BMA

Resident doctors' handbook on the 2016 contract

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

April 2021

Version 2.0

British Medical Association
bma.org.uk

Contents

1. Introduction

The Resident doctors' handbook on the 2016 contract

This handbook is your guide to the main contractual issues that may arise in resident doctors' employment, and on which you may need to seek advice. The guidance in this handbook covers resident doctors working under the new 2016 terms and conditions of service and includes all contractual updates that were introduced as part of the 2018 contract review. The 2016 contract only applies to resident doctors working in England. Any resident doctors working in Scotland, Wales or Northern Ireland should continue to refer to the 2015 handbook which can be found on the BMA's website.

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

BMA members may seek advice from our team of advisers on specific problems relating to the terms of their employment by visiting bma.org.uk/contactus

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

The handbook can also be found on the BMA website:
bma.org.uk/pay-and-contracts/contracts/junior-doctor-contract/bma-handbook-for-junior-doctors-in-england

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2. Training appointments and educational approval

Summary

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

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

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
- placements or programmes in NHS training grades for doctors and dentists can only be advertised if they have the valid educational and dean's approval.
- all recruitment procedures should comply with equality and diversity policies.

A post not in a recognised NHS training grade (eg ST level Trust grade post/clinical fellow/ FY3/Locally Employed Doctor (LED)) cannot be regarded as a recognised training placement or programme. You cannot assume that experience in such non-training posts will count towards the completion of specialty or general practice training.

Employers must seek permission from the postgraduate dean whenever it is proposed to advertise a training placement or programme. Before the advertisement can appear, the postgraduate dean must confirm that:
- there is valid educational approval
- it has the current postgraduate dean's approval

The following two elements must be met for a post to obtain the postgraduate dean's approval:
- posts must meet agreed standards on training, supervision, contractual terms, compliance with contractual working hour limits, accommodation and catering, and their local human resources strategy
- where there is a national or specialty-specific target for the number of doctors or dentists to be trained, the dean's approval must not be granted to placements that may cause these targets to be breached

GMC (General Medical Council) approval of experience

All formal training posts in the UK, that meet the above criteria and are part of a GMC-assured training programme, will now result in a Certificate of Completion of Training (CCT). Previously, training programmes that doctors entered later (eg at ST3), or in cases where the doctor had a certain amount of pre-existing experience, would allow them to leave training with a Certificate of Eligibility for Specialist Registration (CESR) – this is now no longer the case, and completing a GMC-assured training programme will result in a CCT.

Prospective approval of posts

The GMC does not retrospectively approve non-training posts for doctors hoping to gain a CCT. However, doctors in training can ask to have their previous experience counted, as long as it can be demonstrated and it meets UK curriculum and practice requirements.

For further information on OOP (Out of Programme Experience) see chapter 22. Educational and training approval from the GMC 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.

Honorary appointments

An honorary appointment gives a doctor formal status with an NHS employer for the purpose of NHS indemnity and the employer safeguarding processes. An honorary contract is issued for a specific purpose eg gaining experience, observing clinical practice, undertaking clinical research work whilst employed by an academic institution. An honorary contract does not give the doctor status as an employee with a salary or employee benefits. Employers offering honorary NHS appointments to doctors wishing to gain experience in order to pursue clinical specialist training must obtain the dean's approval before the placement is advertised or the appointment confirmed.

LASs (Locum Appointments for Service)

Locum doctors and dentists should not be appointed to training grades where there is no substantive placement to be covered. Locum appointments (apart from Locum Appointments for Training – LATs2) will not normally be recognised for training purposes. Applicants should be told before appointment that, although the substantive placement may attract the relevant approvals, a locum appointment should not be assumed to count towards a CCT. Advice about prospective approval of training for locum hospital placements should be sought from the GMC and the postgraduate dean.

Non-standard grades

If the title of the post is Trust StR or Trust Specialist Registrar then this is a non-standard grade and unlikely to count towards your CCT. Members considering applying for these posts should check with their local HEE office or the Trust's Director of Medical Education.

Responsibility for educational approval

FY1 grade

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

FY2 grade, specialty training grades and fixed-term specialty training appointments

The GMC is required to recognise and approve placements and programmes for the foundation programme, core training programmes, and for all specialty training leading to the award of a CCT. The GMC will take advice from the relevant medical royal college or faculty, which approves placements on its behalf. However, not all placements/programmes confirmed by the dean as having educational and postgraduate dean's approval automatically lead to the award of a CCT, eg Locum Appointments for Training and core training programmes. For detailed information on specialty training please read A guide to postgraduate training in the UK, also known as the *Gold Guide* – this is available for all years at www.copmed.org.uk/gold-guide.

Further information

2021 Guidance for Foundation Schools
Rough guide to the foundation programme

3. Learning and development

Summary

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

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

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

Career development webinars

We deliver a range of webinars that provide real-time teaching delivered live to your computer from a careers expert on topics which are aligned to your training, including:

- Assertiveness in the workplace
- Negotiating and influencing
- Work, stress and positivity
- Presenting skills
- Dealing with conflict
- Interview skills for specialty posts

We recognise that while in-person teaching is ideal, work and other commitments don't always allow for this. Webinars provide a flexible learning approach to career development – if you attend the live webinar, you can post questions to the speaker. Alternatively, the recorded version allows you to watch it at your leisure.

e-learning module resources for resident doctors

The BMA – in partnership with BMJ Learning – have developed a series of non-clinical e-learning modules that offer flexible learning that can be accessed anywhere, anytime. These e-learning modules have been written in response to needs expressed by medical students and doctors at all levels – and many have been written in with input and insight from doctors. They offer tailored guidance and practical learning support on a range of helpful topics that support your personal and professional growth.

Modules in the series include:

- Workload and time management
- Application to specialty training
- Interview skills for specialty roles
- Medical CVs and Application forms
- Career planning
- Developing an effective personal development plan
- Preparing effectively for the Multi-Specialty Recruitment Assessment (MSRA)
- Building professional relationships
- Dealing with pressure in your foundation years

Access these exclusive and valuable modules at learning.bmj.com/BMA.

Specialty explorer

With 65 specialties in the UK to choose from, it can be hard to make a decision about what the right one is for you. The BMA's Specialty explorer can help you consider fields you may not otherwise have considered. Answer a series of questions to receive a personalised report of the top 10 medical specialities that match your preferences.

The questionnaire takes around 10 minutes to complete. Remember, the result acts as a guide for your consideration – it is not a replacement for formal career guidance.
To access the site or for further information please visit bma.org.uk/myspecialty.

More career progression benefits from the BMA

BMA members are entitled to a wide range of benefits from the BMA and the BMJ. Make sure you support your continued non-clinical learning and career progression needs with:

- **BMA Library**: Access to a range of facilities, both in person and online, including thousands of online journals and e-books; expert literature search; and, research support. Visit bma.org.uk/bma-library.

- **BMJ Learning**: Free access to an extensive range of CPD and postgraduate training modules. Visit learning.bmj.com/BMA.

- **The BMJ**: an international peer-reviewed medical journal. As a member you are entitled to a free subscription to The BMJ in print and online. Visit BMJ.com to find out more.

- **BMJ OnExamination**: a leading provider of quality medical exam preparation. Prepare with questions that reflect the curriculum and test and improve your knowledge. For more information and the latest discounts available visit onexamination.com.

- **BMJ specialty journals**: As a BMA member you are entitled to discounted subscriptions to more than 50 of BMJ's specialty journals, some of which are the most influential titles in their field. Visit journals.bmj.com to find out more.

4. Recruitment to specialty training – advice for applicants

Summary

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

All applications to specialty training programmes are managed through the online application portal Oriel.

For most specialties, recruitment is coordinated on a UK-wide basis and led by a specific deanery or royal college. However, this may change for some elements of higher specialty or sub-specialty training. It is crucial to ensure that you are up to speed for the process and requirements of your chosen specialty.

The vast majority of specialty training programme-specific information can be found on the Specialty Training website; you should also check the relevant college, HEE local office or deanery website for information about training programmes and their application processes. You should also ensure that you meet the criteria listed in the person specification for the training programme to which you will be applying.

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

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

Applications to the Foundation Programme also use the Oriel system.

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

Further information
Oriel
HEE specialty training
NHS Jobs
UKFPO for Foundation Training

Recruitment to general practice

The National Recruitment Office coordinates recruitment of doctors to general practice. More information is available on the National Recruitment Office website at gprecruitment.hee.nhs.uk.

Code of Practice: Provision of information for postgraduate medical training

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

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

The key dates for the provision of information are set out below:

Information to be provided	Key dates
Recruiting organisation to provide application information to employer once offer of training programme has been accepted and general information has been provided to applicant.	Minimum of 12 weeks prior to start of post.
Employer to provide doctor specific information about the post being offered.	Minimum of 8 weeks prior to the start of the 1st placement.
Employer to provide the doctor with their rota in the **generic work schedule**.	Minimum of **8 weeks prior** to the start of the placement.
The **duty roster** will be made available at 6 weeks before commencement of post.	Minimum of **6 weeks prior** to the start of the placement.
Employer to issue **statement of particulars and employment contract** to doctor.	At the **start of the post, if not before**. It is now a legal requirement for an employer to provide you with a full statement of particulars by day one of employment.

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

As part of the above efforts, as part of the 2018 Review outcome it has become a contractual requirement for employers to provide trainees with work schedules (and other associated information) eight weeks prior to commencement, and their duty roster six weeks prior to commencement. This means employers are now contractually required to meet these timeframes. However, there are number of circumstances, set out within the TCS, which would mean these requirements would not apply.

Further information
Terms and Conditions of Service, Introduction, paragraph 8 & Schedule 4, paragraphs 10 and 24. More information about the Code – including timescales, links to the national versions, and updates as they occur – is available on the BMA website: bma.org.uk/advice-and-support/career-progression/training/code-of-practice-in-england.

Recruitment to an Academic Clinical Fellowship/Clinical Lectureships

An overview of the academic training programmes across the UK, including links for further information, is available on the National Institute for Health Research website.

Top tips on applying for a specialty training post

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

5. Contracts of employment

Summary

This chapter covers model contracts of employment, individual contracts of employment, job descriptions, and notice periods. It explains the different types of employers and provides some information on the circumstances where local variations can be made to the national terms and conditions of service. It also includes a brief summary of the FY1 shadowing period.

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

Either on or before your first day of employment with a new employer, you should receive a written statement of particulars of employment. This will normally be a contract of employment and a job description. Further information is available in the *Code of practice: Provision of Information for Postgraduate Training* bma.org.uk/advice-and-support/career-progression/training/code-of-practice-in-england.

If you haven't received this contractual information, contact our team of advisers by visiting bma.org.uk/contactus

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

Model contracts of employment

One model contract is designed to be applicable to all resident doctors in the training grades in England. Doctors who carry out academic work should also refer to the medical academics section, chapter 23, for information on medical academic employment contracts. The model contract covers the specific terms of each employment contract and is subject to the TCS (Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016). The model contract can be found on NHS Employers' website, there is also a variation of the model contract to be used for resident doctors who are employed under a lead employer contract.

Individual contracts of employment

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

Honorary contracts

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

Contract Checking service

The RDC urges that resident doctors who are BMA members, use the BMA guide to check that the employment contract offered is in accordance with the nationally agreed model. If a contract does not conform to the national model, residents should give written notice to their employer that they do not accept a non-standard contract and they should not sign it without first seeking advice. You can go to our website for more information: bma.org.uk/pay-and-contracts/contracts/your-contract-of-employment/your-contract-of-employment. Or contact our advisers by visiting bma.org.uk/contact

Further information

BMA website: bma.org.uk/pay-and-contracts/contracts/junior-doctor-contract/junior-doctor-contract-in-england.
Model contract: www.nhsemployers.org/pay-pensions-and-reward/medical-staff/doctors-and-dentists-in-training/terms-and-conditions-contracts/model-contracts-for-the-2016-contract.

Job descriptions

A job description should accompany the contract and forms part of the contractual relationship between the resident doctor and the employer. Ideally, the doctor should be given a copy of the job description on application for the post. The job description should provide an accurate picture of the post and define the hours (including details of the rota) and duties of the job. As mentioned in chapter 4, the requirement for a duty roster to be provided at least 6 weeks prior to commencement of the post was contractualised as part of the 2018 review.

Alterations to the job description should be by mutual agreement. Contact our team of advisers by visiting bma.org.uk/contact us if in any doubt.

Further information

BMA website: bma.org.uk/advice-and-support/career-progression/training/code-of-practice-in-england.

Notice periods

The notice period is the amount of notice that you or your employer must give if either party wishes to terminate your contract of employment. The following minimum periods of notice should apply, (schedule 11 paragraph 5, Terms and Conditions of Service) unless there is an agreement between both parties that a different notice period should apply:

Foundation Year 1	1 month
Foundation Year 2	1 month
Dental Foundation Training	1 month
Specialty registrar (fixed-term)	1 month
Specialty registrar (core training)	1 month
Dental Core Training	1 month
GP specialty trainee	3 months
Specialty registrar (run through)	3 months
Specialty registrar (higher specialty training)	3 months
Specialist registrar	3 months

Employment documentation

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

Resident doctors' employers

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

Doctors in training therefore do not have an employment relationship with Health Education England. In order to ensure that resident doctors are afforded legal protection if they are subjected to detrimental treatment by HEE as a result of whistleblowing, the BMA has reached an agreement with HEE to ensure that resident doctors have equivalent protections from such actions by HEE as they would have if they had a formal employment arrangement.

Foundation programme employers

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

Lead employers

It is open to employers to join together to agree an arrangement whereby one employer administers contracts on behalf of a group of employers. In such cases, the 'lead' employer may hold all contracts and second resident doctors from that employer to other 'host' employers. Such arrangements should assist in better planning and organisation of training rotations, and are strongly supported by RDC. Members offered contracts in which they will be seconded from one employer to another should view our guidance bma.org.uk/pay-and-contracts/contracts/your-contract-of-employment/your-contract-of-employment before signing the contract

Variations to national agreements on contracts and terms of service

Although employers are asked to employ resident doctors on national terms and conditions of service, they have some flexibility to introduce variations to the national model contracts for specialist and specialty registrars. However, this flexibility should only be at the margins of terms and conditions of service, and usually involve additions or modifications to enhance rather than reduce existing rights. It is intended that residents 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 resident doctors' representatives, and through the LNC (Local Negotiating Committee);*
- the postgraduate dean is satisfied that they will not adversely affect the quality of their training; and
- they are agreed by all the employers in the rotational training programme.

*For more information on LNCs, including how you can become involved, see the BMA website: bma.org.uk/what-we-do/local-negotiating-committees

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

Regional RDCs may have appointed negotiators who take the lead in any discussions at deanery or lead employer level. Resident doctors should seek advice from their local representative or LNC chair if they are aware that changes are being considered without any resident doctor input. They can also contact our advisers by visiting bma.org.uk/contactus

Vacant posts

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

FY1 shadowing

Shadowing is an arrangement where a prospective doctor observes an existing FY1 (foundation year one doctor) undertaking the usual activities required of their role before taking over the role themselves. It helps forthcoming FY1 doctors become more familiar with working practices and hospital systems, gain confidence and professional skills, and helps to improve patient care. It can also provide an opportunity to develop working relationships with the clinical and educational supervisors they may work with in the future.

All new FY1s across the UK should receive at least four days paid shadowing at the basic hourly FY1 salary rate for the hours undertaken. The BMA believes that this should be calculated on the basis that the hours undertaken in a four-day shadowing period (32 hours) are four fifths of the full hours (40 hours) for which an FY1 doctor is paid in a week. If your new employer says they will not be paying you for shadowing, or if it is not calculated at this rate, please contact the BMA by visiting bma.org.uk/contactus

There are no nationally agreed contractual arrangements in England for FY1s undertaking paid shadowing placements. RDC believes that the best approach is for a full employment contract to be used as this allows new FY1s to engage fully in clinical activity whilst shadowing.

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

Comprehensive information on shadowing is available on the BMA website.

Further information

HEE guidance: www.nwpgmd.nhs.uk/sites/default/files/HEE%20Shadowing%20Guidance%202014_0.pdf.

NHS Employers advice: www.nhsemployers.org/your-workforce/recruit/national-medical-recruitment/foundation-programme/foundation-programme-shadowing-payment-arrangments-2018.

6. Pay

Summary

This chapter provides information on pay for resident doctors, including information on salary scales; the importance of checking payslips; starting salaries; transitional pay protection; additional payments such as London weighting; and private fees.

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

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

However, as part of the 2018 review of the resident doctor contract in England, trainees received a guaranteed pay uplift of 2% per year for the next four years, up to and including the financial year of 2022/23, alongside other financial investment into contractual changes. In the most recent pay award, the DDRB did not recommend an additional uplift for resident doctors.

Further information
Pay Circulars for England: www.nhsemployers.org/pay-pensions-and-reward/medical-staff/pay-circulars.

Check your payslip

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

- **Pay supplements** – Your pay supplements remunerate you for additional work you undertake over your basic hours, on-call availability, weekend working and for antisocial hours such as night shifts, or a flexible pay premium where applicable. See below for further detail on these. They are also detailed fully in schedule 2 of the terms and conditions of service.
- **DDRB award** – Each year the DDRB considers evidence from the BMA, the UK Health Departments and the employers, and then issues a report outlining its recommended pay award for the next 12 months. Although the DDRB report is published in the spring, it takes time for new pay scales to be issued. Assuming there is a pay award for that year, you normally will not see it in your payslip until May. You will normally receive pay on the new scale one month, followed by arrears of pay for preceding months back to April in the following month. It cannot be guaranteed that the DDRB will recommend a pay increase every year, but on those years that an increase in basic pay is recommended, make sure you check your payslip carefully. If resident doctors are subject to a multi-year pay deal, as they currently are until April 2023, then unless an additional pay award is recommended then there will not be a DDRB pay award recommendation.
- **Other deductions** – The main deductions are income tax and National Insurance contributions, as explained above, as well as student loan and pension contributions. However, you may also have other deductions on your payslip – eg for a car parking permit, or childcare vouchers. These additional deductions can only be made by your employer with your consent. You should raise any queries regarding these directly with your employer (normally the payroll department).

Terms and conditions of pay are set out in schedule 2 of the TCS. There is also detailed guidance on the BMA website which can help you check your payslip and details how pay changes and what to look out for, particularly when changing post: bma.org.uk/pay-and-contracts/pay/payslips/understanding-your-payslip-junior-doctors-on-the-2016-contract.

Pay supplements

Under the 2016 terms and conditions of service, pay is made up a number of elements. Basic pay, with values as set out in the pay circular, is for the average 40 hour working week (for full time trainees).

The pay scale is comprised of five nodal points, linked to the stage of training the resident doctor is working at, they are;

- FY1 Nodal point 1
- FY2 Nodal point 2
- CT1-2/ST1-2 Nodal point 3
- CT3/ST3-5 Nodal point 4
- ST6-8 Nodal point 5

The fifth nodal point was introduced in October 2020 for trainees at ST6 and above, in order to recognise the significantly high service contribution these trainees make. This nodal point is being introduced through a staggered approach from October 2020, as follows:

- In October 2020, the value will be £3,000
- In October 2021, the value will increase to £6,000
- In April 2022, the value will increase to £7,200

Pay under the 2016 contract is typically calculated based on the generic work schedule for the post you are working in.

Additional hours

You can have up to 8 additional hours of work rostered into your work schedule up to an average of 48hrs per week, and these are paid in addition to the basic salary, at a rate of 1/40th of weekly whole-time equivalent for each additional hour worked.

Weekend allowance

The way weekends are paid is that instead of having certain time periods defined as meriting a pay enhancement, such as 'plain' versus 'enhanced' time, instead the enhanced pay for work done at the weekend is determined by the number of weekends that a doctor has to work over the course of the generic work schedule. As such there are two definitions of 'weekend', one for the purposes of pay and one for the purposes of working hour limits. A doctor rostered to work at the weekend (defined as one or more shifts/duty periods beginning on a Saturday or a Sunday) at a minimum frequency of 1 in 8 across the length of the rota cycle will be paid an allowance.

There are two definitions of 'weekend', one for the purposes of pay and one for the purposes of working hour limits. For the purpose of calculating pay, a weekend is considered to be worked if a doctor works any shift that begins on a Saturday or Sunday in a given week.

The weekend allowances are set as a percentage of full-time basic salary in accordance with the rates set out in the table below:

Frequency	Percentage
1 weekend in 2	15%
Less frequently than 1 weekend in 2 and greater than or equal to 1 weekend in 3	10%
Less frequently than 1 weekend in 3 and greater than or equal to 1 weekend in 4	7.5%
Less frequently than 1 weekend in 4 and greater than or equal to 1 weekend in 5	6%
Less frequently than 1 weekend in 5 and greater than or equal to 1 weekend in 6	5%
Less frequently than 1 weekend in 6 and greater than or equal to 1 weekend in 7	4%
Less frequently than 1 weekend in 7 and greater than or equal to 1 weekend in 8	3%
Less frequently than 1 weekend in 8	No allowance

A doctor working less than full time will also be entitled to be paid this allowance when working on a rota where the doctors working full time on that same rota are in receipt of such an allowance. The allowance paid to the doctor working less than full time will be paid pro rata, based on the proportion of the full-time commitment to the weekend rota that has been agreed in the doctor's work schedule. For example, a doctor making a 50% contribution to the rota would be paid 50% of the value of the availability allowance paid to a doctor making a 100% contribution to the rota. If a LTFT doctor works the same number of weekends as a full-time doctor on the same work schedule, they should receive the full-time weekend supplement.

On-call availability allowance

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

Resident on-call – being required to be on site for the whole duration of an on-call shift - is not generally a feature of the 2016 terms and conditions of service, and the definition of 'on-call' is restricted to non-resident on-call (NROC), not including the more informal uses of the term, such as 'holding the on-call bleep' while working a normal shift at your place of work. For doctors employed on a less-than-full-time basis, in any grade, the value of the on-call availability allowance shall be paid pro rata, based on the proportion of full-time commitment to the rota that has been agreed in the doctor's work schedule. For example, a doctor making a 50%contribution to the rota would be paid 50% of the value of the availability allowance paid to a doctor making a full contribution to the rota.

Payment for work undertaken whilst on-call

Doctors shall be paid for their average hours of work done while on-call, in addition to the 8% availability allowance for the whole duty.

The hours paid will be calculated prospectively across the rota cycle, and the estimated average hours at each rate of pay will be set out in the work schedule. There must be separate prospective estimates for anticipated work which will occur during plain time and enhanced time. Such work includes any actual clinical or non-clinical work undertaken either on or off site, including telephone calls; actively awaiting urgent results or updates; any travel time arising from any such calls; and, handover of patients at the end of the shift.

For the purposes of pay, these total estimates shall be converted into equal weekly amounts by dividing the total number of prospective hours at each rate by the number of weeks in the rota cycle.

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

Hours that attract a pay enhancement

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

Where a shift is worked which begins no earlier than 20.00 and no later than 23.59, and is at least 8 hours in duration, an enhancement of 37% of the hourly basic rate shall also be payable on all hours worked up to 10.00 on any day of the week. Where such a shift begins before 20.00, rostering guidance must be adhered to, as defined in schedule 3 paragraph 6 of the TCS.

This is in order to ensure that shifts, which are ostensibly 'night shifts', are paid at the enhanced rate in full, whereas any individual hours worked during the night period, as part of a shift which started earlier, will receive the enhanced rate as well. Employers should not start night shifts slightly earlier, for example at 19.30, in order to avoid paying the enhanced rate for the whole shift. The contract explicitly refers (schedule 3 paragraph 6) to the need to ensure shifts with hours worked during the night period are rostered in the correct way – check the BMA's rota design guidance, available online, if you need help with this.

Where a shift ends after 00.00 and before 04.01, the entirety of the shift will attract an enhancement of 37 per cent of hourly basic rate. These shifts are typically referred to as 'twilight' or 'disco' shifts.

The number of hours in the rota for which an enhancement is paid will be assessed across the length of the rota cycle (as set out in the work schedule), and converted into equal weekly amounts by dividing the total number of hours to be paid at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure and the doctor will be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked. This means you will receive your enhanced hours supplement averaged across the rotation, not in the particular months where you work these enhanced hours.

LTFT allowance

Any doctor training LTFT and paid under the 2016 TCS pay system (which excludes section 2 pay protected trainees) will be paid £1,000 a year, for as long as they train LTFT. This is to account for the relative additional costs of training as LTFT doctor compared to full time doctors (i.e. non pro-rata subscription costs, membership costs, fixed exam costs).

Flexible pay premia

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

Below values correct as of 27 April 2021, taken from Pay and Conditions Circular (M&D) 1/2021 (Published 12 March 2021):

Name of premium	Applicable training programme	Eligibility	Full time annual value (£)
General Practice Premium	General Practice	Payable to ST1, ST2, ST3, ST4 during general practice placements only.	8,965
Hard to fill training programme	Emergency Medicine	Payable to ST4 and above only.	Dependent on length of training programme, see below table
	Psychiatry	Payable to Psychiatry Core Trainees.	3,645
		Payable to Psychiatry Higher Trainees.	3 year higher training programme: 3,645
			4 year higher training programme: 2,734
Dual qualification -OMFS	Oral and Maxillofacial surgery, as per paragraph 42-44 of Schedule 2 of the TCS	Payable to ST3 and above only	Dependent on length of training programme, see below table
Histopathology	Histopathology	Payable to ST1 and above only	4,374
Academia	As per paragraphs 36-41 of Schedule 2 of the TCS	Upon return to training following successful completion of higher degree.	4,374

Length of training programme*	Full time annual value (£)
3 years	7,289
4 years	5,467
5 years	4,374
6 years	3,645
7 years	3,124
8 years	2,734

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

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

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

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

For full details of eligibility for flexible pay premia, see schedule 2 paragraphs 21-47 of the 2016 terms and conditions of service.

Academic Flexible Pay Premium

The academic FPP is available for doctors who are either on an integrated clinical academic pathway (eg NIHR), or doctors who have taken time out of training to pursue a research degree, and upon successful completion of the degree has returned to training. Payment for the premium continues until you exit your training programme.

For doctors on an integrated clinical academic pathway, they shall be eligible to receive the FPP upon successful completion of the degree and return to the same training programme. For doctors taking time out of training in pursuit of a degree, this can either take the form of either a formal Out of Programme Research experience (OOPR), or changing to training LTFT to pursue the degree on a less than full time basis. To be eligible, you must have been appointed to and commenced in a core, higher or run through training programme prior to taking time out of training. You must also return to, or continue in, a training programme.

Protection of salary on changing training path

Where a doctor chooses to switch directly from one training programme (other than a Foundation programme) into an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose) the doctor may be eligible for pay protection. To be eligible for protection, the doctor must take up the first appointment on the new training programme no later than 12 months after leaving the original training programme. This period of time could as a reasonable adjustment be extended in the event that a doctor is disabled (for the purposes of the Equality Act 2010), and/or could be extended to account for sickness absence or parental leave.

Where a doctor opts to switch into a hard-to-fill specialty having achieved an Outcome 1, Outcome 2, Outcome 6, or Outcome 7 in their most recent ARCP, and would have otherwise progressed to the next grade had they not switched specialty, their pay protected amount will be based on the basic salary for the grade they would otherwise be at had they not switched.

Where a doctor opts to switch into a hard-to-fill speciality part-way into a training year without having achieved an Outcome 1, Outcome 2, Outcome 6, or Outcome 7 in their most recent ARCP, or where a doctor opts to switch into a hard-to-fill speciality before their ARCP, their pay protected amount will be based on the basic salary for the grade they were at prior to switching speciality.

The amount of pay protection due to a doctor described will depend on their ARCP outcome, and the doctor will continue to progress up the pay scale whenever they successfully progress onto the next grade as if they had not switched specialties. For example, if a doctor switches into GPST1 and is pay protected at the ST2 pay point, and successfully progresses to GPST2, their pay protected amount will increase accordingly and be based on the ST3 nodal point. Pay for additional hours, hours at enhanced rates, or any other amounts will be based on this higher salary amount. The doctor will receive the relevant flexible pay premium in addition to this.

Where a doctor is pay protected and does not progress onto the next grade, their salary will not automatically increase to the value of the next grade's pay point. For example, where a doctor switches into GPST1 and is pay protected at the ST2 pay point and remains at GPST1 the following year, their pay protection will continue to be based on the ST2 pay point for as long as they remain at GPST1. The doctor will need to progress to GPST2 in order for their pay protection to increase to the ST3 salary. Pay for additional hours, hours at enhanced rates, or any other amounts will be based on this basic salary amount. The doctor will receive any relevant flexible pay premium on top of this.

Where a doctor, for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010), or to caring responsibilities, switches directly from one training programme (other than a Foundation programme) into another training programme, whether or not that programme is an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose), and the doctor's basic pay is reduced as a result of the switch, they will have their pay protected (dependent on their ARCP Outcomes).

In addition to the hard-to-fill training programmes identified in Annex A, for doctors changing specialties only, the JNC(J) will determine and maintain a list of additional specialities to which pay protections applies ('Difficult to Recruit Specialities'). A list of these difficult to recruit specialities appears at www.nhsemployers.org. Those choosing to switch directly from one training programme (other than a Foundation Programme) to a difficult to recruit speciality shall have their pay protection assessed and calculated in accordance with schedule 2, paragraphs 50 to 53 of the TCS.

Protection of salary on re-entering training from career grade

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

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

Where a doctor is already employed in a recognised NHS career grade post, re-enters training for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010) re-enters training into another programme, including those that are not designated as 'hard-to-fill', they will also be eligible for pay protection as outlined above. Such doctors, as outlined above, will have pay protection calculated by comparing the basic salary received whilst employed in the previous career grade post with the sum total of the nodal point applicable to the level they are re-entering training in the hard-to-fill training programme, alongside any additional payments due in that role (including; pay for additional rostered hours, any enhanced rates for hours worked that attract enhancements, any on-call availability allowance, any weekend allowance, and any flexible pay premium).

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

Further information

Terms and conditions, schedule 2 paragraphs 48-61.

London weighting

Resident 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. The categorisation of the London weighting zones needs updating however as all NHS workplaces within the M25 pay the higher rate.

Members may obtain further information or clarification on whether their hospital is within a particular zone by contacting our team of advisers via bma.org.uk/contactus

Overpayment or underpayment of salary

There may be occasions where salaries have either been over or underpaid. Where overpayment has been established, the BMA would expect there to be a negotiated repayment schedule, rather than repayment in a lump sum, to avoid any financial hardship. The employer should provide a breakdown of the sums due. We would advise you not to agree any repayment until the breakdown is obtained. No monies should be deducted without consent, and no interest should be charged on the monies owed. If a repayment schedule is negotiated then it should normally be over the same period as the overpayment took place. We would however expect that any underpayment be repaid at the earliest opportunity and in full.

In both situations, members are advised to contact our team of advisers via bma.org.uk/contactus

Changes to the work schedule affecting pay

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

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

Where changes to the work schedule are requested by the doctor and agreed by the employer, and total pay would be decreased as a result, the doctor's total pay will be reduced in line with the change in the work schedule, from the date that the change is implemented.

Exception reporting

Because of unplanned circumstances, a doctor, in their professional judgement, may consider that there is a duty to work beyond the hours described in the work schedule, in order to secure patient safety. In such circumstances, employers will appropriately compensate the individual doctor for such hours, if the work is authorised by their clinical manager. This authorisation would be given before or during the period of extended working, or afterwards if this is not possible.

When possible and practicable, doctors will use reasonable endeavours to seek approval from their clinical manager before or during the event. However, it is recognised that a doctor may not be able to gain prior authorisation due to circumstances at the time. This should not prevent the doctor from submitting an exception report. Once an exception report has been submitted by the doctor, it must be validated and an outcome agreed within 7 days to allow payment to be made for the additional hours worked.

Compensation should be by additional payment (at the basic hourly pay rate, uplifted by any enhancements that apply at the time that the unscheduled work takes place), or by time off in lieu, or by a combination of the two. Where safe working hours are threatened by such an extension of working hours, time off in lieu will be the preferred option.

If the additional hours of work have caused a breach of rest requirements, the time off in lieu must be taken within 24 hours, unless the doctor self declares as fit for work and the manager agrees, in which case it can be accrued. Time off in lieu arising from breaches of hours but not rest can be accrued.

Where time off in lieu is agreed by the doctor and the report's actioner as the outcome of an exception report, there will be a four week window from the outcome being agreed for the doctor and rota manager to discuss and allocate time off in lieu to a future shift in their working pattern, before the end of that rotation. Where this does not occur, the time off in lieu should automatically be converted by the employer to pay after that four week period. At the end of a rotation, any untaken time off in lieu will be converted into pay.

Where a manager does not authorise payment, the reason for the decision will be fed back to the doctor and copied to the guardian of safe working hours for review. Where a doctor is paid for additional hours worked while 'acting down', their pay will reflect their current nodal point and not the lower nodal point of the grade at which they are 'acting down'.

Where such additional hours are in breach of the Working Time Regulations limit of a 48-hour average working week, or of the absolute contractual maximum of 72 hours worked in a consecutive 168 hour period, or where the minimum rest requirement of 11 hours between shifts has not been achieved, or where eight hours of total rest per 24 hour non-resident on-call shift has not been achieved, or where five hours of continuous rest has not been achieved between 22.00 and 07.00 during an NROC shift, the hours worked which caused these breaches will attract a penalty rate as described in chapter 9 of this handbook.

Medical academic staff

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

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

Private fees for resident doctors

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

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

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

Fee paying work

Resident doctors, like other hospital doctors, may charge a fee for certain types of medical work (i.e. Cremation forms, DVLA forms, Section 12 assessments). However, such activities should normally be carried out in the time in which the doctor is not being paid by their employer. The employer may agree that fee-paying work can be undertaken in work hours, provided that either;

- the doctor remit the total value of the fee to employing organisation, or
- the doctor retains the fee and allows the employer to reclaim the time that the fee-paying work was undertaken from their basic salary, or
- the doctor agrees to carry out additional NHS work outside of their work schedule to make up that time at a later date

If you have any problems with private or fee paying working, contact our team of advisers via bma.org.uk/contactus

Further information
Terms and conditions of service, schedule 8.

Payment of annual salaries

The annual salaries of full-time employees will be apportioned as follows:
– for each calendar month: one-twelfth of the annual salary
– for each odd day: the monthly sum divided by the number of days in the particular month.

The annual salaries of less than full time doctors should be apportioned as above, except in the months in which employment commences or terminates, when they should be paid for the hours worked. RDC disagrees with the calculation method used for odd days, as it is viewed as undervaluing the value of a single day. RDC intends to discuss this with NHS Employers and agree an alternative, more accurate calculation method.

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

Locum pay

Where a doctor carries out additional work for the employer through a locum bank, such work will be paid at the rates determined by that NHS staff bank.

Transitional pay protection

As part of the 2016 contract deal, resident doctors who worked under the 2002 contract or applied for their training programme ahead of the 2016 contract implementation are normally entitled to pay protection. There are two types of pay protection available to this group of doctors. These are outlined below.

Section 1 pay protection
– Available for doctors who were at the earlier stages of their training at the time of implementation of the 2016 contract. (see eligibility criteria below)
– Based on the basic salary and banding that you were earning on the day prior to starting work under the new contract.

Section 2 pay protection
– Available for doctors at later stages of the training programme (see eligibility criteria below).
– Doctors on section 2 pay protection are paid a basic salary on the pay scale (MN37) on which they were previously paid under the 2002 T&Cs.
– Doctors receive annual increments on the anniversary of their previously agreed incremental date until they exit training or until 6 August 2025, whichever is sooner.

Pay protection eligibility

The eligibility criteria for pay protection is set out in schedule 15 of the resident doctors T&Cs. They are complex, so you are encouraged to read them in full and contact the BMA for bespoke advice.

An overview of eligibility is provided below.

Section 1
The following doctors shall be entitled to transitional pay protection under the arrangements described in Schedule 15 at paragraphs 5 to 26, with effect from 3 August 2016:

a. All doctors commencing F1 on 3 August 2016.
b. All doctors remaining on F1 or remaining on F2 as at 3 August 2016.
c. All doctors entering F2 directly from F1 or from other training programmes on 3 August 2016.
d. All new entrants to core or run-through speciality training (CT1 / ST1) from F2 or from other training programmes on 3 August 2016.
e. All doctors moving into CT2, ST2 or CT3 grades from the grade immediately below or from other training programmes on 3 August 2016.
f. All doctors remaining in the CT1, ST1, CT2, ST2 or CT3 grades as at 3 August 2016.
g. All doctors progressing directly from core training or from other training programmes to higher training at ST3 point (or for doctors entering higher training in psychiatry or emergency medicine at the ST4 point) on 3 August 2016.

Additionally, pay protection also applies to doctors who complete a training programme on 2 August 2016, having already accepted the offer of their next training programme, but who, as either a direct result of the differing start dates of different training programmes, or as a result of an agreed deferral of their start date, did not commence their next training programme on 3 August 2016.

Section 2
The doctors identified below will be granted transitional pay protection under the arrangements described in this Schedule at paragraphs 27-41, with effect from 3 August 2016:

a. Doctors already at ST3 or above on a run-through training programme on 2 August 2016.
b. Doctors already in higher specialty training programmes on 2 August 2016.
c. Specialist registrars (SpRs) on a pre-2007 training programme.

You can also use our interactive tool to find out what level of pay protection you may be entitled to.

Further information
See schedule 15 of the terms and conditions of service.
The BMA's transitional pay protection tool may also be helpful to help determine if you are eligible for pay protection. bma.org.uk/pay-and-contracts/pay/transitional-pay/transitional-pay-protection.

7. Work Scheduling

Summary

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

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

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

Principles and objectives of work scheduling

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

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

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

Developing a generic work schedule

A generic work schedule must be provided to a doctor at least 8 weeks before they start a placement. It should feature intended learning outcomes, scheduled duties, time for quality improvement and patient safety activities, periods of formal study, and the doctor's contract hours.

Specifically, the generic work schedule should include:

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

Key criteria

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

Developing a personalised work schedule

The personalised work schedule should be agreed between the resident doctor and educational supervisor, in accordance with the *Gold Guide* and/or other relevant documents. The doctor and educational supervisor are jointly responsible for personalising the work schedule according to the doctor's learning needs and opportunities within the post. This must include adequate allocated time for the doctor to achieve all expected educational outcomes for the post.

The personalised work schedule must be agreed before or within four weeks after the commencement of the placement during scheduled hours of work. Where the personalised work schedule has not been agreed within four weeks after the commencement of the placement, the doctor may submit an exception report.

In some cases, employers may need to make changes to the work schedule in light of significant changes in facilities, resources or services. It is expected that every effort should be made to anticipate and agree on such changes.

Further information

Terms and Conditions of Service, Schedule 4.
Follett review principles: webarchive.nationalarchives.gov.uk/20060715150140/http://www.dfes.gov.uk/follettreview.
The *Gold Guide*: www.copmed.org.uk/images/docs/gold_guide_8th_edition/Gold_Guide_8th_Edition_March_2020.pdf.

Maintaining the work schedule

- As a minimum, there should be an educational review and work schedule discussion at the beginning and end of the placement.
- The personalised work schedule should be agreed at the first formal meeting between the doctor and the educational supervisor. This should occur before or within four weeks after the commencement of the placement.
- If the personalised work schedule has not been agreed within four weeks of the commencement of the placement, you may submit an educational exception report.
- The doctor and educational supervisor should regularly consider progress against agreed learning and service objectives.
- Work schedule discussions should take place to establish if any changes in support, resources, or planned service duties are needed.
- Discussions should take place if the employer or doctor consider that training opportunities, duties, responsibilities, accountability arrangements or objectives have changed or need to change significantly.
- If agreement is not reached regarding the work schedule, the doctor may request a work schedule review (schedule 5, Terms and Conditions of Service).
- A work schedule review can also be requested at any time during the placement if it becomes apparent that the current work schedule does not allow for sufficient training opportunities.

Planning a rota

Limits on working hours

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

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

Further information
Terms and Conditions of Service, Schedule 3, paragraphs 7-20.

Weekend working

All resident doctors will be required to work on the weekend at some point during their postgraduate training. For numerous trainees, weekend working will be a regular occurrence throughout the course of their training.

To limit the anti-social impact of weekend working on trainee's personal lives, the TCS places limits on the frequency at which trainees can be scheduled to work on weekends.
All reasonable steps should be taken to avoid rostering doctors to work at the weekend at a frequency of greater than 1 in 3 weekends. Weekend work for this purpose is defined as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday. The limit on weekend working does not mean that doctors can't work on consecutive weekends, but rather that they cannot work weekends at a frequency greater than 1 in 3 across the length of their rota.

A weekend with one shift scheduled on either the Saturday or Sunday would count towards the rota's weekend frequency the same as a rota with shifts scheduled on both the Saturday and the Sunday. A shift which starts on a Friday and finishes on a Saturday would count towards the rota's weekend frequency for the purposes of the safety limit on the frequency of weekend working. However, such a shift would not count towards the weekend working frequency, where there are no other shifts scheduled on that weekend, for the purposes of calculating the weekend pay allowance for the rota.

Trainees that wish to work at a frequency greater than 1 weekend in 3, by undertaking additional work, for example as a locum, are able to independently agree to do so, but must not work an average weekend frequency of greater than 1 weekend in 2.

Exemption from 1 in 3 weekend working limit
The 1 in 3 weekend working frequency limit can be more problematic to introduce on some rotas than others. The introduction of this limit could require the recruitment of additional doctors or other healthcare professionals to fill the gaps left on the rota, which may not always be immediately possible. Therefore, by exception, authorisation for a rota using a pattern with a weekend working frequency greater than 1 in 3 can be granted if there is a clearly identified clinical reason.

This clinical reason must have been agreed by the relevant clinical director for that rota and deemed appropriate by the Guardian of Safe Working Hours. This justification should be clearly set out and shared with the affected doctors.

Resident Doctor Forums have the ability to challenge the clinical justification provided by an employer, if they do not believe it to be valid, and/or suggest alternative solutions for consideration. The JDF can request that further evidence is provided for the requested exemption. However, JDFs do not have unilateral authority to veto an evidenced clinical justification provided by an employer and the guardian. JDFs cannot reject an appropriately justified exemption on the basis of the collective preference of doctors working on a rota being to not work a clinically necessary higher weekend frequency.

Following the clinical justification being provided by the employer and being reviewed by the JDF, rotas which exceed the 1:3 weekend frequency should be co-produced with the affected doctors and agreed via the resident doctor form. All rotas which exceed the 1:3 weekend frequency limit should be reviewed annually as a minimum, but earlier review dates may be deemed appropriate when agreeing the exemption in order to assess progress in addressing the need for a weekend frequency of greater than 1 in 3 weekends, and to assess whether it is still necessary for the exemption to be retained.

As long as there are no safety implications for both patients and doctors, then it is possible that a rota could remain in place with a weekend frequency above 1:3 where necessary and clinically justified.

Regardless of any clinical justification, there is an absolute limit on weekend working frequency of 1 in 2 weekends. No doctor can be rostered for work at the weekend at a frequency of greater than 1 week in 2. If you are asked to work at a frequency greater than 1 in 2 weekends, please contact the BMA for advice.

Opting out of the WTR

A resident doctor may choose to voluntarily opt out of the WTR average weekly limit of 48 hours. If they do, all other safety and rest limits set out in the WTR and TCS (including the maximum average of 56 hours per week and maximum of 72 hours over a 168 hour period) will still apply. This agreement to opt out is subject to prior agreement, and can apply to either a specified period or indefinitely. You should be mindful that, should you later wish to opt back into this restriction a notice period will apply.

Further information
Terms and Conditions of Service, Schedule 3, paragraphs 47-51.

On-call periods

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

On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so, and where such an on-call pattern would not breach any of the other limits on working hours or rest.

Where a work schedule contains on-call arrangements, then all non-resident on-call duties must be rostered as separate shifts within a rota, and on-call shifts cannot contain within them a resident shift.

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

A work schedule should include an indication of the amount of the expected predictable and unpredictable work during enhanced hours and unenhanced hours.

- Predictable work refers to routine activities which will occur at specific times during an on-call shift. This may include ward rounds, anticipated duties and clinical handovers. Such activities, along with the expected hours of work required, should be specified within a work schedule.
- Unpredictable work refers to unscheduled activities that occur at unspecified times during an on-call shift, including telephone calls, actively awaiting urgent results or updates and travel time arising from any such calls. For these activities, the employer must provide a prospective estimate of the average amount of unpredictable on-call work that will occur during an on-call shift, using the calculation method described below.

To inform the calculation of the prospective estimate of the average amount of work performed during an on-call shift, employers should use all relevant available data. This includes activity data; calls through switchboard; bleeps; admissions; feedback from colleagues in the department; feedback from staff previously and currently rostered for on-call duties on the relevant rota; previous exception reporting data for the relevant rota; and recent diary activities or monitoring data.

Prospective hours should be calculated by totalling the number of hours of on-call work performed across an actual (and typical) week of on-call shifts across the rota reference period of a rota cycle, placement length or 26 weeks, whichever is shorter. From this, an average amount of work for each weekday (Monday to Friday) and weekend (Saturday and Sunday) can be calculated. The total hours should then be divided by the number of on-call shifts from which the total number of hours were drawn to provide an average amount of on-call work - at both the plain time rate and enhanced rate - a doctor can expect to undertake during their rostered on-call shift(s).

All rostered on-call shifts must have a prospective estimate of unpredictable work a doctor can expect to perform, even if it is a very low intensity shift pattern, with 15 minutes being the minimum prospective estimate for an individual on-call shift.

Where a doctor, or doctors, on an on-call rota are regularly exceeding or significantly below the prospective estimate for on-call shifts, a work schedule review is required. Where the prospective estimate is regularly being exceeded, consideration should be given to alternative arrangements, including having an additional doctor on the on-call rota; reducing the workload covered by the on-call doctor; or converting the on-call working pattern to a full-shift working pattern.

On-call handovers

The maximum length of an individual on-call duty period is 24 hours. However, the maximum length of an on-call shift can be extended by between 15 minutes and one hour to allow shift overlap and ensure there is adequate time for clinical handover.

Overlap of on-call shifts is crucial within rotas, as this is critical to the safe transfer of patient information to deliver continuity of care and good quality patient management. Most services will require a minimum handover of 15 to 30 minutes. Some services may need to allow for 60 minutes or in rare cases even longer. Coming in specifically to attend handover or undertake telephone handover is classed as working time and is part of the duty period. Handover cannot be scheduled to overlap with other duties (i.e. clinic / theatre list), it must have dedicated time.

Further information

Terms and Conditions of Service, Schedule 3, paragraphs 24-46 & Schedule 4, paragraphs 16-17.
The BMA's and NHS Employers' joint *Good Rostering Guide*, see Non-resident on call rotas (pg 17-21) www.nhsemployers.org/case-studies-and-resources/2018/05/good-rostering-guide.
Working Time Regulations 1998 (as amended): www.legislation.gov.uk/uksi/1998/1833/contents.

On-call patterns and the Working Time Regulations

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

Further information
NHS Employers' report covering the impact of the SiMAP and Jaeger rulings.

Preventing shadow rotas

The 2016 terms and conditions of service include a clause prohibiting the use of 'shadow' rotas, when an additional doctor is rostered to do an on-call shift for what should be a full shift in order to save money (the availability allowance for on-call duty is 8% of basic pay). If a resident doctor is required to work a night shift or a shift on a weekend as part of a rota, the employer cannot roster a second doctor working that same rota to be available as a non-resident on call for the same night or weekend. The exception is if there is a clearly identified clinical reason agreed by the clinical director, and the work pattern is agreed by both the guardian as being safe and by the DME as being educationally appropriate.

If a resident doctor is asked to work such a rota and feels that it is inappropriate, they should submit an exception report and request a work schedule review, and contact the BMA for individual advice.

Locum work

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

There is no obligation for residents to do locum work, nor to opt out of the Working Time Regulations, to increase the spare hours they have for such work. However, if they do choose to do locum work, they must offer their hours to the service of the NHS first via an NHS staff bank of their choosing.

If the doctor offers hours of locum work to the staff bank but there is no suitable work available, they are then released from the terms of schedule 3 paragraph 52 and given permission to find locum shifts elsewhere (for example, through an agency).

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

LTFT doctors are equally entitled to undertake locum work in the same manner as full time trainees, which is confirmed in HEE guidance.

Further information
Terms and Conditions of Service, Schedule 3, paragraph 52-53 & 47-51.

How to plan a rota

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

Further information

The BMA's and NHS Employers' joint *Good Rostering Guide*, see Roster design (p.g. 6-12) www.nhsemployers.org/case-studies-and-resources/2018/05/good-rostering-guide.

8. Hours of work and WTR

Summary

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

From 2016, there are two different protection frameworks in place to impose limits on working time and rest requirements for resident doctors. The 2016 terms and conditions of service features a new comprehensive list of hours limits and rest requirements which match, and in many cases supersede, the statutory protections imposed by the WTR (Working Time Regulations).

The EWTD is a European Union initiative, which is known as the WTR in British law. However, there are in some cases different rules in the contract for those who have chosen to 'opt out' of the WTR, so it is important to understand the law as well as the contractual rules. If the WTR legislation was to be changed or revoked, the working protections in the contract would continue to apply.

WTR

Background and history

The European Working Time Directive, which came into force in the UK as the Working Time Regulations (WTR) on 1 October 1998 for consultants and other career grade hospital doctors, originally excluded resident doctors. Agreement was later reached to extend the directive to doctors in training, and it has applied in full to residents since August 2009.

WTR provisions

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

WTR rest requirements

The rest requirements are as follows:

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

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

Opting out of the hours limit

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

Employers must not pressurise workers to sign an opt out, and they must continue to keep accurate records of the working hours of all doctors, including those who have opted out. You should be mindful that, should you later wish to opt back in, a notice period will apply. Further guidance for resident doctors on opting out is available on the BMA website.

Medical academic doctors

Resident academic doctors with a substantive NHS contract should be covered by the working time directive where they undertake academic work on a day release basis. They have the same obligation to provide continuity of care for patients as their resident doctor colleagues. The BMA believes that all time spent working either in the NHS or at the university (aggregated) should count towards the weekly hours limit and rest requirements. However, members should be aware that universities have been resistant to the local application of the WTR for academic work.

WTR definition of working time

The way in which working time is defined under the regulations has had important implications for resident doctors' working arrangements in the UK. Two important European Court of Justice rulings (the 'SiMAP' and 'Jaeger' cases) have meant that, currently, working time includes all time spent at the place of work and available to the employer. This includes periods when the doctor is not actually working, for example resting during resident on-call periods.

Further information

Working Time Regulations 1998: www.legislation.gov.uk/uksi/1998/1833/contents.
The Working Time (Amendment No 2) Regulations 2009: www.legislation.gov.uk/uksi/2009/2766/contents/made.
See our guidance for extensive guidance: bma.org.uk/pay-and-contracts/working-hours/european-working-time-directive-ewtd/doctors-and-the-european-working-time-directive.

The resident doctors contract

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

Enforcement of rules

It is vital for doctor and patient safety that trainees do not work beyond the rostered hours agreed in their work schedule and breach the safe working limits enshrined in the contract. The terms and conditions of service include mechanisms to prevent this, and – where this is not possible – to compensate doctors with rest and, where necessary, pay to address the breach.

These are set out in chapter 7 (work scheduling) and chapter 9 (exception reporting, work schedule reviews, and the Guardian of Safe Working).

Working hours

General limits

- Normally a minimum of 11 hours continuous rest between shifts. Breaches of this rest are subject to time off in lieu (TOIL) which must be within 24 hours. If this rest period is not achieved, the doctor will be paid for the additional hours worked at a penalty rate (schedule 2 paragraph 77, Terms and Conditions of Service), and will not be expected to work more than five hours the following day. Their pay will not be deducted for the resultant time off.
- A maximum of seven shifts on consecutive days. After the seventh consecutive shift or day of work, a minimum of 48 hours rest must be rostered.
  - By agreement of the doctors on a rota, this limit can be increased to a maximum of eight consecutive days or shifts.
- No doctor should be rostered to work more than 1 in 2 weekends. A frequency of above 1 in 3 can only be rostered with approval from the Resident Doctor Forum (JDF) in instances where there is a clear clinical reason.

Maximum hourly limits
- A maximum of 48 hours on average of work per week.
- A maximum of 72 hours of work in any period of 168 hours (7 days)
- A maximum shift of 13 hours (for non-resident on-call periods, the maximum is 24 hours, except where the ability to extend beyond 24 hours for handover purposes is utilised).

Consecutive shifts
- A maximum of four 'long shifts' (a long shift is one lasting longer than 10 hours) on consecutive days. A minimum of 48 hours rest must be rostered immediately following the fourth long shift.
  - By agreement of the doctors on a rota, this limit can be increased to a maximum of five consecutive long shifts.
- A maximum of four long shifts finishing after 23.00. A minimum of 48 hours rest must be rostered immediately following the fourth long shift.
- A maximum of four long shifts where at least three hours of work fall between 23.00 and 6.00 on consecutive days. Where night shifts (as defined above) are rostered singularly, or consecutively, then there must be a minimum 46-hour rest period rostered immediately following the conclusion of the shift(s).

Breaks
A resident doctor must receive:
- at least one 30 minute paid break for a shift rostered to last more than five hours;
- a second 30 minute paid break for a shift rostered to last more than nine hours; and
- A third 30 minute paid break for a night shift (as defined above) rostered to last 12 hours or more.

These breaks should be taken separately. If they are combined into one, the break should take place towards the middle of the shift. Breaks should not be taken in the first hour of the shift, or at the end of a shift.

On-call periods

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

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

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

Rest during and after on-call shifts
Whilst on-call, a doctor should expect to get eight hours rest per 24-hour period, of which at least five hours should be continuous rest between 22.00 and 07.00. Where this is not expected to be possible, rostered work on the day following the on-call period must not exceed five hours.

The day following an on-call period (or following the last on-call period, where more than one 24-hour period is rostered consecutively) must not be rostered to last longer than 10 hours.

Where during an on-call period, your expected overnight rest is significantly disrupted, causing you to not achieve at least five hours of continuous rest, undisturbed by work, between 22.00 and 07.00, you must inform your employer immediately, or as soon as reasonably practicable, and arrangements must be made for you to take appropriate rest. Time off in lieu must be taken within 24 hours. If for any reason this is not achieved, then the additional hours will be paid according to the exception reporting and guardian fines provision.

If, as a result of actual hours worked during the on-call period, your rest has been significantly disrupted, as defined in the paragraph above, the default assumption by your employer should be that it may be unsafe for you to undertake work because of tiredness. If this is the case, you must inform your employer that you will not be attending work as rostered, other than to ensure the safe handover of patients. No detriment to pay can result from such a declaration. Arrangements for dealing with this issue must be agreed locally.

Hourly limits

- The maximum length of an individual on-call period is 24 hours, except where the ability to extend beyond 24 hours for handover purposes is utilised.
- A maximum of three on-call periods can take place in seven consecutive days (unless otherwise agreed locally).
- The day following an on-call period (or following the last on-call period if more than one is rostered consecutively) must not be rostered to last longer than 10 hours. If the 5 hours continuous rest requirement during an NROC shift is breached, then a doctor can only work 5 hours the following day.

Low intensity on-call

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

Tips for designing a compliant rota

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

Total hours

It might be possible to reduce hours by redistributing workload.

Frequency of out-of-hours work

The first step should be to identify what work is being done out of hours. In both problem areas, the following might assist:

Bleep policies

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

Organisational changes

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

Skill mix initiatives

- Ensuring adequate staffing levels in support services, both in the 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 the 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 residents.

Reorganisation

- Increasing cross-cover of working patterns where appropriate so that, for example, doctors on a night shift may be able to relieve an 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 forms of working patterns may be investigated.

Further information

The BMA's and NHS Employers' joint Good Rostering Guide www.nhsemployers.org/case-studies-and-resources/2018/05/good-rostering-guide.

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

Summary

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

Resident doctors' work is often varied and requires a certain amount of flexibility. if an individual finds that the work they are actually doing differs from what is set out in their work schedule – either because it is significantly different or regularly varies from what has been agreed – they should raise this with their employer as soon as possible so that immediate steps can be taken to address the issue.

If concerns about individual working patterns cannot be resolved in discussions, then a work schedule review can be requested by either the resident doctor or the employer, to address any concerns through an appropriate process. The same process, of a work schedule review, can be used if a resident doctor is working in line with their work schedule, but a change to the schedule has been proposed and the matter cannot be resolved through an informal discussion.

Exception reporting

This is the process for a resident doctor to report any individual variations from the actual work schedule, on a per shift basis. For example, if a resident doctor is required to work past their scheduled finish time for patient safety and other reasonable purposes, or the training opportunities during the shift are not in line with the expectations listed in the work schedule, then these 'exceptions' to the work schedule must be logged through your employer's exception reporting process. The exception report is then used to assess how common the issue is and how the doctor will be compensated for the exception, which highlights the importance of ensuring an appropriate exception report is completed and submitted within the relevant deadlines, or this will cause issues with the compensation aspect.

Once an exception report has been submitted by the doctor it must be validated and an outcome agreed within 7 days to allow for payment for any additional hours worked; or time in lieu is provided, especially if the additional hours have breached contractual or statutory safe working provisions.

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

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

Breaches, fines and immediate safety concerns

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

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule).
- A breach of the maximum 13 hour shift length.
- A breach of the maximum of 72 hours worked across any consecutive 168 hour period.
- Where 11 hours rest in a 24 hour period has not been achieved (excluding on-call shifts).
- Where five hours of continuous rest between 22.00 and 07.00 during a non-resident on-call shift has not been achieved, then all the episode(s) of the work which occurred during 22.00 and 07.00 will be subject to a guardian fine and the doctor will be paid at the applicable penalty rate.
- Where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved.

Where the guardian determines that the concerns raised in the exception report are valid and correct, the resident doctors affected will be paid for the additional hours at penalty rates. See the relevant tables below (set out in Annex A of the TCS). The guardian will also be responsible for levying a fine against the department employing that doctor for the additional hours worked.

The below penalty rates and fines for hours worked at the **basic hourly rate**:

Nodal Point	Total hourly figure (£) (Basic hourly rate x 4)	Hourly penalty rate paid to the doctor (£) *	Hourly fine paid to the guardian of safe working hours (£) **
1	63.56	23.83	39.73
2	73.56	27.59	45.97
3	87.04	32.64	54.40
4	110.32	41.38	68.94
5	117.08	43.91	73.17

The below penalty rates and fines for hours worked at the **enhanced hourly rate** (See schedule 2, 16-19):

Nodal Point	Total hourly figure (£) (Enhanced hourly rate x 4)	Hourly penalty rate paid to the doctor (£) *	Hourly fine paid to the guardian of safe working hours (£) **
1	87.08	32.64	54.44
2	100.78	37.79	62.99
3	119.25	44.72	74.53
4	151.14	56.68	94.46
5	160.40	60.15	100.25

* The penalty rate paid to the doctor is based upon 1.5 x the 2019 NHS Improvement hourly locum rates for that grade of doctor.

** The hourly amount paid to the guardian is the balance after the hourly penalty rate paid to the doctor has been deducted from the total hourly figure.

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

It has been agreed that the money raised through fines must be used specifically to benefit the education, training and working environment of trainees. The guardian will be responsible for collaborating with the relevant Resident Doctors Forum (or a local equivalent) to decide how funds raised through fines levied should be disbursed to benefit resident doctors.

However, it is important to note that these funds cannot be used to supplement any facilities or resources that the employer should be expected to provide anyway. In order to ensure that doctors can place their trust in this system, details of expenditures will be included in an annual report, which will be open, accessible and subject to audit.

While we expect these processes to improve safety over time, there will be occasions where an exception report highlights an immediate and substantive risk to the safety of patients and/or individual doctors. In such instances, it will of course be necessary for more urgent steps to be taken. Where these concerns exist, they should be raised straight away in a conversation with the relevant senior clinician responsible for the service, rather than with the guardian. This conversation should be followed up with an electronic exception report to the educational supervisor within 24 hours. The responsible clinician who receives the report must comply with one of the following actions, set out in detail in Schedule 5, paragraph 21 of the 2016 terms and conditions of service:

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

Work schedule reviews

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

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

The process of work schedule reviews is as follows:

Written request for work schedule review submitted

↓

Education supervisor engages with doctor within seven working days

↓

Conversation results in one or more of the following outcomes

No change to work schedule required	Prospective changes made to the work	Compensation or TOIL awarded	Organisational review required

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

Further work schedule reviews
If a resident doctor is unhappy with the outcome of the conversation, they are entitled to request a level 2 work review within 14 days of being notified of the decision. This request would need to outline areas of disagreement and the outcome that the individual is seeking. Where the doctor is appealing a decision previously taken by the guardian of safe working hours, the hearing panel will include a representative from the BMA or other recognised trade union nominated from outside the employer/host organisation, and be provided by the trade union within one calendar month.

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

There is a final stage of appeal that can be requested within 14 days of being notified of the level 2 work review decision. This review will be a formal hearing, held in accordance with the final stage of the employer's local grievance procedure, before a panel including the Director of Medical Education (or a deputy). Where the appeal concerns a decision made by the guardian of safe working hours, a representative of the BMA will need to be involved in the panel. The decision of this panel will be final.

Further information
Terms and Conditions of Service, Schedule 5.

Guardian of safe working

The Guardian's role within a trust is to provide assurance, both to staff and employers, that resident doctors are working in compliance with the safe hours requirements set out in the contract, and to make recommendations for how these issues can be quickly and appropriately addressed. An employer or host organisation must appoint a guardian – it is not an option to not recruit one. The guardian will be a senior appointment and will not hold any other managerial role with the employer.

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

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

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

The panel must reach consensus on its appointment - if the resident doctor representatives do not agree with the decision taken by others on the panel, the panel cannot proceed with the appointment. It is a contractual requirement that 50% of the panel be made up of resident doctors, and that consensus be reached.

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

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

Guardians for trainees in non-hospital settings
No trainee should be denied access to a guardian of safe working, regardless of their specialty or the location of their working. There are specific provisions within the contract to ensure that individuals in all non-hospital work settings will also be linked with a guardian. For those who work under a lead/host employer arrangement, the guardian role will be established by the host employers under provisions agreed between the two employers. For GP trainees, however, the lead employer will be responsible for employing a guardian who is familiar with the issues faced by GPs working in practice settings. If there are no lead/host employer arrangements, and a practice employs a GP trainee directly, they will then be expected to appoint an independent guardian themselves.

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

Further information
Terms and Conditions of Service, Schedule 6.
NHS Employers' *Guardian for safe working job description*.

10. Indemnity

Summary

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

Clinical negligence indemnity

NHS bodies and organisations are financially responsible for the clinical negligence of their employees. All NHS Trusts / Health Boards in England, Scotland and Wales are members of state-backed NHS medical schemes. In Northern Ireland, each health and social care trust provides its own indemnity, funded by the Department of Health, Social Security and Public Safety.

The legal and professional requirement that all individual doctors hold adequate and appropriate clinical negligence indemnity cover is fulfilled through their Trust/Health Board's membership of an NHS scheme, or directly through a separate arrangement by the Trust/Health Board. The GMC's website gives further details of the legal and professional requirement for indemnity.

For GP trainees should have their indemnity covered by Health Education England and their employer or lead employer should be notified of this.

It is important that doctors understand what is NHS work and what is not. Doctors need to arrange separate clinical negligence indemnity cover for any clinical work not covered by the scope of NHS indemnity. Clarification should be sought from your employing organisation, or directly from the NHS indemnity schemes' administrators if you are unsure whether you are fully covered by NHS indemnity.

Whilst NHS indemnity provides sufficient clinical negligence indemnity cover for most trainees across specialities, it does not provide sufficient cover for several medical specialities where training placements take place predominantly, or partially, outside of the NHS. These include:

- Public Health (PH).
- Palliative Medicine (PM).
- Occupational Medicine (OM).
- Community Sexual Reproductive Health (CSRH).
- Genitourinary Medicine (GM).
- Sport and Exercise Medicine (SEM).
- Aviation and Space Medicine (ASM).

However, Health Education England (HEE), through central contracts with medical defence organisations, will continue to provide sufficient and appropriate clinical negligence indemnity cover for these trainees. From August 2022, HEE is also expected to provide indemnity cover for trainees undertaking stage 2 internal medicine training specifically during palliative medicine placements in hospices.

Examples of what is and is not usually covered by NHS indemnity are given below.

Work covered:

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

Work not covered:
– category 2 work, for example completing cremation certificates.
– defence of medical staff in GMC disciplinary hearings.
– stopping at a roadside accident, or other 'good Samaritan' acts.
– clinical trials not covered under legislation.
– work for other agencies on a contractual basis or for voluntary or charitable bodies.
– work overseas.
– work where a crime has been alleged.

Resident 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, or Department for Work and Pensions etc.; and making court appearances. For more information on category 2 fees see chapter 6. Private practice or work in independent hospitals which is not covered above also requires separate indemnity. Resident doctors who are required either by their employer, or by their consultant to perform work which takes them over the hours limits set down in the contract and WTR, would be covered by NHS indemnity and defence organisation cover.

Professional indemnity

The BMA advises all doctors to hold membership of a medical defence organisation (MDO) to provide indemnity cover for clinical negligence related to non-NHS work, and professional (non-clinical negligence) issues, including: support in GMC investigations and representation at hearings, assistance with criminal investigations arising from your clinical practice, representation and assistance in coroner inquests, protection for good Samaritan acts, and help responding to patient complaints.

For historical reasons HEE will continue to provide all GP specialty trainees with professional (non-clinical negligence) indemnity fully cover funded by HEE. Doctors who are thinking of changing their MDO should discuss any potential implications of such a transfer with their current MDO.

Resident doctors and data protection

Resident 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 ico.org.uk.

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

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

Further information

The Medical Defence Union
W; www.themdu.com
T: 020 7202 1500
E: mdu@themdu.com

The Medical and Dental Defence Union of Scotland
W; www.mddus.com
T: 0333 043 4444
E: info@mddus.com

The Medical Protection Society
W; www.medicalprotection.org/uk
T: 020 7399 1300
E: info@mps.org.uk

11. Transitional pay protection arrangements

Summary

The 2016 terms and conditions of service became effective on 3 August 2016. The contract was introduced with a phased implementation, completed by October 2017. During this period, and up until 2022 or 2025 dependent on the type of transitional pay protection, there are temporary arrangements in place to allow current resident doctors to transition to the new contract, including pay protection. This is set out in the temporary schedule 15 'Transition arrangements' of the terms and conditions.

Pay protection arrangements

The new contractual arrangements include an initial period of pay protection for some existing doctors. Schedule 15 of the terms and conditions of service deals with the arrangements which are aimed at ensuring no current resident doctor receives a pay cut as a result of the new contract. The arrangements are complex. If you are unsure how this may affect you, we would encourage you to use the BMA's interactive pay protection tool available on our website.

The principle is that resident doctors who were employed on the 2002 terms and conditions will have their pay protected to ensure they do not see any drop in pay as a result of the introduction of the new contract. Given that the transition to the new contract took place from October 2016, this includes new FY1s, who started on the 2002 TCS in August 2016 before moving to the new one once it starts being used later in the year.

Eligibility categories

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

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

The second category, doctors already at ST3 or above on a run-through training programme on 2 August 2016, will have their pay protected by continuing to be paid under the old pay system, including increments and banding (but not band 3). For the purposes of their pay only, the old definitions of 'plain' and 'premium' time will apply.

The 2016 terms and conditions include detailed instructions as to how the old pay system will work with the new contractual terms, including how these doctors can make use of the new exception reporting system under the guardian of safe working. If you qualify for section 2 protection and earn less under the old contract pay system than you would under the new contract, you still get paid under the old contract i.e. the lower amount.

Pay will be protected either until you complete the training programme, or until four years of continuous employment have elapsed (pro rata for those LTFT or taking time out), or until 6 August 2025, whichever is sooner.

Transition of trainees on lead employer contracts

Following the conclusion of the 2018 Review, it was agreed that all trainees who had not yet been transitioned onto the 2016 TCS, due to being employed on lead employer contracts for the duration of their training, would be transitioned over to the 2016 TCS by 5 February 2020. Trainees absent during this period (eg maternity leave, approved out of programmes, etc.) should be transitioned on to the 2016 TCS upon their return to training.

The existing transitional pay protection provisions of schedule 15 should apply in exactly the same manner to trainees who were transitioned over to the 2016 TCS between October 2019 and February 2020. The only exception being that, for trainees who are eligible for section 1 pay protection, the value of the banding supplement of the rota the doctor was working on the day before transitioning should be used, rather than the rota's banding supplement as of 31 October 2015.

Arrangements for those training LTFT, on OOP or absent at the time of transition

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

Arrangements for those not in training in August 2016

If you were not in a training programme – for example, if you are a career grade doctor planning on returning to training – you will not qualify for transitional pay protection if you started training or returning after 3 August 2016, even if you have been in training before. The pay protection covers new FY1 doctors in August and doctors in training on 2 August who either remain in that programme or progress directly to their next one. If, for example, you take a break between core and higher specialty programmes or between foundation and specialty training, you are not eligible.

There are some exceptions.

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

This is a complex area and we recommend you read schedule 15 in full along with the detailed guidance available on the BMA website.

Further information

Interactive pay protection tool: bma.org.uk/pay-and-contracts/pay/transitional-pay/transitional-pay-protection.
Terms and Conditions of Service, Annex B – Transitional banding questionnaire for Schedule 15.
NHS Employers' Transition to the 2016 TCS guidance: www.nhsemployers.org/pay-pensions-and-reward/medical-staff/doctors-and-dentists-in-training/transition
NHS Employers' Pay protection FAQs: www.nhsemployers.org/pay-pensions-and-reward/medical-staff/doctors-and-dentists-in-training/transition/copy-of-pay-protection-faqs-updated-july.

12. LTFT (less than full-time) training

Summary

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

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

There are many reasons, including domestic commitments, disability or ill health, or the undertaking of a particular activity outside of medicine, which may mean you wish to train less than full time. Your training programme and some elements of your contract of employment will be determined to reflect your individual circumstances, and should reflect the formal guidelines referred to below. Access to LTFT training will be dependent on individual circumstances and the availability of LTFT places in your training location. However, the BMA is working with training authorities to improve access to flexible working opportunities, including LTFT training. As a result of these efforts, HEE agreed to implement Category 3 LTFT training. This allows trainees to go LTFT without needing a health reason or caring responsibility to justify the request. Further information on category 3 LTFT training can be found here.

During the 2018 contract review, the BMA negotiated for all employers and host organisations to be required to appoint a Champion of Flexible Training. Joint guidance about how the role should function is available here.

The BMA has produced guidance as a single resource to answer your questions relating to LTFT training. It takes you through the basic principles, explains your rights and responsibilities, and what you can expect from your employer and training organisation (HEE local office or deanery). It aims to ensure you know how to apply, what it is like to train less than full time, possible problems you might run into, how to deal with them, as well as what support is available to you.

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

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

Criteria

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

Category 1

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

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

Category 3
- This is for trainees who choose to train LTFT as a personal choice that meets their individual professional or lifestyle needs. No justification, beyond it being personal preference is required for category 3 LTFT training, but approval of applications will have to take into account service considerations.
- As of April 2021, category 3 LTFT is currently only accessible to trainees in the following specialties; Paediatrics, Obstetrics and Gynaecology, Emergency Medicine, Higher Physicianly, Radiology, Psychiatry, and ICM trainees.
- See the HEE guidance for further information.

Application process

To make the application process run as smoothly as possible, there are a number of things that you need to consider in advance of your application:
- Determine how you fit into the categories and, where possible and/or appropriate, gather as much supporting evidence to demonstrate your circumstances.
- Speak to other colleagues who work LTFT and ask them about their experiences (even if you are about to move deaneries). Useful things to know would include the below:
  - Find out how many hours they are contracted to work per week.
  - Find out how they agreed their training programme to incorporate the full range of training opportunities available to full-time trainees. Perhaps they have worked one half of the week for six months and the other half for another six months.
  - Find out what the full-time trainees do each week, eg what proportion of time do they spend covering ward work, clinics, theatre, emergencies etc. Remember to include time for audit/protected teaching time/research etc.
- If you are applying through open competition and it is your first time applying for a LTFT training post, it may be hard for you to get all this information. Familiarise yourself with similar information in your current work place so you know what you should be looking for when you discuss your programme in your new role.

There are a number of steps to the application process, and it can take up to three months. If you wish to train LTFT in a post, it is recommended that you start this process as soon as possible. The steps to take when applying are as follows.
1. Seek advice on eligibility from your associate postgraduate dean with a responsibility for LTFT training as to your eligibility. Find out who to contact by looking on your HEE local office/deanery website.
2. If you are not already working within the specialty or grade that you wish to train LTFT in, you should apply through competitive entry to a full-time post. If you are already in a full-time training post and wish to train LTFT within that same post, you will not have to reapply for training.
3. Once your application for LTFT training has been accepted, you need to agree your training programme with your HEE local office/deanery.
4. The Regional Specialty Education Committee or Training Programme Director will then obtain approval of the training programme on behalf of the dean and royal college.
5. Finally, funding approval will be given by the deanery and the employer.

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

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

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

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

Appeals

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

You should also contact the BMA for support and advice if you have had your application for LTFT training rejected.

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

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

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

For more information about appeals, see the section in our LTFT guide bma.org.uk/advice-and-support/career-progression/training/flexible-training

Types of LTFT training post

Deaneries in principle offer different ways of incorporating LTFT training into rotas. There are three ways in which doctors can train LTFT: slot-sharing; supernumerary posts; and job sharing. However, access to these different post types is variable.

Slot share

A training placement can be divided between two trainees, so that all duties of the full-time post are covered by two trainees. In a slot share, two LTFT trainees are employed and paid as individuals (often for 60% or more) and work together. The two trainees share an educational post but not a contract, and may overlap sessions.

Reduced hours in full-time post

This is where a doctor only undertakes some of the hours available within an existing full-time post. This can result in the remaining hours being carried over as a gap in the rota, or the extra hours left over being shared between other doctors on the rota (where agreed).

Job-share

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

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

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

Pensions for LTFT trainees

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

Further information
BMA guidance on LTFT training: bma.org.uk/advice/career/applying-for-training/flexible-training.
BMA guidance on LTFT pay: bma.org.uk/pay-and-contracts/pay/ltft/less-than-full-time-trainees-pay-explained.
StRs should refer to 'A reference guide for postgraduate specialty training in the UK' (the *Gold Guide*).
Principles underpinning the new arrangements for flexible training (2005) and *Equitable pay for flexible medical training* (2005), relevant only for trainees in receipt of section 2 transitional pay protection, available at www.nhsemployers.org/pay-pensions-and-reward/medical-staff/doctors-and-dentists-in-training/junior-doctors-dentists-gp-registrars/less-than-full-time-training.
The BMA's and NHS Employers' joint *Good Rostering Guide*, see Good rota design and rostering recommendations for LTFT doctors (pg. 22-25) www.nhsemployers.org/case-studies-and-resources/2018/05/good-rostering-guide.

13. Locum work in the NHS

Summary

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

Resident doctors employed on a locum basis in the NHS can be subject to the terms and conditions of service for hospital medical and dental staff, or under a separate contract for the NHS staff bank they are working for. If a doctor is employed directly by a locum agency, it is not possible to give advice on the terms which agencies may offer, as these vary between agencies. It should be noted that locum posts do not usually attract recognition for training except in certain circumstances.

Locum cover

Employers are obliged to obtain a locum to cover a resident doctor's annual and/or study leave, unless prospective cover (internal cross-cover among doctors on the rota) is in use on the rota. Locum cover must be organised to cover sick leave and maternity leave, except in emergencies as explained below. Employers should first try to arrange an external locum. Where this is not possible, and resident doctors agree to cover for colleagues as an internal locum, and this cover takes place outside of their contracted hours, they should receive either an equivalent off-duty period in lieu or be paid at the prevailing local staff bank locum rate.

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

Cover in emergencies

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

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

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

If your situation is not covered here, or you need more information, please contact our team of advisers via bma.org.uk/contactus for advice.

Further information
Terms and Conditions of Service, Schedule 1, para 3-4.

Spare professional capacity and first refusal

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

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

Where a doctor intends to undertake hours of paid work as a locum, additional to the hours set out in their work schedule, they must initially offer such additional hours of work exclusively to the service of the NHS via an NHS staff bank.

You do not need to offer space capacity to your employer when the additional work you intend on undertaking in the specified time is voluntary or communal in nature, including event and expedition medicine; work for medical charities; non-profits; humanitarian and similar organisations; or sports and exercise.

The employer can, but is not obliged to, offer the doctor the opportunity to carry out additional activity up to a maximum average of 48 hours per week (or up to 56 hours per week if the doctor has opted out of the WTR).

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

Only after the employer has declined the doctor's offer to work additional hours as a locum should the doctor enter into any agreement to carry out any additional work for any other employer, whether directly or indirectly (for example through an agency or limited company). Please note up to 40 hours of work per week are pensionable in the NHS.

Further information
Terms and conditions of service, Schedule 2, paragraph 84 and Schedule 3, paragraphs 47-51 & 52-53.

External locums

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

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

Internal locums

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

Under internal locum arrangements, employers will typically pay resident doctors providing locum cover at locum rates agreed by local staff bank for the whole time they are on duty, provided that such work is undertaken when the doctor would otherwise have been off duty.

Part-time locums

A resident 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.

LATs (locum appointments for training)

Resident doctors in LATs are excluded from the pay arrangement detailed above. Doctors in LAT posts are paid at the incremental point to which they are entitled because of previous experience, not the mid-point.

Other terms and conditions of service

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

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

- **Annual leave**
  Resident doctors acting as locums under NHS terms and conditions are entitled to 27 days leave (rising to 32 days after five years' completed NHS service). This may differ for doctors employed as locums via a staff bank, however, at a minimum they are entitled to the statutory leave provisions. 'Continuous locum service' means service as a locum in the employment of one or more employer uninterrupted by the tenure of a regular appointment, or by more than two weeks during which the resident doctor was not employed in the hospital service. Wherever possible, leave should be taken during the occupancy of the post. If this is not possible, leave may be carried forward to the next succeeding appointment, or payment in lieu of leave earned and not taken may be made. In practice, the latter is more common.

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

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

14. Study and professional leave

Summary

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

Study leave is leave that allows time, inside or outside of the workplace, for formal learning that meets the requirements of the curriculum and personalised training objectives. This includes, but is not restricted to, participation in:

- Study (linked to a course or programme).
- Research.
- Teaching.
- Taking examinations.
- Attending conferences for educational benefit.
- Rostered training events.
- Regional educational events (where the time is protected).

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

Professional leave is leave in relation to professional work. Professional work is work done outside of the requirements of the curriculum and/or the employer/host organisation for professional bodies such as Royal Colleges, Faculties or the GMC/GDC. Non-trade union activities undertaken by for a recognised trade union, for example work on an Ethics Committee would count as professional work, however trade union duties and activities are covered through recognition agreements.

Job interviews for NHS, public health, academic, NHS commissioned community health and hospice appointments should be considered professional leave, with time off accommodated appropriately and a doctor should not be required to take annual or study leave to attend such interviews. Doctors should provide rota coordinators with as much notice as possible to effectively plan the roster.

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

Study leave and reimbursement of related expenses will be granted in line with existing HEE national policy (more information can be found on your local office website), or deanery in the devolved nations.

Entitlement

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

Grade	Days per annum
Foundation Doctor Year 1	15 days
All other doctors in training	30 days

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

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

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

The *Gold Guide* states that:

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

Less than full-time trainees

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

When teaching, courses and educational opportunities fall on a LTFT doctor's non-working day, and where study leave approval is granted, the LTFT doctor must be compensated with TOIL, or payment if the doctor prefers.

Medical academic doctors

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

Applications

The administration of how you can access the funding and time off for study leave varies between nations of the UK. When starting a training programme, resident doctors should check the deanery's policy on study leave. Postgraduate deans have overall responsibility for managing study leave budgets within their areas and will have specific local processes for how these will be accessed.

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

Expenses

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

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

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

Professional leave for overseas conferences

HEE has specific policy relating for conferences overseas, but only when required by the UK curriculum in order to undertake these. It is important that you open discussions with your educational supervisor and training programme director as soon as possible should this be a requirement of your training programme.

Accommodating time off for study leave

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

Requests for study leave will be viewed positively in most circumstances, but with a view to ensuring that the needs of service delivery can be safely met. Applications must also be made in plenty of time in order to increase the chances of their being accepted. Requests for study leave in excess of the limits above should be considered fairly where circumstances indicate such requests to be reasonable, and may be granted by the employer provided that the needs of service delivery can be safely met.

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

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

Appeals

If a trainee has reason to believe that their study leave application was processed unfairly or incorrectly, they are able to request a review of the process by which their application was considered by making a written submission to their individual Deanery in accordance with local policy. This should include the reasons for their complaint and any evidence to support their appeal.

All written submissions must be sent via email or as an attachment, with the original application form and outcome received. This should be emailed to the relevant Deanery, and must be made within 10 working days of being notified of their outcome.

BMA members should seek advice from our team of advisers by visiting bma.org.uk/contactus before embarking on an appeal.

Study leave for GP trainees

The GP trainees subcommittee of the GPC has an agreed policy on study leave for GP registrars. The guidance note regarding study leave for GP registrars is available on the BMA website: bma.org.uk/pay-and-contracts/leave/annual-leave-entitlement/gp-trainee-annual-leave-sick-leave-and-study-leave

Further information

Terms and Conditions of Service, Schedule 10, paragraphs 30-43.
The BMA's and NHS Employers' joint *Good Rostering Guide*, see Managing leave requests in rotas, rosters and work schedules (pg. 13-16) www.nhsemployers.org/case-studies-and-resources/2018/05/good-rostering-guide.

Rough guide to foundation programme – for all foundation year 1 and foundation year 2 trainees. www.foundationprogramme.nhs.uk – See Key Documents.

Local Employer Policy – BMA also advise trainees check the relevant employer's local policy on study / professional leave to ensure the correct application form for requesting this type leave is being used. If there is difficulty in acquiring the policy, please contact the BMA directly for further support.

'A reference guide for postgraduate specialty training in the UK' or the *Gold Guide* – All specialty trainees or StRs (including general practice trainees, those in core training, LTFT training and trainees in academic programmes) should refer to the *Gold Guide*.

15. Annual leave

Summary

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

Basic entitlement

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

On first appointment to the NHS: 27 days.

After five years' of completed NHS service: 32 days.

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

Annual leave for LTFT trainees will be pro-rata.

Principles

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

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

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

Further information

Terms and conditions of service, Schedule 10, paragraphs 1-23.

The BMA's and NHS Employers' joint *Good Rostering Guide*, see Managing leave requests in rotas, rosters and work schedules (pg. 13-16) www.nhsemployers.org/case-studies-and-resources/2018/05/good-rostering-guide

Payment for annual leave

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

Purchase of additional annual leave

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

Daytime work cover

Some departments engage locums for daytime work; some expect residents of the same grade to cover; some expect residents of different grades on the same firm to cover; and some have 'floating' residents. Whichever method is used, resident doctors should ensure that they do not feel exploited or overworked by their colleagues' absence. If this is the case, members should consult our team of advisers by visiting bma.org.uk/contactus

Leave year

The annual leave year runs from the start date of the doctor's appointment.

Untaken leave

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

With the agreement of the employer, and in line with local policy, payment in lieu can be made for up to five days' annual leave (pro rata as appropriate) which could not be taken before a move to a new employer.

Transferring leave from post to post

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

Notification of leave

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

Fixed leave

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

Sickness during annual leave

If a resident doctor falls sick during annual leave and produces a statement to that effect at the time, (eg a self-certificate) the resident 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 resident doctors are entitled to eight paid public holidays each year as follows: New Year's Day; Good Friday; Easter Monday; May Day; Spring Bank Holiday; Late Summer Holiday; Christmas Day; and Boxing Day. This is in additional to annual leave entitlement.

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

Working on public holidays

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

Public holidays and zero hour days
Where a doctor's working pattern includes scheduled rest days (sometimes known as zero hours' days), and such a day falls on a public holiday, the doctor will be given a day off in lieu of the public holiday.

Further information
Terms and conditions of service, Schedule 10, paragraphs 24-29.

Annual leave for locums

Information on annual leave for locums is available in the 'Locum work in the NHS' section of the handbook (see chapter 13).

16. Maternity, paternity and shared parental leave

Summary

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

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

Eligibility

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

- They have 12 months' continuous service with one or more NHS employers at the beginning of the 11th week before the EWC (expected week of childbirth).
- They notify their 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 their intention to take maternity leave and of the date they wishes to start their maternity leave.
- That they intend to return to work with the same or another NHS employer for a minimum period of three months after their maternity leave has ended and provides a MATB1 form from their midwife or GP giving the expected date of childbirth.

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

Changing the maternity leave start date

If the employee subsequently wants to change the date from which they wish their leave to start, they should notify their 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, their expected return date based on their 52 weeks' paid and unpaid leave entitlement under this agreement; and
- the length of any period of accrued annual leave and accrued leave for public holidays which it has been agreed may be taken following the end of the formal maternity leave period.
- the need for the employee to give at least 28 days' notice if they wish to return to work before the expected return date.

Keeping in touch

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

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

Keeping in touch (KIT) days

KIT days have been introduced to help make it easier for employees when it is time to return to work after a period of maternity leave. KIT days may be used for training or other activities that enable the employee to keep in touch with the workplace. However, they are not compulsory, and any such work must be by agreement and neither the employer nor the employee can insist upon them.

An employee may work for up to a maximum of 10 KIT days, excluding the first two weeks of compulsory maternity leave immediately after the birth of the baby, without bringing their maternity leave to an end. Any days of work will not extend the maternity leave period, but will be paid at the employee's basic daily rate for the hours worked, less appropriate maternity leave payments.

Paid maternity leave

Amount of pay

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

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

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

Calculation of maternity pay

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

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

In the event of a pay award being implemented during the paid maternity leave period, the maternity pay due from the date of the pay award should be increased accordingly. If a pay award was agreed retrospectively, the maternity pay should be 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 SMP purposes, average weekly earnings for the period of sick absence shall be calculated on the basis of notional full sick pay.

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

Unpaid contractual maternity leave

Employees will also be entitled to a further 13 weeks' unpaid leave, bringing the total leave to 52 weeks.

Commencement and duration of leave

An employee may begin their maternity leave at any time between the 11th week before the expected week of childbirth and the expected week of childbirth provided they give the required notice.

Sickness prior to childbirth

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

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

Pre-term birth

Where an employee's baby is born prematurely, the employee will be entitled to the same amount of maternity leave and pay as if their baby was born at full term.

Where an employee's baby is born before the 11th week before the expected week of childbirth, and the employee has worked during the actual week of childbirth, maternity leave will start on the first day of the employee's absence.

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

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

Still birth

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

Miscarriage

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

Health and safety of employees pre- and post-birth

Where an employee is pregnant, has recently given birth, or is breastfeeding, the employer should carry out a risk assessment of their working conditions. If it is found, or a medical practitioner considers, that an employee or their child would be at risk were they to continue with their normal duties, the employer should provide suitable alternative work, for which the employee will receive their 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 their normal duties would prevent them from successfully breastfeeding their child.

Return to work

An employee who intends to return to work at the end of their full maternity leave will not be required to give any further notification to the employer, although if they wish to return early, they must give at least 28 days' notice.

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

Returning on flexible working arrangements

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

If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period, this will not affect the employee's right to return to their job under their 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 their employer of their 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 their maternity leave, they will be liable to refund the whole of their maternity pay, less any SMP, received. If there is no right of return to be exercised because the contract would have ended if pregnancy and childbirth had not occurred, the repayment provisions set out above will not apply. In cases where the employer considers that to enforce this provision would cause undue hardship or distress, the employer will have the discretion to waive their rights to recovery.

Employees not returning to NHS employment

An employee who satisfies the required eligibility conditions but who does not intend to return to work with the same or another NHS employer for a minimum period of three months after their maternity leave is ended, will be entitled to pay equivalent to SMP, which is paid at 90 per cent of their average weekly earnings for the first six weeks of their maternity leave and to a flat rate sum for the following 33 weeks.

Employees with less than 12 months' continuous service

If an employee does not satisfy the eligibility conditions for contractual maternity pay, they may still be entitled to SMP. SMP will be paid regardless of whether they satisfy the eligibility conditions above. If their earnings are too low for them to qualify for SMP, or they do not qualify for another reason, they should be advised to claim MA from their local Job Centre Plus or social security office.

Fixed-term contracts or training contracts

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

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

Rotational training contracts

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

Contractual rights

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

Salary advancement

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

Accrual of annual leave and public holidays

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

Public holidays will also accrue during maternity leave.

Pensions

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

Ante-natal care

Pregnant employees have the right to paid time off for ante-natal care. Ante-natal care may include relaxation and parentcraft classes, as well as appointments for ante-natal care. The pregnant employee's partner is entitled to unpaid leave to attend two ante natal appointments. Unpaid leave, up to a maximum of six and a half hours per appointment can be accessed.

Post-natal care and breastfeeding mothers

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

Continuous service

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

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

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

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

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

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

University or honorary contracts

Doctors holding university and NHS honorary contracts will be subject to the maternity leave scheme that is in operation at their place of employment. A university contract, with or without an NHS honorary contract, does not count as continuous service under the NHS maternity scheme.

However, where an employee has a university contract with an NHS honorary contract this period of employment will not constitute a break in service, although it cannot be counted towards service for the purposes of further maternity leave.

Unfair dismissal

Regardless of length of service or hours of work, it is unlawful for an employer to dismiss an employee or to select them for redundancy, solely or mainly because they are pregnant or have given birth, or for any other reason connected with their pregnancy or childbirth.

Defence body and professional subscriptions

Doctors who take parental leave should contact the bodies they hold subscriptions with, as special beneficial arrangements often apply.

Further information

Further guidance on maternity leave and pay, including specific guidance for resident doctors, can be found on the BMA website: bma.org.uk/pay-and-contracts/maternity-paternity-and-adoption/finance/your-maternity-leave-entitlements-under-the-nhs-scheme. If you feel that you are being denied your employment rights, contact our team of advisers by visiting bma.org.uk/contactus in the first instance. They will assess your circumstances and provide support. If necessary, they will arrange for local representation.

Paternity leave

NHS scheme

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

Eligibility

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

Benefits

The occupational paternity scheme entitles you to two weeks' leave at full pay, less any statutory paternity pay (SPP) for which you are eligible.

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

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

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

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

Statutory scheme

Those with insufficient NHS service to qualify for the occupational scheme may still be eligible for the statutory paternity pay scheme, as set out on the government website.

Eligibility

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

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

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

Length of paternity leave

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

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

Leave can start on any day of the week on or following the child's birth, but must be completed within 56 days of the actual date of birth of child; or if the child is born early, within the period of the actual date of birth up to 56 days after the expected week of birth. Only one period of leave is available to employees, irrespective of whether more than one child is born as the result of the same pregnancy.

Statutory paternity pay
During their paternity leave, most employees are entitled to statutory paternity pay (SPP) from their employers.

SPP is paid by employers for either one or two consecutive weeks as the employee has chosen. The rate of SPP is the same as the standard rate of SMP.

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

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

Self-certificate
Employees must give their employers a completed self-certificate as evidence of their entitlement to SPP. A model self-certificate for employers and employees to use is available on the BIS website. Employers can also request a completed self-certificate as evidence of entitlement to paternity leave. The self-certificate must include a declaration that the employee meets certain eligibility conditions, and must 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, they may take advantage of whichever is the more favourable. Any paternity pay to which they have a contractual right reduces the amount of SPP to which they 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 should contact the BMA for advice.

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

Further information
Further guidance on paternity leave can be found on the BMA website: bma.org.uk/pay-and-contracts/maternity-paternity-and-adoption/leave/paternity-leave-for-doctors.

Shared parental leave

Shared parental leave provides eligible parents, of either sex, greater flexibility in how they share the care of their child in the first year following birth or adoption. You can use shared parental leave all in one go or take blocks of leave between periods of work. You can choose to be off work at the same time as the other parent or choose to stagger the leave and pay between you.

Shared parental leave is a statutory right, meaning that everyone who is eligible can claim it, regardless of their particular terms and conditions of service. However, as part of the 2018 review the BMA negotiated for resident doctors to have access to the NHS Staff Terms and Conditions of Service provisions for enhanced shared parental leave and pay; these provisions mark a significant improvement to statutory provisions.

Entitlements under the occupational scheme

Entitlements for shared parental leave
Employees can choose to end their maternity or adoption leave early to access shared parental leave. All employees will have the right to take 50 weeks of shared parental leave (minus any maternity or adoption leave already taken).

Shared parental leave can be taken at any time within one year from the birth or placement for adoption, providing the compulsory two weeks' maternity or adoption leave has been taken.

Entitlements for shared parental pay
The entitlement to Shared Parental Pay is that proportion of maternity or adoption pay not already taken. Where such pay (excluding pay during the compulsory two-week maternity/adoption leave period) has been received by either parent, the maximum joint entitlement set out below will reduce proportionate to the amount of maternity or adoption pay which has either been taken and paid to either parent.

It is also a requirement that employees return to work for the NHS for a minimum of three months after the ShPL period; failure to do so is likely to mean having to repay the entire shared parental pay.

Process for taking shared parental leave

In order to access enhanced shared parental leave employees will be required to complete the appropriate forms produced by ACAS and available on the Government website (see resources section). Some employers may provide their own standard forms for employees to use.

To start shared parental leave, the mother or primary adopter must either return to work following maternity or adoption leave, or provide notice confirming that they intend to bring their maternity or adoption leave and pay entitlements to an early end.

Following notification of their intention to take shared parental leave, an employee should provide a minimum of eight weeks' notice to book a period of leave. An employee can provide up to three notices to book leave. This includes notices to vary a previously agreed pattern of leave. Each of the three notices to book leave may include a single, continuous, or discontinuous block of leave. Requests for single blocks of leave cannot be refused, though employers are not bound to agree to discontinuous leave pattern.

To be eligible for NHS occupational shared parental leave provisions, it is not a requirement for both partners to work for the NHS. When a couple is considering using shared parental leave, they should assess and compare the shared parental leave provisions of both of their employers, if not both working for the NHS, as the non-NHS employer may have a more or less favourable shared parental leave policy.

NHS Employers guidance provides examples of how leave could be shared, for further details please see the link in the resources section.

Eligibility

To qualify for shared parental leave you must share responsibility for raising the child at the time of birth or adoption with the other birth parent or adopter or your partner (married, civil partner or co-habiting).

To be eligible for shared parental leave you must:

- be an employee with a minimum of 26 weeks' service with your employer by the end of the 15th week before the due date or matching date for adoption and meet the minimum earnings threshold.
- the other parent must also meet the statutory 'employment and earnings test' by being an employed in the UK for a total of 26 weeks (not necessarily continuously) in the 66 weeks preceding the week the child is due to be born or matched for adoption. The other parent must have earned at least an average of £30 (gross) a week in 13 of those 26 weeks (not necessarily continuously).

Continuous service for the purposes of qualifying for leave includes service with one or more NHS employers.

For more detail and to check whether you meet the statutory requirements visit Gov.uk eligibility checker.

Breaks in service

As per paragraph 15.106 of the NHS Staff TCS, the following breaks in service won't affect your eligibility for ShPL but don't count towards your total NHS continuity of service for other entitlements:

- a break in service of three months or less
- employment under the terms of an honorary contract
- employment as a locum in a general practice setting for a period not exceeding 12 months
- a period of up to 12 months spent abroad as part of a definite programme of postgraduate training on the advice of the postgraduate dean or college or faculty advisor in the speciality concerned
- a period of voluntary service overseas with a recognised international relief organisation for a period of 12 months, which may exceptionally be extended for 12 months at the discretion of the employer which recruits the employee on their return
- absence on an employment break scheme in accordance with the provisions of Section 34 of this Handbook
- absence on maternity leave, adoption leave, or shared parental leave (paid or unpaid)
- for doctors and dentists in training, time spent outside of NHS employment in an Out of Programme (OOP) placement approved by the Postgraduate Dean
- for doctors and dentists in training, time spent employed in the health service of a UK Crown Dependency as part of an approved training programme

Insufficient continuous service due to rotation

The NHS Terms and Conditions of Service Handbook (15.88) clarifies the process for when an employee changes employer because their training programme has required them to do so, and this means they do not have enough statutory continuous service with their current employer to access statutory shared parental pay. Provided that an employee would have otherwise had sufficient statutory continuous service, the value of statutory shared parental pay must be paid by their current employer.

Shared Parental Leave in Touch Days or 'SPLiT Days'

SPLiT days are intended to facilitate a smooth return to work for employees returning from shared parental leave. To enable employees to take up the opportunity to work SPLiT days, employers should consider the scope for reimbursement of reasonable childcare costs or the provision of childcare facilities.

An employee may work up to a maximum of twenty SPLiT days without bringing their shared parental leave to an end. Any days of work will not extend the shared parental leave period. This will enable employees on shared parental leave to work either continuously or on odd days without bringing an end to their shared parental leave and pay.

Any SPLiT days are voluntary and to be negotiated with the employer and paid at the basic hourly rate for the hours worked, less any SPL pay. Time off in lieu must be arranged on the return to work, for a full day or a half day, depending on when the work is done.

Further information

Gov UK applying for leave and pay (form)
NHS Employers occupational shared parental leave guidance
NHS Staff Handbook Section 15: leave and pay for new parents

17. Sick leave

Summary

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

Scale of allowance

Resident 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 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 of service	six months' full pay and six months' half pay

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

Employers can extend these allowances in exceptional cases. Because these periods are relatively short, resident 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 resident doctor's sick leave entitlement as on the first day of sickness and subtracting the total sick leave taken in the 12 months prior to the current absence. When calculating total periods of absence, days taken as unpaid sick leave are not counted towards the final figure. Specific conditions apply to absence due to injury, disease or other health conditions resultant through the discharge of duties in employment, and injury resulting from a violent crime. For the purposes of calculation of the allowance, 26 working days are equivalent to 'one month'.

Previous qualifying service

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

Where a resident doctor on a recognised training programme goes overseas or on an out of programme appointment for clinical training (OOPT), clinical experience (OOPE) or research (OOPR), their previous NHS or other approved service should be taken fully into account in assessing entitlement to sick leave allowance. This is provided that the employer considers that there has been no unreasonable delay between the training abroad or out of programme appointment ending, and the commencement of the subsequent NHS post.

Limitation of allowance when insurance or other benefit is payable

Sickness allowance, when added to sickness benefit, severe disablement allowance, invalidity benefit, statutory sick pay, compensation payments or other social benefits receivable, may not exceed the resident doctor's normal salary for the period, and the occupational sick leave allowance would be restricted accordingly.

Notification of sickness

A resident doctor who is incapable of working because of illness should as soon as practicable 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 resident doctor admitted to hospital must submit a doctor's statement on entry and on discharge in substitution for periodical statements. However, if the period of absence is less than seven calendar days, only a self-certificate is required.

'Fit notes' have now replaced sickness certificates. If you have any concerns about your sick leave or payment during this period, contact our team of advisers by visiting bma.org.uk/contactus

Injury sustained on duty

It is important to note that a period of absence due to injury that is sustained by resident 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 resident 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, i.e. 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 resident 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 resident doctor a sum not exceeding the sickness allowance which would have been payable, subject to the resident 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 resident 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 resident doctor has failed to observe the conditions of this scheme, or has been guilty of conduct prejudicial to their recovery, and the employer is satisfied that there is substance in the report, the payment of the allowance can be suspended until the employer has made a decision. Before making a decision, the employer must advise the doctor of the terms of the report, and provide an opportunity for the doctor to submit their observations and appear or be represented at a hearing.

SSP (statutory sick pay)

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

Medical academic doctors

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

Carrying over annual leave as a result of sickness related absence

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

Further information

Terms and conditions of service, schedule 10 paragraphs 44-68.
NHS terms and conditions of service handbook (amendment number 41) 2015, section 14 & 22 www.nhsemployers.org/tchandbook.
Employment Relations Act 1999: www.legislation.gov.uk/ukpga/1999/26/contents
Maternity and Parental Leave Regulations 1999 amended by Maternity and parental leave (amendment) Regulations 2002 and 2001: www.legislation.gov.uk/uksi/1999/3312/contents.

18. NHS pension scheme

Summary

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

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

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

Under this scheme, the pensionable age is linked to the state pension age. Please therefore refer to the government state pension age calculator to find out when you would be eligible to receive your NHS pension.

Example

If you earn £75,000 in pensionable income this year and the CPI rate is 3%, your pension accrual for this year would be 1/54 x £75,000 = £1,389. This accrual would be increased by the revaluation rate (CPI 3% + 1.5%) to £1,452. Every year, the total of the previous years' pension accrual will be increased by the relevant rate for that year.

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

The following will be pensionable in the NHS Pension Scheme:
- all hours worked up to 40 hours per week on average and paid at the basic pay rate.
- London weighting.
- pay protection amounts as described in Schedule 2 paragraphs 48-61.

If you have not been able to find the answer you need on our website's guidance pages, you can contact the BMA's pensions department if you need further help at pensions@bma.org.uk.

19. Travelling and other expenses

Summary

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

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

Resident doctors who are required to travel on NHS business are entitled to receive certain mileage allowances, or may be offered a lease car. The circumstances under which residents may receive mileage allowances are set out in Schedule 12 of the Terms and Conditions of Service and the NHS Terms and Conditions of Service Handbook. The following is a brief summary of the provisions.

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

The mileage payable for such journeys is usually subject to a maximum allowance. Schedule 12, paragraph 15 of the terms and conditions of service sets out the entitlement in detail.

Further information
Terms and Conditions of Service, Schedule 12.
NHS Terms and Conditions of Service Handbook, Section 17: www.nhsemployers.org/tchandbook.
NHS Employers' Guidance for GP trainee mileage.

GP trainee home-to-base mileage

Doctors working in a GP practice setting who are required to use their own vehicle on the expectation that home visits may be required to be undertaken shall be reimbursed for the cost of mileage from home to principal place of work, and any associated allowances.

Further information
Terms and Conditions of Service, Schedule 12, paragraphs 16 and 23.
NHS Employers GP trainee mileage guidance: www.nhsemployers.org/pay-pensions-and-reward/medical-staff/doctors-and-dentists-in-training/2018-review-of-the-junior-doctor-contract/guidance-for-gp-trainee-mileage.

Rates of mileage allowances

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

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

Insurance

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

You need business car insurance if you are using your car during work hours. Business use doesn't include commuting to and from work, but travelling between different work locations or driving to see patients would be classed as business use.

Reserve rate of reimbursement

The reserve rate of reimbursement, 28 pence per mile, as set out in Table 7 above will apply if a resident doctor uses their own vehicle for business purposes in the following situations:

- when suitable public transport (eg rail or bus) is available, subject to a maximum of the public transport cost which would have been incurred, and in accordance with the rules on eligible miles in paragraph 15, schedule 12 of the 2016 TCS and table 8 in Section 17 of the NHS Terms and Conditions of Service Handbook.
- when a doctor is required to return to work on any day and thereby incurs additional travel to work expenses.
- If a doctor unreasonably declines the employer's offer of a lease vehicle. In this situation, reasonableness should be determined by a joint agreement between the employer and doctor as to whether a lease vehicle is appropriate, and the timeframe for which the new arrangements will apply. All the relevant circumstances of the doctor and employer will be considered, including the doctor's personal need for a particular type of car and the employer's need to provide a cost effective option.

For the agreed principles underlying local lease vehicle policies, see Annex 13 of the NHS Terms and Conditions of Service Handbook.

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

In all other circumstances, the standard rates apply.

Carriage of official passengers

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

Garage expenses, tolls and ferries

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

Pedal cycles

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

The Crown/lease car scheme

A Crown or lease car is any vehicle owned or contract-hired by an employer. The Crown/lease car scheme was introduced for hospital doctors in 1990. Although the outline of the scheme has been agreed nationally and is applicable to all employers, it is operated locally and may vary considerably between employers.

Eligibility

The default position is that resident doctors will use their own vehicles for travel in the performance of their duties, except where the employer has made a specific alternative provision. Use of a lease vehicle should be considered whenever it is expected that the business miles travelled in a year will exceed 3,500 miles.

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

Types of car

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

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

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

Taxation
As far as HM Revenue & Customs is concerned, private use of Crown/lease cars constitutes a tax benefit, and their treatment is therefore the same as a company car given to any employee. Resident doctors interested in Crown/lease cars should be aware that the scheme will only be economically advantageous to some individuals, depending on variables such as private and business mileage, size of car, and the tax position. They are therefore advised to proceed with caution. BMA members should seek advice from our third party suppliers bma.org.uk/pay-and-contracts/your-finances/your-finances-and-protection/medical-accountancy-and-tax-advice and/or their accountant.

Further information
Terms and Conditions of Service, Schedule 12 paragraphs 8 & 17.

NHS Terms and Conditions of Service Handbook, Annex 13: www.nhsemployers.org/tchandbook.

Subsistence allowances

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

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

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

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

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

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

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

costs basis.

Day meal allowances

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

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

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

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

Resident 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 t he employer.

Late night duties expenses

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

Further information

Terms and Conditions of Service, Schedule 12, paragraphs 36-44.
NHS Terms and Conditions of Service Handbook, Annex 14: www.nhsemployers.org/tchandbook.

Telephone and postage expenses

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

Further information

Terms and Conditions of Service, Schedule 12, paragraph 45.

20. Relocation and excess travel expenses

Summary

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

The principle behind the provision of relocation & excess travel expenses is that a trainee should not be financially disadvantaged by reasonable costs incurred through relocating in fulfilling the requirements of their training. However, trainees are not expected to profit materially from public funds used for reimbursement in respect of relocation and associated expenses.

Relocation & excess travel expenses are a much underutilised entitlement that resident doctors have. Given the personal financial costs that trainees can incur from relocating and travelling in pursuing their training. RDC highly recommends that resident doctors familiarise themselves with their entitlements under relocation & excess travel expenses policies, to ensure they are reimbursed for any eligible costs.

Introduction of National Relocation & Excess Travel Framework

There is now a national relocation & excess travel framework that has been agreed between Health Education England and the BMA. This national framework replaced the previous regional policies or local employer relocation & excess travel policies that existed.

Previously the scheme for reimbursement of removal expenses gave employers discretion on the scope and level of removal expenses that they may reimburse. However, in many regions and localities the BMA had negotiated and agreed policies for resident doctors at the employer or within the region. In some regions have established removal expenses policies covering all employers in the region.

In October 2019, HEE brought a proposal to the BMA to consider the development of a single national framework for Relocation & Excess Mileage Arrangements for doctors and dentists in training. This was supported in principle, as RDC was concerned by the lack of consistency in provision between local / regional policies. This national approach provides clear, reasonable and consistent assistance to all trainees who face the financial costs of moving house to take up training and who are disadvantaged as a result of training programmes which cover large geographical areas.

Following HEE's initial engagement with the BMA on a national level regarding the introduction of this policy, significant improvements were made to the policy to address the concerns RDC had raised.

The implementation of the national policy occurred in November 2020, following RDC's approval.

The national policy replaced existing local policies or arrangements for doctors who started new training programmes from August 2020 onwards. As a condition of RDC's support for the national policy, it was agreed that regional agreement by regional BMA structures – typically Regional RDCs - would be required for the national policy to replace any existing regional policies which covered trainees who began their programmes prior to August 2020. Almost all regions in England have agreed that the national policy should replace the existing regional / local policy for trainees who started a training programme in the region prior to August 2020. Therefore, it is very likely that the below guidance is applicable to you, however, if you are uncertain contact your local BMA representatives or advisors or your employer's medical staffing department to receive confirmation.

Further information

HEE: *New national arrangements for the payment of relocation and expenses costs*.
BMA: *Relocation expenses boost for residents*.

Scope of National Framework

This national policy supports a trainee in moving into a HEE training region from other parts of the country, or from a devolved nation, to take up a training programme or a trainee already living in the region where they are training to move to a more central location which facilitates commuting to the majority of the prospective educational placements on the training programme.

Where a trainee relocates to a geographical location further away, in terms of travel time or distance from their training place of work they will not be entitled to claim any additional excess mileage incurred unless it can be demonstrated that the new residence is closer to the majority of the remaining placements for their training programme.

The following groups are eligible to claim expenses under this framework:
- Medical Trainees from Foundation Year One onwards including trainees in academic training programmes
- Dental Trainees from Dental Core Training onwards including trainees in academic training programmes
- Public Health Trainees including trainees in academic training

Trainees who are on an out of programme (OOP) experience will not be eligible to claim relocation, temporary accommodation or excess mileage payments whilst they are out of programme but may claim expenses in order to support them returning to their training programme. The exception to this is trainees on approved OOPT (Out of Programme for Training) experience, who are able to claim expenses whilst on their OOP.

Trainees appointed to single-site training programmes (ie they do not change geographical location during the entirety of the training programme) will not be eligible to claim excess mileage payments, but can claim relocation expenses.

The national framework and the maximum financial allowance payable do not include any costs incurred as a result of accommodation provided following night duty shifts and on call commitments, etc which should be provided by the placement organisation under appropriate Trust Health & Safety policies and in accordance with the requirements of schedule 12 and 13 of the 2016 national Terms and Conditions of Service.

Total available allowance

The total maximum sum that you are able to claim up to throughout your training is £10,000. This is for the entire period of your postgraduate training and is not proportioned for trainees working less than full time. This maximum sum applies to all eligible expenses.

The maximum sum is based upon an assumption of 8 years reckonable service in any approved HEE training programme.

Exceptions to the maximum allowance limit

Trainees who exceed this period of training, for example trainees whose CCT is awarded after completion of ST7/8 and trainees working less than full time, who have exhausted the £10,000 maximum allowance will be entitled to continue to claim for excess mileage and/or removal expenses, with the expectation that any claims they submit over and above the maximum allowance will be treated in the same manner as those under submitted by the trainee whilst under the £10,000 limit.

Individual trainees who can demonstrate exceptional circumstances, for example married or cohabiting trainees who 'shared' removal costs; or significantly long/expensive commutes due to rotation placements or other exceptional personal circumstances (including trainees with disabilities) will be able to apply for additional recompense via the Postgraduate Dean. Where a trainee's designated place of work for their current placement, or a prospective placement, is changed due to reasons beyond the control of the trainee (eg reconfiguration of services, removal of training places, redeployment due to emergency service pressures, etc.), then any eligible relocation or excess travel expenses shall be reimbursed in accordance but not count towards a trainee's overall maximum expenses limit.

In adherence with the Armed Forces Covenant, any eligible costs incurred by a trainee due to their, or their partner's, active military service shall be claimable. Any expenses paid to a trainee, which are related to military service, will not count towards an individual trainee's £10,000 maximum allowance.

Taxation of expenses

Expenses used for removal and relocation are exempt from income tax as per the relevant HMRC guidance up to a maximum of £8,000 per claim.

Excess mileage claims will likely be subject to tax, as it is considered to represent 'ordinary commuting'. This may not be the case if you are employed under a lead employer model and your excess mileage claims could be exempt from tax. Trainees should clarify their personal position with their employer.

Please be aware that to be eligible for tax relief, your expenses must be incurred, or the benefits provided, before the end of the tax year following the one in which you start your new job (a tax year runs from 6 April one year to 5 April the next).

Further information can be obtained from your local tax office.

Further information
HMRC : www.gov.uk/expenses-and-benefits-relocation.
www.gov.uk/hmrc-internal-manuals/employment-income-manual/eim61017.

Removal expenses

Eligibility criteria
In order to be eligible for removal expenses, trainees should relocate their primary residence at least 30 miles from their old residence or at least one hour's travel time, in normal traffic, and live within a 'reasonable commute' distance from the majority of the anticipated prospective hospitals/placements on their training programme. A reasonable commute distance is deemed to be no further than 20 miles in radius.

Where the first placement of a trainee's training programme is considered to be located on the periphery of where the rest of the trainee's placements are due to be, or anticipated to be. Then the trainee will be eligible to claim removal expenses (up to a maximum of £500) if they choose to relocate within 20 miles of their place of work for this first placement. In this scenario, a trainee's residence does not need to be within 20 miles of the majority of the placements for their training programme.

Eligible expenses
The property for which reimbursement of removal and associated expenses are being claimed for should be of a broadly comparable standard.

Trainees who are buying their first property or are moving from one rental property to another can only claim the cost of removal of furniture and effects (up to a maximum of £500) and for expenses relating to a search for accommodation. No other expenses will be reimbursed in these circumstances. House purchase costs will not be reimbursed to first time buyers or applicants whose existing property is not being sold.

The above two limitations exist, as the purpose of the policy is not to support trainees in getting on to the property ladder, but is rather to reimburse them for reasonable costs they incur in the fulfilment of their training. Reimbursement of costs associated with the purchase of a first property, would be providing financial assistance to trainees in getting on to the property ladder, which they would not receive if they were in normal circumstances. One failed purchase may be reimbursed where the trainee is not responsible for the abandonment of the transaction, or the trainee's withdrawal is entirely reasonable. However, this reimbursement will be included in the maximum limit for reimbursement.

Below is a list of the relocation expenses that can be claimed for, this is not an exhaustive list and you should review the national policy to check whether you are eligible to claim for a certain expense:

- Search for new accommodation
  - Cost of two preliminary visits to the area of their new employment in search of accommodation
  - Expenses for preliminary visits may be reimbursed; accommodation and subsistence for a maximum of four nights and return travel at public transport rate or standard rail fare, for the trainee and their immediate family.
- House sale fees
- House purchase fees
- Storage costs
- Removal fees
- Travel expenses on removal
- Continuing commitments (eg ongoing mortgage / rent costs of old property up to 12 mths)
- Nursery registration fees
- Re-direction of mail

Excess mileage expenses

Most training programmes will involve trainees working at numerous placements over a period of many years which may cover a significant geographical area and it is recognised that it is not reasonable or practicable to expect trainees to relocate upon every rotation. Therefore, the national framework allows trainees to claim for excess mileage expenses, payable at the reserve rate – 28p per mile, incurred as a result of rotation.

Eligible mileage

Trainees can claim for mileage costs from home to the place of work less 17 miles each way. Trainees are not eligible for reimbursement of mileage costs for the first 17 miles of their journey as this is not defined as 'excess travel'.

GP trainees working in a GP practice setting who are claiming home to base mileage cannot claim concurrently for excess mileage for the same mileage under this framework. Trainees appointed to single-site training programmes are not eligible to claim excess mileage as they are expected to live within a reasonable commute, less than 20 miles, of the place of work.

Where a trainee's permanent residence is outside of the relevant HEE regional footprint and they choose not to relocate, there is no entitlement to excess mileage payments unless it can be demonstrated that their residence is within reasonable commuting distance of the majority of the placements on their training programme. Otherwise, agreement of any financial assistance will be subject to the agreement of the Postgraduate Dean on the grounds of exceptional personal circumstances.

Trainees who use public transport for journeys can claim expenses based on the equivalent mileage that would have been incurred if performing the journey by car. The trainee will be reimbursed for the 'excess mileage' incurred as per the Reserve mileage rate.

Trainees who travel to work by bicycle, can claim excess mileage for journeys over and above 17 mile each way. Mileage will be payable at 20p per mile.

Cap on excess mileage

Excess mileage claims should be limited to 53 paid miles each way per day (ie a total journey of 70 miles each way). It is however recognised that regional geographies and travel systems as well as individual circumstances will vary and therefore trainees who wish to exceed these normal limits should discuss their personal position with the employer in the first instance. Payment of excess mileage claims should not be agreed where, in the judgement of the employer and following agreement with HEE via the Postgraduate Dean the journey time and/or the distance involved exceeds the normal limit for daily commutes and is likely to be detrimental to the safety of the trainee, and/or to the satisfactory performance of the trainee's duties/where patient safety will be affected.

Temporary accommodation

Where a trainee, who does commute long distances which are deemed to be acceptable normally, identifies a day, or a run of days, where they would prefer to stay in temporary accommodation close to their place of work, in anticipation of working the next day, rather than commuting back to their home they can claim for the cost of their normal return journey excess mileage and use this to fund the cost of their accommodation for that night(s). A trainee cannot claim twice.

Where daily travel distances are agreed to be excessive, temporary accommodation expenses can be agreed. These expenses will be included within the maximum allowance payable of £10,000 except in exceptional circumstances. The regional maximum monthly allowances are set out below:

HEE Region	Regional Temporary Accommodation Allowance
North West	£735 / mth
North East & Yorkshire	£680 / mth
Midlands	£735 / mth
South West	£715 / mth
South East	£820 / mth
London	£890 / mth
East of England	£740 / mth

These maximum temporary accommodation allowances are calculated based upon the BCIS (Building Cost Information Service) data for regional property rental costs.

Process for claiming expenses

You should complete the application form which will be available from your HEE Local Office Website and/or the employer. You should submit a request for confirmation of eligibility for reimbursement as soon as possible and before incurring any costs.

Re-imbursement will not normally be made until you commence working in the appointment. You should submit actual expenses claims within three months of the expenditure being incurred.

Where a trainee has relocated, and incurred eligible expenses in advance of commencing in a prospective training programme placement due to extraneous circumstances (eg relocating from abroad, relocating in advance to align with school years, etc.), then a trainee will be able to submit claims for eligible expenses within three months of commencing in their post, rather than three months from when the expense was incurred.

Original receipts in respect of removal expenses will be required as proof of expenditure. Reimbursement will not be made to third parties.

Receipts are not required for excess mileage claims.

Trainees claiming reimbursement of excess mileage or temporary accommodation should complete the relevant claim form on a monthly basis. Claim forms will be available from your employer.

Regional flexibilities

In recognition of each region's different geography, economies and travel systems. There is some flexibility within each region to address this in terms of commuting times, toll charges, temporary accommodation and public transport charges.

These flexibilities include:

HEE Region	Regional flexibility
Midlands	M6 toll with agreement of the Postgraduate Dean
East of England	Dartford Dart/Tunnel crossing charges
London	Cost of travel into TFL Zones 1-3 Dartford Dart/Tunnel crossing charges
North West	Mersey Tunnel and the Mersey Gateway Bridge toll charges
South East	Isle of Wight ferry charges Dartford Dart/Tunnel crossing charges
South West	Tamar Bridge and Torpoint Ferry tolls
Yorkshire & the Humber and North East	Humber Bridge and Tyne Tunnel toll charges

Further information

HEE: Funding arrangements for the payment of relocation and expenses
www.hee.nhs.uk/our-work/doctors-training/enhancing-working-lives/funding-arrangements-payment-relocation-expenses.

21. Accommodation and catering

Summary

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

If a doctor's duties require them to be resident, either because they are resident on-call or to maintain emergency response times, then the employer is required to provide accommodation. In addition, if a doctor, for good reason, cannot obtain suitable accommodation and whose recruitment and retention would otherwise prove difficult, the employer may provide accommodation.

There is no longer a statutory requirement in the UK for FY1 doctors to be resident, which in turn means that hospital accommodation no longer needs to be provided without charge to FY1s in England.

Overnight accommodation when on-call

No charge should be made for on-call accommodation for resident doctors who are required to work overnight in the hospital on a resident on-call working pattern. This is detailed in Schedule 13 paragraph 13 of the terms and conditions of service.

Where a doctor is rostered to work on a non-resident on-call working pattern, and the doctor elects voluntarily, subject to the availability of accommodation, to be resident during the on-call duty period, a charge for any such accommodation shall be made and, provided that prior consent has been given, shall be deducted from the doctor's salary.

When necessary to be resident for non-resident on-call because of emergency response requirements, employers must provide accommodation without charge.

Where a doctor is rostered to work on a non-resident on-call working pattern and is required to return to work during the night period, and the doctor considers it unsafe to undertake the return journey home due to concerns over tiredness, the employer shall, where possible, provide an appropriate rest facility if requested, where the doctor can rest, without charge. In this situation, the hours where the doctor is resting in hospital will not count as working time.

Where the provision of an appropriate rest facility is not possible, the employer must cover the cost of alternative arrangements for the doctor's safe travel home. Where necessary, the employer must also cover reasonable expenses as determined through locally agreed policies for the doctor's return journey to work.

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

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

Accommodation for doctors on long shifts

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

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

Further information

Terms and conditions of service Schedule 13, paragraphs 9-13.
NHS Employers' report covering the impact of the SiMAP and Jaeger rulings.

Accommodation between duty periods

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

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

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

Standards of catering

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

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

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

Guidance on hospital accommodation and catering

Fatigue and Facilities charter

Most NHS Trusts have signed up to the BMA Fatigue and Facilities charter. This outlines the minimum requirements for access to food out of hours, rest facilities and mess provision. If you believe your work sites facilities are not up to standard, contact support@bma.org.uk. The below are the provisions of the charter - even if your employer has not signed up to the charter, you should consider these to be reasonable minimum standards.

Rest facilities for doctors working on-call

An employer should make sleep facilities available free of charge for all staff who are rostered or voluntarily resident on-call at night. An individual room should be provided, with:

- a bed, of good quality, with linen changes every three days and for every new occupant.
- an independently controlled source of heating - towels, changed daily and for every new occupant.
- a telephone with access to hospital switchboard.
- electrical power points.
- adequate sound and light-proofing to allow good quality sleep day and night.

Catering

A catering facility should be:

- open 365 days a year.
- provide adequate, varied, efficiently served and freshly prepared meals.
- offer healthy eating and vegetarian options, as well as options for a range of cultural and dietary requirements.
- serve hot food for extended meal times for breakfast, lunch and dinner, where possible with a minimum late opening until 11pm, and a further two-hour period between 11pm and 7am.
- Make hot food available if the canteen is closed, through a supply of microwave meals or a similar arrangement. Supplies should be enough for all staff on duty, readily accessible to doctors in training, and regularly restocked. Offer card payment or change machines where necessary.

Mess facilities

An employer should provide an easily accessible mess for resident doctors with appropriate rest areas, which are accessible 24 hours a day, seven days a week, allowing staff to nap during breaks.

Nap/rest areas should be separate from food preparation or routine break areas, and the mess should not be used for organised shift handovers or other clinical work. It should be an area of rest and not a clinical environment.

An employer should provide these areas on site for staff (not necessarily exclusively resident doctors), wherever is most appropriate:

- lounge (with power points, telephone connection and TV aerial).
- office/study area (with power points, telephone connection and internet access) .
- kitchen (with sink, hotplate, microwave, toaster, fridge, freezer, kettle, coffee machine and supply of tea, coffee, milk and bread).
- changing facilities and showers.
- storage area including lockers for doctors.
- secure cycle storage.

22. OOP (Out of Programme) experiences

Summary

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

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

Different types of OOP

OOPC **Out of Programme Experience for a career break** (eg to work in industry, or for ill-health reasons).

OOPE **Out of Programme Experience for Clinical Experience** (which has not received approval from GMC for contribution towards a trainees CCT). An OOPE is for gaining professional skills that would enhance future practice eg enhancing skills in medical leadership, academia, medical education or patient safety, or enhancing clinical skills related to but not part of the curriculum. Such experience may benefit the doctor (eg working in a different health environment/country) or may help support the health needs of other countries (eg with Médecins Sans Frontières, Voluntary Service Overseas, global health partnerships). Note OOPE is not applicable in foundation training.

OOPP **Out of Programme Pause** is new opportunity where trainees can step off training to undertake NHS work or similar patient facing work in the UK. They can potentially accrue skills and capabilities which will count towards their training. OOPP has been piloted in other regions and, because of the pandemic, is being rolled out nationally.

OOPR **Out of Programme Experience for Research** (including a registerable higher degree) can be up to three years.

OOPT **Out of Programme Experience for Training**, which has approval from the GMC and will contribute towards obtaining your CCT.

OOP and CCT

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

Application details

Application processes vary depending on the deanery/HEE local office. It is therefore recommended that you check the specific deanery/HEE local office website for guidance specific to the region.

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

Full details of the approval process are on the GMC website at www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/out-of-programme.

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

Application timeframes

The deanery/HEE local office will normally expect trainees to have been in their current training programme for at least a year before they can apply for time OOP. Those in core training programmes are not normally afforded time out for OOP. Deferring the start of a training programme is different, and deans will not normally agree to deferment except on statutory grounds like maternity, or for time to complete a higher degree. However, more flexible deferment may be available for those with an offer for GP training.

Duration of OOP

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

Returning to training

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

SuppoRTT

SuppoRTT was developed by HEE, with input from the BMA, to provide targeted assistance to help doctors get back 'up to speed' when they return to training. The Supported Return to Training strategy and investment plan outlines HEE's ten commitments to support trainees with their return to training.

A trainees' time out of programme is coordinated by local HEE offices; including before, during and after. Doctors returning to training can access personalised advice and support through their local HEE office. HEE have created resources for everyone returning to training, a trainee will develop their individualised 'return to training' package with their appropriate Educator/Supervisor using their local HEE SuppoRTT Team processes.

Each regional HEE office offers a slightly different 'menu', but because the programme is individually tailored, there is room to request things which a trainee requires, providing it is approved by their Supervisors/Educators. SuppoRTT can offer:

- A period of enhanced supervision
- Refresher courses and simulation training
- Mentoring or professional coaching
- Conferences and workshops
- Funding for other courses or development, as individually required.

Further information regarding SuppoRTT is available here, along with details for local HEE SuppoRTT teams.

Application refusal

If the application for time OOP is refused, or the GMC will not approve time OOP for contribution towards CCT, the following course of action is recommended. Write to the deanery/HEE local office to request written confirmation of the reasons the application for OOP was refused and written confirmation of the amendments to the application that would satisfy their criteria for an OOP request.

Upon receipt of the letter from your deanery/HEE local office, find out if it is possible to amend the application for time OOP to fulfil the criteria set. If you have any problems, contact our advisers by visiting bma.org.uk/contactus

Further information
The Gold Guide sets out the rules for undertaking time OOP. Prior to making an application for time OOP, please refer to the guides in detail.
The Gold Guide contains more specific details on the process and most deaneries/HEE local offices follow this process. The deanery/HEE local office website will have guidance specific by region.

The BMA website has further information available at: bma.org.uk/advice-and-support/career-progression.

Thinking of working abroad?

The BMA international department has published guidance on working abroad and working in the EEA, which is available on the BMA website: bma.org.uk/advice-and-support/career-progression/working-abroad/working-abroad-as-a-doctor.

This guidance includes information about the key points to consider before you go, including deciding where to go, and how you can apply.

The BMA also has guidance on its website about working in developing countries: bma.org.uk/advice/career/going-abroad/volunteering-abroad.

This guidance aims to support doctors at all stages in their careers, from trainees, specialty doctors and associate specialists, to consultants and GPs, in successfully taking time out from working as a doctor in the NHS to gaining professional experience in developing countries. It also aims to support deans and employers in the NHS to understand how best to support doctors as part of the wider workforce.

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

For further information, please contact the BMA international department at info.international@bma.org.uk.

23. Medical academic doctors

Summary

This chapter provides more information about training and working as a medical academic. It also outlines what you might expect to encounter in the medical academic workplace, including information on contracts and pay.

What is a medical academic?

A medical academic is a doctor that undertakes teaching and/or research, and may also be involved in the management of those activities. Many medical academics also undertake clinical work, usually as part of a joint academic and clinical role, with each aspect of the role informing and enhancing the others. This may be via an integrated programme or through a separate academic post or qualification.

Trained doctors undertaking these roles can be employed by universities or other higher education institutions, and may work in medical schools or in postgraduate medical centres. They usually have an honorary contract with a local NHS organisation, though the honorary contract for Senior Academic GPs in England is held by NHS England. They spend roughly half their time undertaking clinical sessions, though the proportion of time or allocation of academic blocks can vary between posts and between stages of the career. Those doctors also with clinical commitments are known as clinical academics, and should be on a pay scale equivalent to that in the NHS. Additional pay premia may also be available following the completion of such a post or qualification.

Training opportunities in academic medicine

The 'Integrated Academic Training Pathway' clearly defines the key entry points to academic medicine, and outlines a transparent career structure where the stages of progression are identifiable from the outset. Starting at foundation level – which gives trainees a taster of academic medicine – and progressing through two specialty phases and often a period 'out of programme', or alternatively with academic training time allocated alongside reduced clinical components, the Pathway is intended to be the dominant career route for medical academics. Of the training opportunities offered, the majority will be research focused, with some concentrating on medical education.

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

The BMA would argue that the Follett Review Principles should apply even from FY1 level. ACFs in England should, therefore, hold honorary university contracts, and the BMA advises that an honorary contract may also be useful for residents on academic foundation programmes. These, however, are by no means automatically forthcoming and we would encourage members with any questions to seek support or have their contract checked by the BMA.

Follett Review Principles

All medically qualified academic staff working for both the NHS and a higher education institution should be employed subject to the principles recommended by Professor Sir Brian Follett in September 2001 in his Review of appraisal, disciplinary and reporting arrangements for senior NHS and university staff with academic and clinical duties. The recommendations are broadly accepted by both sectors and are known as the Follett Review Principles. The key principle is for NHS and university organisations involved in medical education and research to work together jointly to integrate the separate responsibilities. The application of these principles to resident doctors has recently been explicitly agreed to by NHS Employers.

Academic foundation programmes (AFPs)

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

For further information see the *Rough guide to the academic foundation programme (UKFPO)*: foundationprogramme.nhs.uk/programmes/2-year-foundation-programme/academic-training.

Academic clinical fellowships (ACFs)

The ACF is the first phase of specialist academic training in England, and usually leads to the undertaking of a higher degree by means of a competitive peer-reviewed research fellowship or educational training programme. General clinical training and practice will still form the majority of the responsibilities of those on the fellowships, with 25 per cent of a trainee's time protected for sessions aimed at developing the necessary academic skills required to develop ideas for and prepare applications to more substantive clinical fellowships or funding to do a higher degree.

A maximum of three years (four years for a GP) is allowed to secure a research/teaching fellowship – although it is expected that one may be secured in less time – with a further three years for the completion of the higher degree. Part-time opportunities of a longer duration may also be available. If they have previously completed an MD or PhD, trainees may apply to continue postdoctoral research under the ACF, as long as they meet the entry requirements for the specialty.

Successful applicants to an ACF will be employed by the NHS under the national terms and conditions agreed for resident doctors. They are classed as trainee members of the National Institute for Health Research (NIHR) faculty. ACFs should also have honorary academic contracts with the relevant university in order to have ease of access to HEI facilities and some further training.

NIHR ACF posts are allocated partnerships made up of the HEE local office, the university and relevant NHS trust. The local office manages the recruitment process, with advertisements usually appearing from October. Applications are made through Oriel, and a specific ACF application form will need to be completed.

After shortlisting the candidates, the local office will organise interviews towards the end of the year. The interview will assess both clinical and academic potential. The candidates will then be ranked. More guidance on the NIHR process can be found here.

Out of programme research

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

Clinical lectureships (CLs)

CL posts are the second phase of specialist academic training in England, and are designed to enable trainees to complete clinical training in conjunction with postdoctoral research or higher educational training. The CL phase lasts up to four years, and a trainee's continued academic career development will be the responsibility of the organisation in which they are based.

The programme enables the trainee to undertake a substantial piece of postdoctoral research or educationalist project and, in secondary care, leads to the attainment of a Certificate of Completion of Training (CCT) and the end of clinical training. Clinical lecturers are also classed as trainee members of the NIHR faculty.

Clinical lecturers will be employed primarily by the higher education institution in which they hold a post. As the clinical academic timetable split will be half and half, a clinical lecturer should also have an honorary contract with the NHS to cover their clinical duties. A separate contract may be needed to cover out-of-hours work.

The BMA's view is that the honorary contract should mirror the substantive resident doctor contract as much as possible. However, we have not yet been able to agree this with NHS Employers. We therefore advise that you have your honorary contract checked before signing it.

We have, however, agreed a Clinical academic trainee induction and governance checklist with NHS Employers. NHS Employers advises that the employing trust completes the checklist to help give trainees clear and consistent information about issues including supervision arrangements, local policies and governance structures, how to raise concerns, induction and honorary contract arrangements.

The only variance to the contract guidance is for academic GPs. They will normally have gained their CCT at the end of the ACF. This means that the pay rates agreed for academic trainees, based on these in secondary care, do not provide anything like parity with the pay of newly qualified GPs. The BMA is working with the Society for Academic Primary Care on this barrier to GP participation in academic trainee. However, NIHR has agreed informally that GP CLs should be paid on the old consultant pay-scale (see section 7 of the pay circular for England-based medical academics on the BMA website). GP CLs are advised to seek to ensure that they receive this rate as a minimum, and to build in this pay rate and increments into bids for funding.

Other routes

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

Academic and clinical progression

The progress of all trainees who undertake postgraduate specialty training is formally assessed through the Annual Review of Competence Progression (ARCP), which reviews evidence both for a trainee's progression and the appropriateness of their clinical and academic training programmes. The BMA's view is that adherence to Follett Principles should mean that the review process is done jointly, though we recognise that it may not always be possible to get both supervisors in the same room at the same time for the ARCP. One supervisor dialling in for at least their part of the review would be an acceptable compromise.

Full details regarding the monitoring of clinical progress and the roles and responsibilities of both trainee and supervisor are set out in the MMC's 'Reference guide for postgraduate specialty training in the UK', known as the *Gold Guide*. Academic progress is assessed by the academic supervisor across three generic domains – generic and applied research skills, research governance, and communication/education.

Supervisors

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

Mentoring

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

Role of postgraduate deaneries

The BMA fully expect postgraduate deaneries to be involved in ensuring the clinical element of training accords with national standards. The deanery office can be approached for advice, and we would urge trainees to establish a good relationship with clinical and education supervisors early on.

Terms and conditions

All institutions should provide information about their human resource policies to prospective employees. Terms and conditions of medical academic contracts may differ from NHS contracts. Look out for the details regarding pension schemes, annual leave and maternity leave. If you are in doubt, contact the BMA to have your contract checked before signing.

The extent to which terms and conditions vary from NHS contracts depends on the grade of doctor, whether the doctor undertakes clinical work and, because HEIs are incorporated under individual statutes which govern their operations, the university employing the academic.

The research funders have agreed to a set of Principles and Obligations all UK institutions and clinical trainees in receipt of nationally competitive funding for clinical academic research training. This includes obligations regarding contracts. It is worth noting though that the contracts of employment are with the university or the NHS not the funder (www.nihr.ac.uk/documents/clinical-principles-and-obligations/21858).

Despite all that, we would still advise members to have both their substantive and honorary contracts checked by First Point of Contact before signing them.

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

Intellectual property

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

Pay

Resident academics employed by higher education institutions should have pay parity with their NHS colleagues. They should be paid equivalent to a specialty trainee. Further guidance regarding medical academic pay is available here.

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

Medically qualified academics who do not undertake clinical work will be subject entirely to the terms and conditions of the HEIs. This includes resident doctors who have secured grant funding for research (including from the MRC or the Wellcome Trust), but who hold a contract of employment with an academic institution.

Resident doctors taking time out of a training programme to complete a period of research will be paid according to university pay scales or in accordance with grant funding. Trainees are advised to try and build the agreed pay and incremental points into the pay-scale and ensure agreement in meeting any pay awards. As the grant may be a fixed amount divided equally between each year, the funder may want to pitch the amount for pay at the mid-point of the pay-scale, effectively over-paying the employer at the start and under-paying at the end.

Moving between sectors

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

A+B contracts

Some medical academics are employed on 'A+B contracts'. They are then employed:
on a part-time basis, with both a medical and dental school or MRC and an NHS organisation (in which case, the consultant will be treated as part time by both the university and the NHS employer).

Short-term or fixed-term contracts

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

Under the Regulations, fixed-term employees cannot be treated less favourably than comparable permanent employees, unless the different treatment can be objectively justified. If fixed-term employees believe that their rights under these Regulations have been infringed, they should contact the BMA.

Trainees are advised to check the pay rates offered under these contracts and the arrangements for returning to the NHS before accepting these contracts.

Pension

If you stop working for the NHS and take up an academic post with a university, you may be able to continue to pay into the NHS pension scheme via what is known as a 'direction' arrangement. Further guidance is available on the BMA website: bma.org.uk/pay-and-contracts/pensions/leaving-the-nhs-pension-scheme/moving-between-nhs-and-university-employment-and-your-pension.

You are advised to seek independent financial advice on the relative merits of the NHS Pensions Scheme and the Universities Superannuation Scheme.

Leave and pay for new parents

For medical academics employed by a university, terms and conditions are determined by the type of contract they have. Universities are independent employers, and will have their own policies dealing with leave and pay for new parents who are employees. You will have the same statutory entitlements as any other worker, but your contractual entitlement may differ from those with contracts with another employer or with the NHS.

Redundancy

As with parental leave and pay, universities are independent employers, and will have their own policies dealing with the possibility of redundancy in relation to all staff. You will have the same statutory entitlements as any other worker, but your contractual entitlement may differ from those with contracts with another employer or with the NHS.

24. Overseas doctors and international medical graduates

Summary

The UK immigration system is a points-based system, introduced on the 1 January 2021. The system applies to both non-EEA and EAA nationals entering the UK to work after that date. The immigration system is not enacted through legislation so the UK Government can, and does, change the system on a regular basis.

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

International students and graduates

Under the immigration system, a student visa route is available for EU, EEA and Swiss citizens and non-EU nationals. Applicants can apply for a visa to study in the UK if they:

- have been offered a place on a course by a licensed student sponsor.
- have enough money to support yourself and pay for your course - the amount will vary depending on your circumstances.
- can speak, read, write and understand English.

From the summer of 2021, international graduates who have completed their degree can work, or look for work, in the UK at any skill level for up to 2 years, or 3 years for PhD graduates.

International medical graduates on the Foundation Programme

In December 2020, the skilled worker route replaced the Tier 2 (general) worker route, and the UK government announced an exemption for health and care professionals to the immigration health surcharge from 31 March 2020. The immigration route for international medical graduates on the UK Foundation Programme is:

- A student visa is needed to take up a Foundation Programme post.
- At the end of the Foundation programme, the doctors will transfer onto the Health and Care Worker visa under the Skilled worker route in order to take up a core specialty training post.

International medical graduates are eligible to apply for a FY2 standalone programme, as long as they can demonstrate they have the right to work as a doctor in training in the UK. Applications from doctor who require sponsorship under the Health and care visa will be considered alongside other applications.

You can find further information from the following sources;
UKFPO
F2 Stand-alone Applicant Guidance 2021
HEE

International medical graduates and the Health and Care visa

Doctors working in healthcare will be eligible to apply for the Health and Care visa. Those currently on a Tier 2 visa who need to extend their visa can switch onto the Health and Care worker visa. They can apply and pay for their visa online. It is cheaper to apply for and they do not need to pay the immigration health surcharge.

Once they have submitted all of the required documentation, they will usually get a decision on their visa within 3 weeks.

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

BMA immigration advice service

If you are a BMA member, you are entitled to access our immigration advice service which provides free, basic immigration advice in connection with your employment and/or study in the UK. If you contact us via the below, we will send you a form to fill out, which will then be sent on to our specialist advisors to review.
E: support@bma.org.uk

Initial free advice covers:
- Advice on applications for leave to enter or remain in the UK that are within the immigration rules.
- Diagnosis of your need for specific immigration advice.
- One-off advice.

Further information
BMA Website: bma.org.uk/advice-and-support/international-doctors.
The UK Visa and Immigration website: www.gov.uk/government/organisations/uk-visas-and-immigration.

25. Revalidation

Summary

Revalidation is the process for doctors to assure the General Medical Council (GMC) that they are up to date and fit to practice. All doctors who wish to retain their licence to practise are now legally required to be revalidated every five years.

What is revalidation?

Revalidation is the process for doctors to positively affirm to the GMC that they are up to date and fit to practise. It applies to all licensed doctors in the UK working in the NHS and the private sector, and all branches of practice. Only doctors who have GMC registration with a licence to practise are legally required to revalidate.

The process

Revalidation is based on an evaluation of a doctor's practice in the workplace and their participation in an annual appraisal process. The appraisal is based on the GMC's *Good Medical Practice*. Doctors also need to collect and reflect on a range of supporting information about their practice (including evidence of continuing professional development and feedback from patients), to be discussed at their appraisal. Doctors are supported through the process of revalidation by the organisation in which they work – a 'designated body'.

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

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

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

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

Further information

The BMA webpages provide updates on revalidation at bma.org.uk/revalidation.
The GMC website www.gmc-uk.org/doctors/revalidation.asp.
GMC Online, a secure area of the GMC website designed to make administration easier for doctors www.gmc-uk.org/registration-and-licensing/managing-your-registration/gmc-online.

26. Raising concerns and whistleblowing

Summary

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

What is whistleblowing?

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

Why should I raise a concern?

Doctors have a professional duty, under Good medical practice, to raise concerns. Concerns in the workplace can vary in nature, but they will all have one common factor: ensuring patient safety. It is important to remember that raising a concern is different from raising a personal complaint or grievance. Get in touch with us at the early stages, and we can guide you through this process.

You should not become a target for poor treatment because you raised a concern. If you do, we can help you. The Public Interest Disclosure Act 1998 gives statutory protection to employees who disclose information reasonably and responsibly in the public interest, and who are victimised or dismissed as a result.

Concerns about training

Concerns about training may well be bound up with patient care issues, and complaining about training may sometimes lead to raising concerns about patient care, particularly regarding clinical supervision. Issues with training may be a cause for concern for both trainees and trainers, and the GMC, employing organisations, and postgraduate deaneries are empowered to address this type of concern.

If you want to contact the postgraduate deanery/HEE local office for this, your Training Programme Director would be the best first point of contact. You can and should approach them if local routes, such as speaking to the educational supervisor, are unsuitable or unsuccessful.

What types of concern should I raise?

It can sometimes be hard to know whether you should raise a concern. You should be guided by this question: if you let the situation carry on is it likely to result in harm to others? If in doubt, you should always err on the side of caution and raise your concern following your employer's policy.

Issues you might have concerns about could include:

- unsafe patient care or conditions.
- unsafe working conditions.
- inadequate induction or training for staff.
- inadequate response to a reported patient safety incident.
- suspicions of fraud.
- bullying towards patients or colleagues, or a bullying culture.

You can use the GMC's raising and acting on concerns flowchart to help you decide whether to raise a concern.

Raising concerns: the principles

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

How to raise a concern

Report what has happened

You should use formal reporting methods, like Datix. Doing this can be essential to protecting yourself legally. It may also make it more likely that your concerns will be taken seriously.

There may be other methods for incident reporting, depending on which nation you are in and your branch of practice.

If you don't feel comfortable raising a concern via your employer, concerns relating to health and safety matters can also be made to the Health and Safety Executive via its online concerns form. Your anonymity will be maintained by the HSE if you make this clear on the form.

Check your employer's raising concerns policy

You should be able to find this on your employer's website. It may also be called 'speaking up' or 'whistleblowing'. You can see what a model policy should look like in England by viewing the examples we have on our raising concerns guidance page.

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

Follow the policy and raise your concern

When you have identified the right person to approach, you can raise your concern either verbally or in writing. You should:

- include key information eg details of what happened, where and when it happened, and who was involved.
- include any relevant documentation or evidence you may have, don't worry if you do not have evidence, it is not up to you to prove that something has happened.
- think about and, if possible, be clear about the outcome you would like to see.
- frame your concern as an opportunity for improvement and helping to address a shared problem.
- use the right tone and remain professional.

Make a record
It is important to keep a written record of raising your concern so you can refer to this later. You can either put it in writing in the first instance or, if you raised your concern verbally, make a dated note of what you said.

What happens next?
The person you have spoken to:
– should thank you for speaking up and listen carefully.
– may need to investigate your concern.
– will decide on the most appropriate action to take.
– tell you what they are going to do.

You should not be subjected to detrimental treatment, such as unwarranted criticism, disapproval or disciplinary action as a result of raising the concern. If you think you are in this situation, call us for advice.

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

Your legal protection

You may be protected under whistleblowing law if you have raised a concern and suffered detrimental treatment or lost your job as a result. The protection is available only in certain circumstances, and the rules are complicated. If you think you are in this situation, call us for advice.

Whistleblowing agreement with HEE
Trainees have a unique employment arrangement, which sees you contracted to work as employees – of a hospital trust for example – while you are simultaneously undergoing training in an arrangement with Health Education England (HEE). Despite it not being established that they are your employer, HEE can have significant influence over your career, ultimately having the right to terminate employment.

It is important therefore that resident doctors are able to make protected disclosures of wrongdoing without fear of unfair treatment by HEE, yet the law on whistleblowing only covers the employee-employer relationship.

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

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

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

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

Further information

The BMA has detailed guidance available at: bma.org.uk/advice-and-support/complaints-and-concerns/raising-concerns-and-whistleblowing/raising-a-concern-guide-for-doctors.
Guidance on the HEE agreement is available at: bma.org.uk/media/1582/bma-hee-whistleblowing-guidance-sept-2016.pdf.
BMA information on the Francis Inquiry and NHS Culture work: bma.org.uk/media/2034/bma-csc-future-vision-nhs-report-sept-19.pdf.
Protect website: protect-advice.org.uk.

27. The regulatory framework

Summary

This chapter provides a summary of the regulatory framework, and includes information on occupational health services and sources of professional advice.

Freedom of Information Act (FOIA)

The Freedom of Information Act 2000 (the Act) provides the public with access to information held by public authorities. Broadly, the primary purpose of the Act is to foster an open and transparent government, and make public authorities accountable for their actions. Public authorities include the Department of Health and Social Care, NHS Trusts, and any person providing primary, general and personal medical services. However, health practitioners only have to provide information related to their NHS work.

The Information Commissioner's Office (ICO) is responsible for implementing and enforcing the Act. A public authority's primary obligations under the Act are to publish information proactively and respond to requests for information.

Under the Act, individuals are able to make a request in writing to a public authority for information. A public authority has a duty to inform the individual whether they hold the information requested, and to provide that information (subject to exemptions). Generally, the public authority must comply with the request within 20 working days.

Importantly, the Act provides a number of exemptions where a public authority is not required to comply with a request for information. However, many of these exemptions are subject to the 'public interest test', involving the exercise of determining whether the public interest in withholding the information outweighs the public interest in disclosing it.

Failure to respond to a request for information within the prescribed timeframe, or inadequately responding to a request, may lead to a complaint to the ICO. The ICO have a general duty to investigate the complaint.

It is a criminal offence to alter, block, destroy or conceal information: the penalty for which is a fine. There are no penalties for failing to provide or publish information. However, failure to comply with a decision, enforcement or information notice from the Information Commissioner is contempt of court, and can lead to a fine or possibly imprisonment for a senior officer within a public authority.

FOIA and the Data Protection Act

It is important to understand the distinction between the Act and the Data Protection Act 2018 (DPA). The Data Protection Act is designed to protect the private lives of individuals and protect one's right to privacy, whereas the Act aims to get rid of unnecessary secrecy. These two aims are not necessarily incompatible, but require careful consideration and judgement. When someone makes a request for information that includes someone else's personal data, you should contact your employer's information governance officer, who will be able to provide you with advice as to what you need to do.

Notably, the Act does not give an individual access to their own personal data, including medical records. This information can be obtained through a subject access request administered under the DPA, which is also overseen by the ICO.

If an information request relates to an individual's 'non-private' life, for example, if it concerns someone acting in an official or work capacity, this information would normally be disclosed. However, details of an individual's 'private life' (eg details of the person's family life or personal finances) will likely be afforded protection under the DPA.

The terms DPA (Data Protection Act) and GDPR (General Data Protection Regulation) are often used interchangeably; the DPA 2018 is the UK's interpretation of the EU GDPR. Since the end of the transition period after leaving the EU, the EU GDPR no longer applies to the UK. The GDPR has now been incorporated into UK data protection law as the UK GDPR, so in practice there is little change to the core data protection principles, rights and obligations that existed before. The UK GDPR sits alongside the DPA 2018 with some technical amendments so that it works in a UK-only context.

Further information
Members should familiarise themselves with local policies on freedom of information and data protection. The ICO publish useful resources on publication schemes and responding to FOI requests on their website.
General resources for medical professions can be found here: ico.org.uk/for-organisations/in-your-sector/health.
A FOI guide can be found here: ico.org.uk/for-organisations/guide-to-freedom-of-information.

We encourage our members to utilise the tools and resources provided by the ICO, and to seek advice whenever they are unsure of their obligations under the Act.

General Medical Council (GMC)

The GMC is the regulatory body of the UK medical profession. The overarching objective of the GMC is 'the protection of the public'. To this end, the GMC controls entry to the medical register, and determines the principles and values that underpin good medical practice. Where a doctor fails to meet the standards, the GMC can take action - if necessary, by erasing the doctor's name from the medical register.

The GMC's *Good medical practice* guidance sets out a doctor's professional obligations and duties, and advises on standards of good clinical care, professional relationships with colleagues, matters of probity, and doctors' health. The GMC can only take action when a doctor's fitness to practise is called into question. Broadly it can act in the following circumstances:

- when a doctor has been convicted of a criminal offence.
- when there is an allegation of serious professional misconduct that is likely to call into question a doctor continuing in medical practice.
- when a doctor's professional performance may be seriously deficient, whether or not it is covered by specific GMC guidance.
- when a doctor with health problems continues to practice while unfit.
- when a doctor does not have the necessary knowledge of English.
- When a decision by a regulatory body either in the UK or overseas to the effect that fitness to practise as a member of the profession is impaired.

The Council published the most recent edition of *Good Medical Practice* in November 2020. The guidance sets out the principles and values on which good practice is founded and standards of competence, care, and conduct expected of doctors in all aspects of their professional work. *Good medical practice* sets broad standards on clinical care; teaching, training and appraisal; relationships with patients; dealing with problems in professional practice; working with colleagues; probity; and health.

Further information
Good medical practice, GMC (2013) www.gmc-uk.org/guidance/good_medical_practice.asp.
GMC website: www.gmc-uk.org.
PSA website: www.professionalstandards.org.uk.

Occupational health services

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

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

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

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

The functions of an occupational health service are to advise employees and employers about the interaction between health and work; to maximise the beneficial effects of this interaction; and to minimise the adverse effects. It should be noted that occupational health is primarily a preventative and not a treatment service. However, much of the output of an effective occupational health service is directly or indirectly therapeutic to organisations and the individuals employed by them. Occupational health services provide recommendations and guidance that employers should consider, but it is not mandatory for the employer to implement these recommendations.

Further information

BMA advice on Occupational Health bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/supporting-health-and-wellbeing-at-work-report.
NHS Employers www.nhsemployers.org.
A safer place to work (2003) www.nao.org.uk/publications/0203/nhs_health_and_safety.aspx.

Violence against doctors

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

The paper recommended training for doctors on the management of potentially violent situations, partnerships with other relevant local agencies (such as the police), and raising awareness of patients' responsibilities and acceptable behaviour. The BMA has further guidance and information regarding this issue available here.

Doctors are advised and encouraged to report violent incidents and, through their LNC, to ensure that employers put in place protocols for recording such incidents and effective strategies for dealing with the problem. The HSE has also produced guidance on the assessment and management of violence against staff in the healthcare sector.

Further information
Government guidance: www.gov.uk/government/news/stronger-protection-from-violence-for-nhs-staff.
BMA guidance: bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/preventing-and-reducing-violence-against-staff.

Sources of support

BMA Counselling is a free and confidential service available 24/7, and allows doctors to speak to a team of fully-qualified counsellors. Callers can access in the moment support and/or a structured course of 6 counselling sessions.

The service is free to all doctors and medical students in the UK, regardless of BMA membership, as well as to their partners and dependents (aged 16-24 in full time education). The telephone number for the service is 0330 123 1245. The number is free from a landline, and most mobile phone providers also list 0330 numbers as a free call. If your mobile phone tariff does not include 0330 numbers as free you can either call and ask the counsellor to call you back, or complete the 'Contact Us' section here on the Health Assured website to request a call back.

Any issue can be discussed including, but not limited to:
- workplace problems
- exam pressures
- stress and anxiety
- loss of confidence
- personal and relationship difficulties
- alcohol and drug misuse
- bereavement
- debt and other financial concerns

BMA Peer support

BMA Peer support offers doctors the option of speaking in confidence to another doctor about whatever personal or professional issue may be troubling them. It's confidential peer support with an emotional focus and our peer support doctors can provide a reflective space, working with you to gain insight into your problems.

Some of the common issues that doctors might contact this service about include issues around their career, anxiety or stress, and following allegations or complaints.
The service is completely confidential, and is not linked to any other internal or external agencies. Simply call the same number as for the counselling service above (0330 123 1245) and request peer support, and after providing some basic information you will be given the details of one of our peer support doctors for you to contact.

Please visit bma.org.uk/advice-and-support/your-wellbeing for further information or email wellbeingsupport@bma.org.uk.

Further information
BMA wellbeing support directory: bma.org.uk/media/3823/bma-wellbeing-support-services-contacts-february-2021.pdf.
DocHealth: www.dochealth.org.uk.
NHS Practitioner Health: www.practitionerhealth.nhs.uk.

28. The British Medical Association and its structures

This chapter provides a brief overview of the structures of the BMA, and the work of the resident doctors committee.

The British Medical Association

The BMA (British Medical Association) is a voluntary association set up in 1832 'to promote the medical and allied sciences and for the maintenance of the honour and interests of the medical profession'. It is the professional association of doctors in the UK and is registered and certified as an independent trade union under employment legislation.

The BMA has collective bargaining rights for all NHS doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields.

The BMA offers advice to members on contractual and professional matters, and provides individual and collective representation at a local level through BMA regional services. As a spokesperson for the medical profession to the public, the Government, employers, MPs, and the media, the BMA addresses matters as wide ranging as medical ethics and the state of the NHS.

BMA RDC (resident doctors committee)

The RDC's purpose and remit is to consider and act in matters affecting those engaged in hospital practice in the training grades, including matters arising under the National Health Service Act or any Act amending or consolidating the same, and to safeguard the interests of hospital medical staff in the training grades in relation to those Acts. bma.org.uk/RDC.

The regional RDCs welcome attendance from any resident doctor either living or working in the respective RDC area. Contact us by visiting bma.org.uk/contactus for more information

National and regional resident doctors committees

Resident doctors in the three devolved nations of Scotland, Wales, and Northern Ireland are represented by their national RDCs. Resident doctors in the English regions are represented by RRDCs (regional resident doctors committees). These committees send members to the UK RDC, which is responsible for representing all resident doctors in the UK.

The GP trainees committee, the public health medicine registrars subcommittee and the joint academic trainees subcommittee also send members to the UK RDC.

Joint negotiating committee residents

It is through the JNC(R) (joint negotiating committee residents) that the RDC Terms and Conditions of Service and Negotiation Subcommittee negotiate with the Department of Health and Social Care and NHS Employers on matters concerning terms and conditions of service of hospital resident staff.

BMA divisions

BMA divisions represent members in all disciplines and branches of practice in their local areas. Every UK member belongs to one of the 180 divisions, and each division can submit motions for debate and send representatives to the ARM.

Regional representation

Regional councils in England are forums to discuss matters of regional interest and issues affecting the profession across all branches of practice.

Each regional council has up to 25 voting seats, elected by BMA members whose registered address is in that area, including UK council members from the region.

They report to UK council and can send motions and representatives to the ARM.

LNCs (local negotiating committees)

LNCs are now established in almost all NHS organisations which employ doctors. LNCs consist of local representatives of all grades of doctor, including resident doctors employed by the organisation who will meet regularly to identify issues for negotiation with local management and agree their objectives.

They will meet with management representatives in a joint negotiating committee in order to conclude and monitor the application of local agreements, and agree and monitor arrangements for the implementation of national agreements within the organisation. Professional and administrative support to LNCs is provided by BMA regional services bma.org.uk/what-we-do/local-negotiating-committees.

BMA council

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

The BMA UK council currently has 60 voting members. Each is directly elected by the membership to give a geographical and branch of practice mix. There are also a number of ex-officio non-voting members, including those who chair the many committees reporting to council. bma.org.uk/what-we-do/uk-national-and-regional-councils/uk-and-national/uk-council.

ARM (annual representative meeting)

The ARM determines the policy of the BMA. The representatives are either elected by the BMA divisions or are appointed by the branch of practice committees.

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