to time and any reference in those terms and conditions to an employing Authority shall be construed as if it were to include a reference to an employing Trust.

Duties

6. (a) Your hours and duties are as defined in the attached job description (For rotations, the job description may differ for each individual post/placement). You will be available for duty hours which in total will not exceed the duty hours set out for your working pattern in paragraph 20 of the Terms and conditions of service.

Your working pattern is described as [full shift]* [partial shift]* [24-hour partial shift]* [on-call rota]* [hybrid comprising [full shift]* [partial shift]* 24 hour partial shift]* [on-call rota]*]* with controls on hours as defined in the Terms and conditions of service paragraph 20.

You will receive a base salary (for practitioners in posts allocated to payband FC, you will receive a pro-rata base salary) as detailed in table 1, appendix 1 of the Terms andconditions of service.

A non pensionable supplement at payband ……. will be payable in accordance with paragraph 22 of the Terms and conditions of service (For

rotations, banding supplements may differ for each individual post/placement).

Banding supplements may be altered (in accordance with paragraphs 9(e) and 10(c) below) in the light of changes in working patterns in order to make posts compliant with the New Deal. If the payband changes, you will be issued with a letter of variation (in accordance with paragraph 7 below). Pay protection will apply in accordance with paragraph 21 of the Terms and conditions of service.

Pay

7. (a) Your base salary will be £…….. per annum, paid monthly [and will progress by annual increments of £……. to £……. per annum]* in accordance with the current national agreed salary scale for your grade. (These rates are subject to amendment from time to time by national agreement.) See note 1.

[(b) Your incremental date will be …….]*

[(c) You will receive, in addition to your base salary a supplement at the rate of ……. per cent of your base salary for duty contracted at [Band 1 A/B/C]* [Band 2 A/B]* [Band 3]* [Band FA]* [Band FB]* as set out in paragraph 3(d) above, which will be payable monthly. [(These rates may be amended from time to time by national agreement).]*

[(d) In addition, you will be paid the following allowances:

eg peripheral allowances, London weighting]*

Pension

8. (a) Your appointment will be pensionable and your base salary will be subject to deduction of superannuation contributions in accordance with the NHS Pension Regulations 1995 unless you opt out of the scheme. (Any supplement payable to you is not pensionable.) Details of the NHS scheme are given in the scheme guide, which is enclosed.

(b) There [is]* [is not]* a contracting out certificate in force for the purposes of section 3(5) of the Employment Rights Act 1996.

(c) Pay supplements over and above base salary are non-pensionable.

For practitioners contracted to work 40 or more hours of duty per week:

Your pensionable pay for contributions purposes must be based on your actual whole-time basic pay (1.0) only.

For practitioners contracted to work less than 40 hours of duty per week:

Your pensionable pay for contributions purposes will be the appropriate proportion of actual whole-time basic pay (1.0). However, your contributions must also be paid on any additional hours of duty you work between your contracted hours and a maximum of 40 hours per week.

Your employer must make arrangements to track and record these additional hours (see paragraph 5(e) above) for pension purposes.

Monitoring of working patterns

(a) The trust is contractually obliged to monitor junior doctors' New Deal compliance and the application of the banding system, through robust local monitoring arrangements supported by national guidance. You are contractually obliged to cooperate with those monitoring arrangements.

(b) These arrangements will be subject to:
- review by the regional improving junior doctors working lives action team (or equivalent); and
- for the trust, the performance management systems.

(c) The trust must collect and analyse data sufficient to assess hours' compliance and/or to resolve pay or contractual disputes. Therefore, when the trust reasonably requests you to do so, you must record data on hours worked and forward that data to the trust.

(d) The trust is required to ensure that practitioners in the HO and PRHO grades from 1 August 2001 and practitioners in the SR, SpR, R and SHO grades from 1 August 2003, comply with the controls on hours of actual work and rest detailed in sub-paragraph 22.a of the Terms and conditions of service.

(e) You are required to work with your employer to identify appropriate working arrangements or other organisational changes in working practice which move non-compliant posts to compliant posts and to comply with reasonable changes following such discussion.

Revision to pay banding

10. (a) The trust will notify you in writing of its decision on banding.

(b) Full details of the procedure for appealing against banding decisions are in the Terms and conditions of service sub-paragraph 22.l.

(c) Full details of the procedure for rebanding posts are in the Terms and conditions of service sub-paragraph 22.m.

Notice

11. You are entitled to receive three months notice of termination of employment and are required to give [insert name of employing authority/Trust] three months notice. See also note 2.

Registration and insurance

12. (a) You are required to be registered with the [General Medical Council]* [and]* [General Dental Council]* throughout the duration of your employment.

(b) You are normally covered by the NHS Hospital and Community Health Services indemnity against claims of medical negligence. However, in certain circumstances (especially in services for which you receive a separate fee) you may not be covered by the indemnity. The Health Departments therefore advise that you maintain membership of your medical defence organisation. See also note 3.

Additional work

13. You agree not to undertake locum medical or dental work for this or any other employer where such work would cause your contracted hours (or actual hours of work) to breach the controls set out in paragraph 20 of the Terms and conditions of service.

Residence

14. [The appointment requires you to be resident at [insert name of hospital]. No charge will be made for lodgings, in accordance with the Terms and conditions of service.

[See also note 4]*

[The appointment requires you to be resident in [insert name of hospital house or flat]. The terms of your occupation are set out in the enclosed tenancy agreement/licence.

[See also note 4]*

[The appointment does not require you to reside in hospital, but you have chosen to do so; and a deduction from salary for lodgings will accordingly be made, in accordance with the Terms and conditions of service.

[See also note 4]*

[The appointment does not require you to reside in hospital, but you have chosen to do so; and the terms of your occupation of [insert address of hospital house or flat] are set out in the enclosed tenancy agreement/ licence.

[See also note 4]*

[It is your responsibility to ensure that when on-call you will be available by telephone and able to reach your hospital in time to meet your clinical commitments]*

Leave

15. (a) i. You will be entitled to five weeks' annual leave with full pay each year. The trust's leave year runs from ……..

or

ii. for those on the third incremental point or above, you will be entitled to six weeks' annual leave with full pay each year. The trust's leave year runs from ……..

(b) In the current leave period [insert dates] your entitlement will be …… weeks.

(c) Full details of both annual leave and sick leave allowances and the conditions governing those allowances and study leave, are set out in the Terms and conditions of service.

Property

16. (a) [Insert name of employing authority/trust] accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.

(b) Notwithstanding (a) above, [insert name of employing authority/Trust] undertakes, so far as is reasonably possible, to ensure that lodgings are maintained in a secure condition.

(c) You should, through the exercise of normal diligence, also seek to maintain the security of your lodgings.

Deductions

17. The [insert name of employing authority/trust] will not make deductions from or variations to your salary other than those required by law without your express written consent. [BMA note: this includes council tax, which should not be deducted without your permission.]

Sickness Absence

18. The provisions relating to absence by you because of sickness appear in paragraph 225-244 of the Terms and conditions of service.

Grievance procedure

19. (a) Should you have any grievance relating to your employment you are entitled to discuss the matter in the first instance with the consultant (or consultants) to whom you are responsible, and where appropriate to consult, either personally or in writing, with [insert name of the appropriate personnel officer], at [insert address of personnel officer].

(b) The agreed procedure for settling differences between you and [insert name of employing authority/trust] where the difference relates to a matter affecting your conditions of service is set out in Section 42 of the General Whitley Council conditions of service (or in any replacement provision which may come into force from time to time). You may also discuss matters relating to your training with the postgraduate dean.

Disciplinary procedure

20. The provisions relating to disciplinary procedure appear in section 42 of the General Whitley Council conditions of service as incorporated by paragraph 189 of the Terms and conditions of service.

Acceptance

21. If you agree to accept the appointment on the terms specified above, please sign the form of acceptance on the following page and return it to me. A second signed copy of this is attached, which you should also sign, and retain for your future reference.

Yours faithfully.....

Signature .....

On behalf of .....

NOTES

[ ]*: A square bracket followed by an asterisk indicates 'delete as necessary'.

1. Your salary gives ..... years' incremental credit for previous service. If you have any enquiry about how this has been calculated, please contact [insert name and address of personnel officer].

2. (a) The Departments and the profession have agreed that minimum period of notice of three months should be applied to specialist registrars unless there is agreement by both parties to a contract that a different period should apply: [insert if appropriate]

   (b) The Employment Rights Act 1996 provides entitlement to minimum periods of notice, dependent upon an employee's length of continuous employment, as follows:

Period of continuous employment	**Notice entitlement**
1 month or more but less than 2 years	Not less than 1 week
2 years or more but less than 12 years	Not less than 1 week for each year of continuous employment
12 years or more	Not less than 12 weeks

3. Copies of HC(89)34 and the leaflet on indemnity arrangements issued in December 1989 (are enclosed)* [may be obtained on request]*.

4. Copies of the enclosure to EL(91)82 relating to standards of residential accommodation [are enclosed]* [may be obtained on request]*.

5. Copies of HSC 2000/031 – Modernising pay and contracts for hospital doctors and dentists in training, [are enclosed]* [may be obtained on request]*.

PLEASE DO NOT DETACH

I hereby [accept]* [confirm my acceptance of]* the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it.

Signature .....

Date .....

This offer, and acceptance of it, shall together constitute a contract between the parties.

Appendix III

Guidelines for training grade job descriptions

Job descriptions for training grade posts which must be attached to contracts should include information on the following areas:

The post

1. The job description should include:

a) a brief statement of the reason why the vacancy has arisen

b) a description of the hours and duties of the post, including a provisional list of daily commitments and the arrangements for emergency duty

c) a person specification. This should be a statement of the key attributes the appointee should possess, covering both previous clinical experience and personal qualities which are felt desirable. Any criteria should be capable of use at the appointment committee.

Job descriptions and person specifications should be couched in non-sexist language. Requirements about age, qualifications and length or nature of experience should not be included unless specifically required for the post. Employee/person specifications should not include requirements on marital status nor include references to marriage plans or domestic arrangements.

The training scheme

2. There should be a description of the training opportunities offered by the post, including, where applicable, a description of the training scheme and rotation of which the post forms part. This section can take the form of a uniform brochure or prospectus produced for all posts in a particular training scheme.

People

3. This section should set out the names of those with whom the postholder will have most contact. The list should include the consultant(s) to whom the doctor will be clinically accountable, the person in charge of training, both in the district or unit and in the overall training scheme, and the person in the medical personnel department who will be the postholder's main contact point.

Terms and conditions

4. This section should detail the terms and conditions of service of the post, including remuneration, and state if the post is compulsorily resident. This could be a separate, standard leaflet.

The district, unit and service

5. This section, which could be presented in a format for use in many different posts, should describe the service, including an overall description of the district and unit.

Facilities

6. Information should be provided on accommodation and other facilities available, eg doctors' mess, catering facilities, car parking.

[Source: Junior doctors, the New Deal: living and working conditions of doctors in training; NHS Management Executive 1991]

All training posts should have deans and educational approval, and this should be clearly stated in the advertisement. It is strongly advised that junior doctors should be extremely wary about applying for non-approved or non-standard posts which could be seriously disadvantageous to future career prospects and are unlikely to be recognised by medical royal colleges. Junior doctors who have any concerns about a post should seek advice from their postgraduate dean's office.

Appendix IV

Retrospective claim form for payments as on a locum basis

To Claimant:

(i) This claim form has been agreed by the Joint Negotiating Committee for Hospital Medical and Dental Staff. Its purpose is to allow junior hospital medical and dental staff to claim payments for work performed as on a locum basis with their own employing authority for which prospective agreement was not obtainable in time.

(ii) Please read the notes overleaf before completing the claim form.

Personal details

Surname: .....

Forenames: .....

Address for correspondence: .....

.....

.....

Grade: Specialty: .....

Location of post held .....

(a) name of hospital .....

(b) name of department .....

Claim for payments: Please enter hours claimed at locum rate.

(a) the time, date and number of hours claimed; (b) the basis of the claim.

Hours	Date	Time from	Basis of claim

Total hours claimed: .....

I have read and accept the notes overleaf and have performed the above duties outside my regular contractual commitment:

Signature of claimant .....

Date .....

Signature of authorised signatory .....

Date .....
(to be signed by a person designated to authorise payment)

For office use

Please pay the above named for ..... hours at locum rates.

Checked by .....

Date .....

Authorised by .....

Date .....

[Source: HSG(93)1 Doctors and dentists in training: TCS/model contract guidance, appendix C]

Notes

1. Paragraph 111a and paragraph 111c of the Terms and conditions of service of hospital medical and dental staff (TCS) are as follows:

Paragraph 111a:

Practitioners in the grades of SR, R, SHO or HO may be employed on a locum tenens basis by their own employing authority but not within the hours for which they are already contracted and provided that such employment does not cause their average weekly hours to exceed the limits set out in paragraph 20 (except in circumstances where they are acting up as a consultant).

Paragraph 111c:

A practitioner employed in the grade of SR, SpR (except Locum Appointments for Training), R, SHO, HO or PRHO accepting an appointment as on a locum basis (cf. sub-paragraph 110.f) in any of these grades, in a hospital identified in the job description applicable to the practitioner's main employment, will contract for each hour in such appointments at the standard hourly rate in accordance with the pay banding arrangements with effect from 1 December 2000 as set out in table 2 of appendix I, or shall be entitled to receive a day's leave for each week night (the night of Friday/Saturday being classed as a week night) or complete Saturday (including the night of Saturday/Sunday) or Sunday (including up to the start of normal duty on Monday morning) of additional duty. The taking of such leave shall be subject to the needs of the service and to the authority's approval. Any such leave which has not been taken within twelve months or by the end of the practitioner's contract, whichever is the earlier, shall be relinquished. Payment shall then be made retrospectively under the terms of this sub-paragraph for the actual amount of additional duty undertaken at the time and for which the practitioner has not otherwise been paid and has been unable to take leave in compensation.

2. It has been agreed that the effect of these two paragraphs is to allow an employing body to contract prospectively with one of its own employees, in any of the grades referred to above, for duty in circumstances defined by paragraphs 110 and 111 of the Terms and conditions of service which the employing body would otherwise seek to cover by appointment of a locum not already in its employment, and that payment should be at the standard locum rate. **In these circumstances the above claim form is not required**.

3. It has also been agreed that a practitioner in one of the grades referred to above may seek retrospective authority for payment for duty performed as on

a locum basis for his or her own employing body when, exceptionally, the prospective agreement of the employing body was not obtainable in time. **In these circumstances the above claim form should be completed**, and signed by the claimant and a person designated by the employing body as responsible for authorising payments, within 10 days, wherever possible, of the completion of the duty.

4. Where it is thought desirable to continue an arrangement entered into as in paragraph 3 above, the agreement of the employing body must be obtained at the earliest possible moment. The arrangement must not continue for more than three days without the agreement of the employing body.

Appendix V

Protecting your pay

Pay protection is a difficult issue for pre-registered house officers. It is important that you get written confirmation from your employer of the banding that you will be paid for the job you have accepted.

In order to have the best chances of ensuring that your pay on graduation is the correct amount with the correct banding applied, the BMA has devised a letter for you to send to your future employer once you are notified of the post(s) you will take up.

Clearly this letter should be used for SHO/SpR jobs as well, with suitable modification, both for stand-alone jobs and rotations.

Please feel free to edit the attached letter to suit your own personal requirements. If you do not receive a response from the Trust it is important to pursue this without delay. Contact *ask*BMA for further details or information (see page 175).

Template letter

Deanery address
<insert>

Doctors Address
<insert>

Date

Dear <insert trust deanery contct name>

Acceptance of <insert position>

Thank you for your letter offering me the position of <insert position> in <insert specialty> in the <insert region> Deanery region. I should like to accept this offer and inform you that my earliest start date will be <insert date>.

Please find enclosed the relevant completed documents you requested.

I should be grateful if you can write to me by return of post and provide me with a list of each possible post that I may take up during this entire rotation, together with the current pay banding applicable to each of these posts.

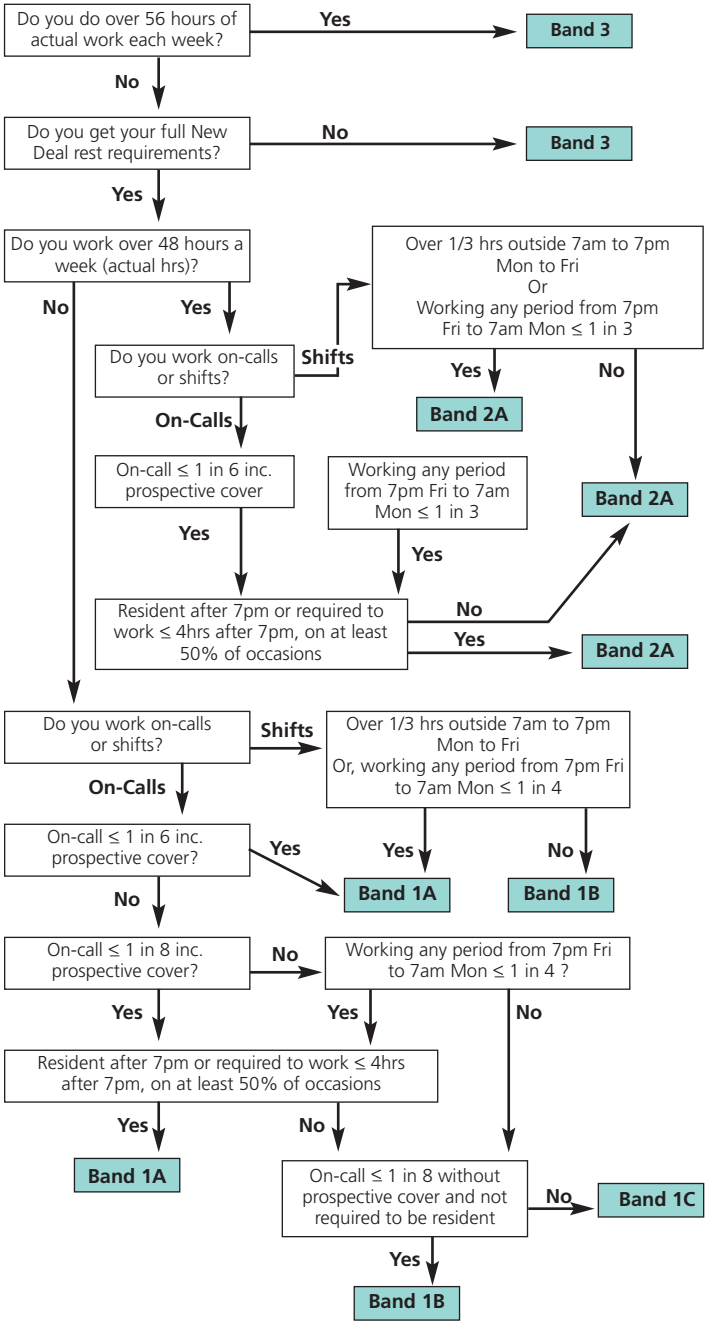
I look forward to hearing from you as soon as possible.

Thank you

Yours sincerely

<insert name>

Appendix VI



NB 1 in 4 means a rota frequency of one in four or more often (1 in 4, 1 in 3, 1 in 2 etc)

APPROVAL TO CHANGE BAND

Trust: Hospital: .....

Specialty(ies): .....

Numbers of Doctors in Working Arrangement by Grade

PRHO: SHO: SpR: Other: .....

Working Pattern: .....

Current Banding: ..... Proposed Banding: ..... Effective Date: .....

Stage	Evidence Required	Documentation	Confirmed Y/N
1a. Consult post-holders on proposed changes and obtain agreement of the majority participating in the working arrangements.	Approval of majority of current/incoming post-holders	Template signed by trust junior doctor representative confirming agreement of majority of current/incoming post-holders	
1b. Submit details of the new working arrangements to the action team for information and invited comment.	Full details of proposed working arrangements and/or rota summary (eg from ND2000 software)	Letter signed by action team chair or delegated authority confirming theoretical compliance of working arrangements	
1c. Obtain agreement from clinical tutor for education purposes.	Full details of proposed working arrangements Comments of action team	Letter signed by dean or delegated authority confirming educational acceptability of working arrangements	

If exceptionally and because of the impracticality of full implementation of new working arrangements a trust wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the regional action team (or its equivalent) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements.

Stage Evidence	Required	Verification	Confirmed Y/N
2. Submit request for provisional approval of working arrangements to action team	Signed letter from trust giving reasons for inability to fully monitor before rebanding. Evidence of full or partial testing/monitoring of proposed arrangements	Letter signed by action team chair or delegated authority authorising an offer of provisional banding.	

Current Banding: **Provisional New Banding:** **Implementation Date:**

Action Team Signatory Date:

Stage	Evidence Required	Verification	Confirmed Y/N
3. Monitoring of working pattern and confirmation of banding	Completed monitoring returns from 75 per cent of doctors on rota over full two week period Summary of monitoring results	This signed template	

Previous banding: **Verified New Banding:** **Effective Date:**

Trust Signatory Date:
(Designation)

Rota Signatory Date:
(Junior Doctor LNC representative)

Action Team Signatory Date:
(Designation)

Information

Terms and conditions of service, paragraph 21-22

AL(MD) 4/2003 AL(MD)1/2001

Postgraduate deaneries

England

Severn and Wessex deanery	www.swndeanery.co.uk
Peninsula deanery	www.swndeanery.co.uk
Eastern deanery	www.easterndeanery.org
Mersey deanery	www.merseydeanery.ac.uk
North Western deanery	www.pgmd.man.ac.uk
London deanery	www.londondeanery.ac.uk
Kent, Surrey and Sussex deanery	www.kssdeanery.ac.uk
Northern deanery	www.mypimd.ncl.ac.uk/pimd_new1
Yorkshire deanery	www.yorkshiredeanery.com
Trent deanery	www.trentdeanery.nottingham.ac.uk
Oxford deanery	www.oxford-pgmde.co.uk
West Midlands deanery	www.wmdeanery.org
Leicestershire, Northamptonshire and Rutland deanery	www.lnrdeanery.nhs.uk
South Yorkshire and South Humber deanery	www.sywdc.nhs.uk

Scotland

Glasgow deanery	www.nes.scot.nhs.uk
Edinburgh deanery	
Aberdeen deanery	
Dundee deanery	

Wales

www.uwcm.ac.uk

Northern Ireland

www.nimdta.ac.uk

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