Offer in principle to BMA Junior Doctors Committee

Introduction

There is a shared objective to bring the junior doctors (soon to be resident doctors) industrial dispute to a resolution as quickly as possible. This document sets out the Government's best and final offer.
The Government has listened carefully to the points raised by the BMA Junior Doctor Committee (JDC) about how levels of pay are seriously impacting the morale and motivation of their members. This offer is made in the context of an extremely difficult fiscal position.

A new relationship between the medical profession and the Government is being forged, one of mutual respect and collaboration. This offer intends to restore junior doctors' confidence and trust in the Government as we progress with improvements on these important issues for junior doctors, and by extension their patients and the future of the NHS.

Part 1: Reforms to pay for junior doctors

Pay for 2023-24

The Government will invest an average of a further 4.05% into 2023-24 pay scales for junior doctors. This means that the 2023-24 pay scales are on average 13.2% higher than in 2022-23 – an improvement of 4.4 percentage points from the current 2023 – 24 pay scales.

The offer targets a greater proportion of the investment envelope at Nodal Point 3, whilst ensuring that acceptable differentials remain between the Nodal Points.

Uplifts will be applied to the pay scales for the 2016 and 2002 contracts as well as to local pay scales which mirror those contracts.

The effective date for these changes will be 1 April 2023 and junior doctors will receive a payment to reflect backpay.

Pay for 2024-25

In addition, the Government will accept the recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) and uplift each Nodal Point by 6% plus £1000, on a consolidated basis, with an effective date of 1 April 2024.

The combined impact on the 2024-25 pay scales of the adjustments to the 2023-24 scale will be as follows:

Junior Doctor 2016 contract						
Nodal point	Current 23/24 pay scale	Additional uplift from deal	Uplift from deal	24/25 DDRB recommendation	24/25 DDRB recommendation uplift	New 24/25 Pay Scale
1	32,398	3.71%	£1,202	9.0%	£3,016	£36,616
2	37,303	3.71%	£1,384	8.60%	£3,321	£42,008
3	43,923	5.05%	£2,218	8.20%	£3,768	£49,909
4	55,329	3.71%	£2,053	7.70%	£4,443	£61,825
5	63,152	3.71%	£2,343	7.50%	£4,930	£70,425

Note: The journey towards the 2024-25 pay scales are given in annex A.

2002 contract

- Under the offer, all Junior Doctors on the 2002 contracts and Locally Employed Doctors mirroring those contracts would receive an initial uplift of 3.71% to the current 2023-24 pay scales, applied with the usual methodology used to calculate uplifts in the pay circulars.

- Subsequently applying the 2024-25 DDRB recommendation of 6% + £1,000 means that the 2002 contracts receive an average uplift of ~9.9% + £1,000 compared to the current 2023-24 pay scales, again applied with the usual methodology used to calculate the uplifts in the pay circulars.

Pay for 2025-26

The government acknowledges concerns raised by the BMA and other parties that the medical profession is not as attractive a career prospect as it once was.
The Secretary of State for Health and Social Care would therefore like the DDRB to consider, as part of its pay recommendations, the overall reward package and career progression for junior doctors to ensure that medicine is an attractive and rewarding career choice to deliver our consultants and GPs of the future.

Flexible Pay Premia

The 2016 terms and conditions will be amended to set out that the DDRB, as part of their annual remit, should uplift Flexible Pay Premia in line with their pay recommendations for junior doctors.

Part 2: Measures aimed at improving the experiences of junior doctors

Rotational placements

As part of the work to develop a ten-year Health Plan, DHSC will lead work in partnership with the BMA Junior Doctor Committee, NHS England, devolved administrations, the Medical Royal Colleges, the GMC and employers to reform the current system of training and rotational placements. This will be agreed by all parties.

Whilst maintaining the high standards of training required to practice as a doctor, the workwill seek to review the training model with regard to the number and frequency of rotationsand to review and, where needed, redesign curriculums.

The work will also seek to prioritise the experience of junior doctors, minimise the administrative and bureaucratic hurdles involved in rotating; address the relocation, logistics,travel and accommodation issues; seek to reduce and minimise disruption to personal and family life; and ensure more consistent support systems across different rotations and geographies.

This work will also include a separate NHSE review of training numbers, both to address thetraining bottlenecks which already exist and the planned expansion of medical school places, to ensure patients have access to the junior doctors they need today, and the consultants and GPs they will need in the future. NHSE's work will have to have regard to the implications for the Devolved Administrations.

Exception reporting

Doctors must be paid/receive time off in lieu (TOIL) for all time worked above contractedhours subject to making an exception report.

We will renegotiate with the JDC the provisions applicable to exception reporting based on the following principles:

1. Doctors should be enabled and encouraged to exception report.

2. They should not suffer any detriment as a result of reporting.

3. None of these changes should undermine the Guardian of Safe Working Hours'ability to undertake their roles and identify unsafe working practices.

4. As with all claims for overtime/additional working, there needs to be a sign-off process, but challenges to claims should be by exception rather than the norm.

5. The system for reporting should be clear and straightforward.

6. In reference to exception reports asserting a doctor worked additional hours of two hours or less in one occurrence, the only determination the employer will seek to reach when deciding whether to pay the doctor is whether or not the additional hourswere indeed worked; the perceived retrospective merits of the doctors' decision to work the additional hours should not be considered when determining whether to make payment for the additional hours.

7. Exception reports arising from a doctor having worked more than two hours in one occurrence, should be investigated to ensure safe staffing is maintained and could besubject to a locally determined process, which must be agreed upon with the BMA Local Negotiating Committee.

8. Claims should be based upon clear agreed criteria for what constitutes additionalworking, for example theatre overruns.

9. All educational exception reports to go to DME for approval.

10. All other exception reports to go to HR or Medical Workforce HR for approval.

11. Review the contractual deadlines to ensure that they are sufficient for exception reporting submission to remove the undue burden from doctors and replace with timeframes that empower doctors to manage exception reporting when convenient tothem as professionals.

12. The underlying ethos to this change should be to empower and trust doctors to conduct themselves professionally, and to remove wherever possible, and minimisewherever it is not, the time-consuming aspects of the process.

Part 3: Expectations in return for reform

BMA rate card

If this deal is accepted by the membership, the BMA will withdraw the rate card for junior doctors in England with immediate effect.

End of the dispute

If the BMA Junior Doctors Committee in England accept this offer, it is made under therequirement that:

- the BMA Junior Doctors Committee in England do not call any strike action for the duration of the referendum;

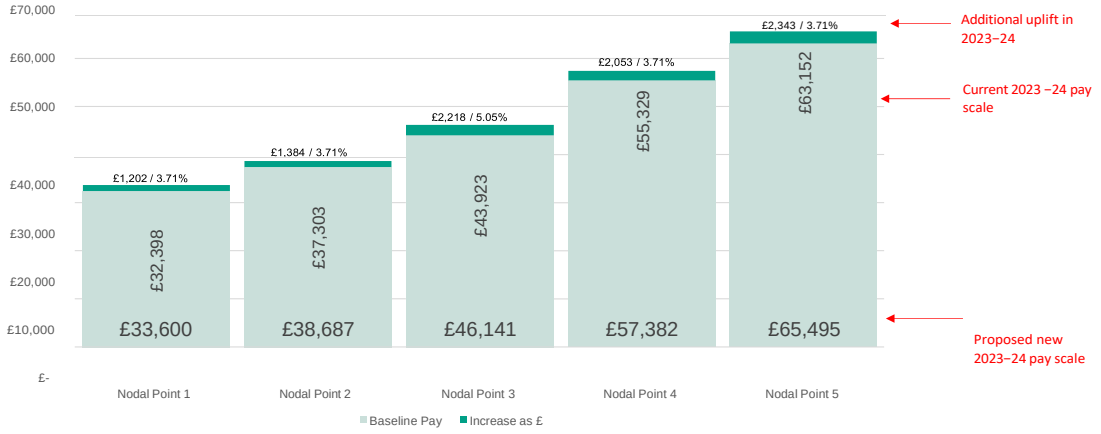
- the BMA, the Junior Doctors Committee, and its officers will consistently and firmlyrecommend to their members that this offer should be accepted; and

- the BMA agree that the acceptance of the offer by their members terminates the presenttrade disputes in relation to the junior doctor workforce in England.

Annex A: Journey towards 2024-25 pay scales for the 2016 contract

Step 1) Targeted uplift averaging 4.05% applied to current 2023-24 pay scale

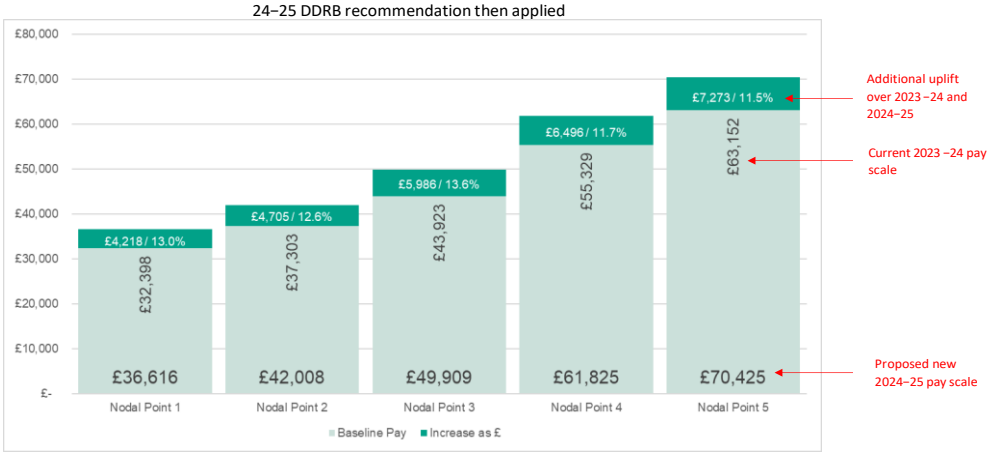
Uplifts averaging 4.05% applied to 23 –24 pay scales (4.4% against 22 –23 pay scales)
Target NP3 with 1% more than the average uplift (5.05%), 3.71% uplift to remaining points including those on 2002 contracts and LEDs.



The £ and % increases are compared to the current 2023 -24 pay scale

Step 2) 2024-25 DDRB recommendation then applied to the revised 2023-24 pay scale

Uplifts averaging 4.05% applied to 23 –24 pay scales (4.4% against 22 –23 pay scales)
Target NP3 with 1% more than the average uplift (5.05%), 3.71% uplift to remaining points including those on 2002 contracts and LEDs.
24–25 DDRB recommendation then applied



The £ and % increases are compared to the current 2023 -24 pay scale

Cumulative impact of uplifts from 2022-23 pay scale to 2024-25

2022-23 pay scales with 2023-24 DDRB applied,
Then uplifts averaging 4.05% applied to 23-24 pay scales, with NP3 targeted with 1% more than the average uplift (5.05%) and 3.71% uplift to remaining points including those on 2002 contracts and LEDs,
24-25 DDRB recommendation then applied