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Helping and supporting you at work

The BMA is dedicated to supporting its members in virtually all aspects of their professional lives. For all your employment advice and information, please call our team of advisers on 0870 60 60 828 between 8.30am and 6.00pm, Monday to Friday except UK-wide bank holidays, or email your query to support@bma.org.uk anytime.

Members should always call 0870 60 60 828 in the first instance. Your enquiry will be dealt with efficiently by our resident team of employment experts, with most queries being answered directly over the phone or by return email.

If, after contacting our team of advisers, it is found that you need direct representation locally, you will be referred to a member of our Regional Services team.

A world of service from your BMA
one line 0870 60 60 828
and online www.bma.org.uk

To help us help you, please remember to keep your BMA membership and contact details up to date.
Introduction

The Junior doctors’ handbook 2008

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

The handbook has been produced to provide information to help junior doctors understand their terms and conditions of service and matters arising in the course of their employment. BMA members may seek advice on specific problems relating to the terms of their employment by contacting our team of advisers on 0870 60 60 828.

Junior doctors working in the Channel Islands or the Isle of Man should note that their conditions of employment may be different and should seek advice from our team of advisers on 0870 60 60 828. Every effort was made to check accuracy at the time of printing but there may have been later changes.

The Association is happy to receive any comments on the handbook, or any suggestions on how to improve the services provided for junior doctor members. Comments should be sent to the JDC at BMA House (a reply-paid card can be found inside the back cover of the handbook).

June 2008

* In Northern Ireland for GWC read Joint Council for Department of Health, Social Services and Public Safety, and for NHS read Health and Personal Social Services.
Junior doctors who work outside the NHS

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

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

Advice on any of these areas can be obtained in the first instance from our team of advisers on 0870 60 60 828.

Staff grade and associate specialist doctors

Advice on terms and conditions of service can be obtained from our team of advisers on 0870 60 60 828. The BMA has a committee which negotiates the terms and conditions of service for staff and associate specialist doctors; the staff and associate specialists committee (SASC).

Representation of junior doctors

The British Medical Association

The British Medical Association is the professional association of doctors in the UK and is registered as an independent trade union to represent doctors both locally and nationally. Officially recognised by the Doctors and Dentists Review Body, the Government and NHS Employers, the BMA has sole bargaining rights for all NHS doctors employed under national agreements, irrespective of whether or not they are members. It is also recognised by many employers of doctors practising in other fields.

The junior doctors committee (JDC) of the BMA represents all junior hospital doctors. The JDC has sole negotiating rights with the Department of Health for all junior doctors employed in the NHS. There
are also national JDCs for Scotland, Wales and Northern Ireland. As a result of devolution the Scottish JDC negotiates directly with the Scottish Government on some areas. The Welsh and Northern Ireland JDCs will deal with certain issues in Wales and Northern Ireland in discussion with their respective national assemblies. However, the Scottish, Welsh, Northern Ireland and UK JDCs are committed to retaining the same terms and conditions of service for all UK junior doctors.

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

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

**Regional and national representation**

The regional junior doctors committee (RJDC) represents junior doctors at regional level. The RJDC consists of junior doctors from hospitals from within the region and appoints representatives to the JDC. Each RJDC may appoint one or two regional negotiators to act on behalf of junior doctors in any regional negotiations that take place, for example on removal expenses. There are RJDCs in Scotland but not in Wales and Northern Ireland.

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

If you wish to attend a regional JDC meeting or a meeting of the Scottish, Welsh or Northern Ireland JDC please contact our team of advisers on 0870 60 60 828, who will put you in contact with your BMA National Office or BMA Regional Centre.

**Representation at local level**

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

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

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

The BMA accredits the representative and this provides certain protections and rights. Any junior doctors interested in becoming a BMA junior doctor representative should call 0870 60 60 828 for further information.

**Local procedures for dealing with problems**

**Grievance procedure**
Each Trust should have a procedure that permits junior doctors to resolve differences that they may have with that employer. Grievance procedures are usually designed to deal with individual grievances. The procedure should state the nature of the differences that can be resolved by using the procedure and should specify the number of levels of appeal available. Copies of the local procedure should be available from the human resources department of the Trust. October 2004 legislation requires all Trusts to have a grievance procedure. Members are strongly advised to contact our team of advisers on 0870 60 60 828 before lodging a grievance.
Disputes procedure

Each Trust should have a disputes procedure to be used where there is a collective dispute between the employer and a number of staff. Such a dispute could be about, for example, annual leave arrangements or accommodation difficulties.* Section 42 of the General Whitley Council handbook sets out a protocol that should be used by employers when drawing up a disputes procedure. Copies of the local procedure should be available from the medical staffing department of the Trust. It is recommended that you seek specialist employment advice from our team of advisers on 0870 60 60 828 before a grievance is lodged.

* Appeals against pay banding allocation and changes in banding should first be directed through our team of advisers on 0870 60 60 828.

Disciplinary matters

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

Depending on the outcome of the investigation and NCAS involvement, a formal disciplinary procedure may be followed.

If the allegation is about misconduct (eg a refusal to comply with a reasonable request from the Trust), the Trust’s local misconduct procedure for all hospital staff should be followed. If the allegation is about the doctor’s professional capability (eg incompetent clinical practice), the Trust should follow a capability procedure based on the national framework for handling concerns about capability. The NCAS should continue to be involved throughout the procedure.
If junior doctor members are advised that disciplinary action is being contemplated against them, they should contact our team of advisers on 0870 60 60 828 immediately. Doctors should not respond to any disciplinary allegation until they have had the opportunity to seek advice and representation.

Complaints procedure

On 1 April 1996 a system was implemented to deal with complaints by patients against doctors. The procedure places emphasis on solving complaints at an early stage locally. All Trusts must establish their own complaints procedure which complies with national guidelines and make this available to staff. More detail is available in the BMA's Consultant handbook, available from our team of advisers on 0870 60 60 828.

In Scotland, a new complaints procedure was introduced in 2005 under HDL (2005) 15 which involves local NHS board procedures with a possible review by the Scottish Public Services Ombudsman.
Contracts of employment

Model contracts of employment

There is one model contract that applies to all junior doctors in the training grades. The model contract is reproduced at Appendix I of this handbook (for the Scotland model contract, see circular PCS (DD) 2007/7). A separate model contract exists for specialist registrars pursuing post-CCT sub-specialty training; such post-CCT training should be extremely rare and the model has not therefore been reproduced. Further details about such contracts are available from our team of advisers on 0870 60 60 828.

The JDC recommends that doctors in the Foundation Programme are employed by one Trust acting as a ‘host Trust’ during the two-year programme. The host Trust would usually be the Trust where trainees are based for the majority of their programme. The host Trust would then second the foundation trainees to any other Trusts that form part of the programme. Even where this arrangement does not exist, foundation trainees will need to be seconded from their last Trust to a GP practice when undertaking a GP placement. Further information on this issue can be found on the BMA website, or from our team of advisers on 0870 60 60 828.

The model contract covers the specific terms of each individual’s employment contract and is subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff (TCS) and the General Whitley Council (GWC) conditions of service.

A contract of employment is an important legal document. The model contract has been agreed at national level between the JDC, NHS Employers in England and the health departments in the devolved administrations. Once signed, the contents are binding and it may be impossible to make changes. Contracts should follow the national models, but some hospitals are including unacceptable clauses which differ from those national agreements. Even seemingly advantageous clauses are unlikely to be without problems. The BMA offers its members a contract checking service, and the JDC advises that junior doctors who are BMA members should seek this professional advice from our team of advisers on 0870 60 60 828 before signing a contract.
If a contract does not conform to the national model, juniors should give written notice that they do not accept a non-standard contract and should not sign it without first seeking advice by calling 0870 60 60 828: there is too much to lose.

**Job descriptions**

A job description should accompany the contract, and indeed forms part of the contractual relationship between the junior doctor and the Trust. Ideally, the doctor should be given a copy of the job description on application for the post. In any case, it is a legal requirement that the doctor be given a job description within two months after the beginning of the employment. The job description should provide an accurate picture of the post and define the hours (including details of the rota) and duties of the job. The JDC recommends that the rota, in particular, is provided by the Trust six weeks before the doctor is due to begin a placement. Alterations to the job description should be by mutual agreement.

**Notice periods**

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

<table>
<thead>
<tr>
<th>Position</th>
<th>Notice Period</th>
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<tbody>
<tr>
<td>House officer</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Foundation house officer 1</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Foundation house officer 2</td>
<td>1 month</td>
</tr>
<tr>
<td>Senior house officer</td>
<td>1 month</td>
</tr>
<tr>
<td>Specialty registrar (fixed term)</td>
<td>1 month</td>
</tr>
<tr>
<td>Specialist/specialty registrar</td>
<td>3 months</td>
</tr>
</tbody>
</table>

Additionally, Section 86 of the Employment Rights Act 1996 (Employment Rights (NI) Order 1996 in Northern Ireland) provides entitlement to minimum periods of notice, dependent upon an employee’s length of continuous employment. For hospital medical and dental staff these are as follows:
Employment documentation

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

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

A model letter of acceptance, including the bandings for each part, is attached at Appendix 1.

Junior doctors’ employers

Since April 1996 almost all junior doctors’ contracts have been held at Trust level. The exceptions to this are the contracts of trainees in public health medicine and GP specialty trainees in their vocational year. The JDC objected strongly to the movement of contracts to Trust level as it feared that it would jeopardise training rotations and threaten nationally agreed contracts and terms of service for junior doctors.

As a result of these objections, the NHS Executive built in a number of safeguards to the new arrangements (see below). Postgraduate deans have a key role in monitoring the quality of training and may withdraw funding if training is found to be inadequate. Despite this, it is worth being aware that each Trust in a rotation may issue a different contract
and members should seek advice from our team of advisers on 0870 60 60 828 before signing if in any doubt.

It is open to Trusts to join together to agree an arrangement whereby one Trust administers contracts on behalf of a group of Trusts. In such cases the ‘lead’ Trust may hold all contracts and second junior doctors from that Trust to others. Such arrangements should assist in better planning and organisation of training rotations, and the JDC strongly approves of them. Members offered contracts in which they will be seconded from one Trust to another should seek advice from our team of advisers on 0870 60 60 828 before signing the contract.

In Scotland, junior doctors’ contract are held by health boards and there are currently no lead employer arrangements in place.

**Variations to national agreements on contracts and terms of service**

Although Trusts are required to employ junior doctors on national terms and conditions of service, they have some flexibility to introduce variations to the national model contracts for specialist and specialty registrars, registrars and senior registrars. However, this flexibility should be only at the margins of terms and conditions of service, and should usually involve additions or modifications to enhance rather than reduce existing rights. It is thus intended that juniors should hold a uniform contract throughout a rotational training programme, with only the employer’s identity changing as they move between posts in the rotation.

Any local variations to national agreements on contracts and terms of service must meet the following important conditions:

- they have been negotiated with local junior doctors’ representatives, for example, the LNC (see page 6); and
- the postgraduate dean is satisfied that they will not adversely affect quality of training; and
- they are agreed by all the Trusts in the rotational training programme.
It is essential that junior doctors’ representatives are involved at all stages in any negotiations aimed at seeking variations to national agreements and that the above safeguards are met. Generally, discussions will be held at deanery level and proposals will need to be endorsed by each Trust and its LNC. It is therefore crucial that the LNC should have a junior doctor representative who is able to attend meetings. Regional JDCs (see page 5) may have appointed negotiators who are taking the lead in any discussions at deanery level. Junior doctors should seek advice from our team of advisers on 0870 60 60 828 if they are aware that changes are being considered without any junior doctor input.

In Scotland, health boards must employ junior doctors on national pay and conditions and can only introduce any flexibility if they apply for and receive a variation order from the Scottish Government Health Directorates.

**Vacant posts**

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

**Training agreements**

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

All training posts must have educational and dean’s approval and this should be clearly stated in advertisements. Junior doctors should be extremely wary about applying for non-approved or non-standard posts that could be seriously disadvantageous to future career prospects and are unlikely to be recognised by medical royal colleges. Junior doctors who have any concerns about a post should seek advice from their postgraduate dean. All specialty training and fixed term training appointments must adhere to national person specifications – www.mmc.nhs.uk

NHS training posts must be of an acceptable standard and accord with NHS workforce agreements. The following key features must apply to all training posts:

- A post or programme must have educational approval and approval by the postgraduate dean or it cannot be designated a training post or programme.
- A post not in a recognised NHS training grade (e.g., ST level Trust post) cannot be regarded as a recognised training placement or programme. Experience in such non-training posts cannot be assumed to count towards the completion of specialist or general practice training.
- Placements or programmes in NHS training grades for doctors and dentists can only be advertised if they have the valid educational and dean’s approval. All advertisements should contain the following statement from the postgraduate dean: ‘The postgraduate dean confirms that this placement and/or programme has the required educational and dean’s approval’.
- All recruitment procedures should comply with equal opportunities policies.

Trusts must seek permission from the postgraduate dean whenever it is proposed to advertise a training placement or programme. Before the advertisement can appear, the postgraduate dean must confirm that:

- There is valid educational approval.
- There is current postgraduate dean’s approval.
The following two elements must be met for a post to obtain postgraduate dean’s approval:

• posts must meet agreed standards on training, supervision, contractual terms, compliance with the New Deal, accommodation and catering and local human resources strategy
• where there is a national or specialty-specific target for the number of doctors or dentists to be trained, dean’s approval must not be granted to placements which may cause these targets to be breached.

**PMETB approval of experience**

If a doctor has been in an educationally approved post in the UK (eg SHO or FTSTA) they can enter specialist training at an appropriate point above ST1 and proceed to a Certificate of Completion of Training (CCT). If their posts have offered experience but have not been educationally approved, they can still enter beyond ST1, but will need to join the Specialist Register by the Article 14 (Certificate of Eligibility for Specialist Registration (CESR)) route.

**Prospective approval of posts**

As of 1 January 2007, PMETB no longer retrospectively approves non training posts for doctors hoping to gain a CCT. As stated above, posts that have offered experience but have not been educationally approved can be used to further training, but will require the doctor to join the Specialist Register by the Article 14 (CESR) route. However, doctors may gain prospective approval of research or overseas posts which will then count towards a CCT.

**This approval must be agreed by PMETB and the Dean in advance**

www.pmetb.org.uk/fileadmin/user/Policy/Policy_Statements/Prospective_approval_of_overseas_posts_-_Guidance_2_Oct_06.pdf

Educational and training approval from PMETB 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.
Overseas doctors
On 7 March 2006 the Home Office announced that it would be making changes to the UK’s immigration rules to introduce a points-based system of managed migration. Implementation of the new regulations would be staged, but those affecting postgraduate doctors would come into effect from 3 April 2006. To find out more about the changes to the Highly Skilled Migrant Programme and Work Permit applications, please visit www.bia.homeoffice.gov.uk/workingintheuk

In addition, on 6 February 2008, the Home Office announced temporary measures to be introduced from 29 February 2008. This will prohibit the following people from accessing post-graduate medical training posts:

From 29 February:
• migrants from overseas who are applying to the Highly Skilled Migrant Programme (HSMP)
• migrants already in the UK who are applying to switch to Tier 1 (General).

The following people will be exempt from the regulations:
• those granted leave to remain in the UK as a Highly Skilled Migrant prior to 29 February 2008
• postgraduate doctors or dentists who had sought leave to remain as a Tier 1 (General) Migrant prior to 29 February 2008.

Honorary appointments
Trusts offering honorary NHS appointments to doctors wishing to pursue clinical specialist training must obtain the dean’s approval before the placement is advertised or the appointment confirmed.

Locum appointments for service (LASs)
Locum doctors and dentists should not be appointed to training grades where there is no substantive placement to be covered. Locum appointments (apart from LATs at ST3 level and above) 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 Postgraduate Medical Education and Training Board and the postgraduate dean.

Trust grade titles
Trusts have been told by the BMA that non-standard titles can also be misleading and that they should not use them.

Responsibility for educational approval
Foundation House Officer 1 grade
The learning objectives for this year are set by the General Medical Council (GMC). In order to attain full registration with the GMC, doctors must achieve specific competences by the end of this year. In practice, the postgraduate dean normally undertakes this function.

Specialty training grades and fixed term specialty training appointments
The PMETB is required to recognise and approve placements and programmes for all specialist training leading to the award of a CCT (ie from F2 onwards). PMETB will take advice from the relevant medical royal college or faculty, which approves placements on its behalf. However, not all placements/programmes confirmed by the Dean as having educational and postgraduate dean’s approval automatically lead to the award of a CCT, eg Locum Appointments for Training. For detailed information on specialty training please read A guide to postgraduate training in the UK, also known as The gold guide – www.mmc.nhs.uk

SpR grade
Even though this grade is closed to new entrants, many trainees continue on SpR contracts. These are educationally approved in the same way as the specialty training grades. For detailed information on SpR training please read A guide to specialist registrar training; NHS Executive 1998, also known as The orange guide – www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006614
Revalidation

A white paper ‘Trust, Assurance and Safety – the regulation of health professionals in the 21st Century’ was published on 21 February 2007 which reaffirmed the Governments commitment to the introduction of a system of revalidation. The white paper set out new proposals to ensure that all the statutorily regulated health professions have in place arrangements for the revalidation of their professional registration through which they can periodically demonstrate their continued fitness to practise. The Government has announced its intention to change the way doctors are regulated in the UK in the Health and Social Care Bill which entered Parliament in November 2007. Part 2 of the Bill includes provision to amend the legislation governing doctors.

All doctors wishing to practise in the UK will require a licence to practise. As a first stage the GMC will issue these licences to practise as soon as it is practicable to do so. Doctors will need to participate in revalidation in order to retain this licence. The purpose of revalidation is to ensure that patients can have confidence that their doctors are up to date and fit to practise. This process should encourage doctors to reflect meaningfully on their work, using evidence gathered through various methods such as audit. The licence to practise will have to be renewed every five years through an appraisal process that will include both formative and summative elements, which will confirm that the doctor has objectively met the standards expected.

At the time of writing the precise processes and requirements regarding revalidation had not been finalised. Within the white paper it is recognised that it will take time to develop standards, identify the assessment methodology and complete the pilot studies necessary for the widespread introduction of revalidation. Until the proposals for revalidation are established, junior doctors are advised to continue to collect evidence for the professional development folders based on the principles of competence, care and conduct set out in Good medical practice. Further information is available on the GMC website.

References
GMC. Good medical practice. May 2001
**BMA’s position on the Government’s proposals**

Some improvements to the regulation of the medical profession are needed, but any reform must be workable in practice and maintain a system in which both the public and doctors can have confidence that fairness and justice will be delivered. The greatest protection for the public is to have a system where doctors feel able to admit to faults or failings in themselves and colleagues, confident in the knowledge that these will be dealt with in a fair, sensitive and supportive manner.

The BMA is concerned that some of the Government’s proposals are not only unfair to doctors but will compromise their clinical independence with consequent risks to patient care. There is a strong sense among doctors that many of the proposals, when taken together, will amount to the loss of professionally-led regulation.

The BMA strongly opposes Clause 104 which imposes a requirement for all the health professional regulatory bodies and the new Office of the Health Professions Adjudicator to use the civil standard of proof (the balance of probabilities) in fitness to practise cases. The GMC currently uses the criminal standard (beyond reasonable doubt). It would be an injustice to remove a doctor’s livelihood based on a lower standard of proof than is used currently.

The BMA also has concerns about the removal of the adjudication function from the GMC and therefore the creation of a separate body, the Office of the Health Professions Adjudicator. We are also very worried about the role of the proposed ‘responsible officers’ because we see them as having a conflict of interest between their various roles.

The loss of professionally-led medical regulation has the potential to compromise doctors in their role of speaking out for their patients with consequent risks to patient care. With a state-owned NHS which is virtually a monopoly employer, doctors could be compromised in their ability to use their clinical independence to get the best treatment for their individual patients, diminishing their professionalism and with consequent risks to patient care. This could also lead to the practise of
defensive medicine which is not in the best interests of either patients or the NHS budget.

**GMC fitness to practise procedures**
On the 20 August 2007 the GMC launched a consultation on implementing the civil standard of proof in fitness to practise hearings.

**Sources of information**
- BMA webpages on professional regulation
- DH webpage on the Professional Regulation and Patient Safety Programme
Hours of work, the European Working Time Directive (EWTD) and the New Deal

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

European Working Time Directive (EWTD)

The EWTD, which came into force on 1 October 1998 for consultants and other career grade hospital doctors, originally excluded junior doctors. Agreement was reached in May 2000 between the European Parliament and the Council of Ministers on the arrangements and a timetable for doctors in training to be included within the Directive, and it has been applicable to juniors since August 2004. The EWTD is designed to protect the health and safety of workers by restricting the number of hours an individual can work and imposing minimum rest requirements for all workers.

Unlike the New Deal, the EWTD is enshrined in UK and European law and is therefore not optional. An individual junior doctor can voluntarily sign a waiver and ‘opt out’ of the limit on working hours, but contractually (under the New Deal) can do no more than an average of 56 hours of actual work a week. Junior doctors are not able to ‘opt out’ of the rest requirements of the EWTD. The JDC would urge caution where anyone is considering opting-out of the hourly limit, especially as this could impact upon colleagues.

<table>
<thead>
<tr>
<th>Timetable for EWTD implementation</th>
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<tbody>
<tr>
<td>August 2000</td>
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<tr>
<td>August 2004</td>
</tr>
<tr>
<td>August 2007</td>
</tr>
<tr>
<td>August 2009</td>
</tr>
</tbody>
</table>
The rest requirements which came into effect in August 2004 are as follows (derogations apply – see below):

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

* Night workers are defined as someone who works at least three hours of their daily working time during night time. Junior doctors are unlikely to be classified as night workers; however, this can not be assumed and should be looked at on an individual basis.

The SiMAP and Jaeger cases

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

The ruling declared that all time spent resident on call would count as working time. While the ruling applied to a specific case, the assumption is that if British doctors work under similar arrangements, then a similar interpretation of ‘working time’ applies. The ECJ judgement on 9 September 2003 in the ‘Jaeger case’ involving secondary care doctors confirmed the SiMAP judgement.

The SiMAP ruling has effectively meant that resident on-call rotas are no longer workable and new ways of working need to be developed.
Countdown to 2009

In the run up to the implementation of the 48-hour week in August 2009, employers will be aiming to bring Band 2 rotas down into Band 1, which will require significant changes to working patterns and the formal rebanding process to be followed. In all cases it is essential that employers do not implement new, EWTD compliant rotas that are detrimental to training and clinical tutors should make sure that junior doctors’ education and training does not suffer in the drive to reduce hours. For more information on the banding system and the rebanding process see page 34. Guidance on designing rotas and further information on the EWTD is available on the BMA website.

Derogations – compensatory rest

The UK Government decided to derogate from the EWTD rest requirements noted above, as allowed in the Directive (Section 21). This means that while employers do not have to apply these rest limits as prescribed, they must provide equivalent compensatory rest instead for every occasion that the employee does not achieve the rest. The exact method to provide compensation for periods of rest not achieved by the employee is still unclear, but the BMA continues to lobby at EU and UK level for improved guidance in this area. The BMA strives to seek a solution that protects safety at work while protecting opportunities for training. If a junior doctor believes EWTD limits are being breached in their job, they should contact our team of advisers on 0870 60 60 828 in the first instance. There is a right to complain to HSE for all workers, who can issue enforcement notices and may fine and prosecute employers who do not comply.

The New Deal

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

Regional improving junior doctors’ working lives action teams or regional action teams (RATs) (who used to be responsible for overseeing and monitoring the implementation of the New Deal at a local level and the allocation of posts into pay bands in accordance with the pay banding system) have now been brought under the jurisdiction of the local strategic health authorities (SHAs) and many regions now lack suitable equivalent structures to enable the juniors’ contract to be implemented as intended. The role, nevertheless, has remained. The JDC continues discussions with NHS Employers about how this issue can be resolved.

In Scotland the New Deal Review Board, which includes representation from the Scottish JDC as well as the Scottish Government and NHSScotland employers, monitors the New Deal with the assistance of regional New Deal support officers (see their website at www.newdealsupport.scot.nhs.uk). In Northern Ireland the New Deal and EWTD is monitored by the NI Implementation Support Group (NI ISG). This Group was set up by the Department of Health Social Services & Public Safety (DHSSPS) in August 2001 to facilitate the implementation of the New Deal and the EWTD. NIJDC have been and continue to be actively involved in the work of the group and its subcommittees, two members of NIJDC meet every two months with the Medical Project Officer to scrutinise monitoring data and rotas to approve rebandings – no posts are rebanded without liaison with the NIJDC reps. In Wales, the New Deal was relaunched in spring 2001 under the SAFER initiative, which stands for safety-accommodation-facilities-education-rest.

Trusts have a contractual responsibility to monitor the hours of work of junior doctors. Junior doctors are also contractually obliged to take part in monitoring as designated by their Trust.
No doctor should be pressurised into changing monitoring data to ensure compliance or to reduce the rota’s proper banding. Monitoring forms should be completed accurately to reflect the hours worked and rest achieved. If you feel you are being pressurised or if you do not think that your employer is monitoring appropriately, talk to your BMA representative or call our team of advisers on 0870 60 60 828.

**Limits on contracted hours, hours worked and duty periods**
Both the New Deal and the EWTD apply simultaneously, and this can sometimes cause confusion. Compliance with both regulations can be achieved by following the least number of working hours and the most rest required (see below for further information).

**Hours of duty and hours of actual work**
As explained in the previous section, the EWTD has applied to doctors in training since 1 August 2004. The number of hours juniors can work in a week and the rest breaks that are needed are therefore prescribed by the regulations, and the EWTD definition of work is as laid down in the SiMAP and Jaeger rulings.

However, confusion creeps in where the EWTD and New Deal definitions differ. Under the New Deal:
- ‘duty’ is counted as all time working or on call, including rest while available
- hours of actual work are defined as all time spent on duty carrying out tasks for the employer, including any periods of formal study leave/teaching.

The confusion can be cleared up by remembering that for matters of pay and banding the New Deal definitions apply. For compliance with the EWTD, the SiMAP definition applies. The SiMAP ruling on the EWTD has meant that hours of duty and hours of actual work are treated the same, with all hours spent ‘at the disposal of the employer’ whether working or resting counting as working time for the purpose of the working hours restrictions.
**Contracted hours**

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

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

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

However, the EWTD and SiMAP rulings have meant that, in effect, doctors can work no more than 56 hours on average (since August 2007) at the hospital per week.

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

**New Deal controls on duty periods and rest requirements**

Since 1 August 2001 for pre-registration grades and since 1 August 2003 for all other training grades, all New Deal hours limits and rest requirements (see below) have been a contractual requirement.

In addition to the limits on contracted hours and hours worked, the New Deal lays down maximum periods of continuous duty, minimum periods of off duty between duty periods and minimum periods of continuous off duty for each type of working arrangement. These are as follows:
There is a limit on the maximum continuous duty days for all working arrangements: 13 days.

Where the maximum periods of continuous duty, minimum periods of off duty between duty periods and minimum periods of continuous off duty differ to those set out in the EWTD the shorter of the duty hours and the longer of the periods between duty periods will prevail.

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

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

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

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

Below is a table setting out the rest requirements for each working pattern as laid down in HSC 1998/240. The rest requirements apply equally to flexible trainees as to full-time juniors; the hours’ limits should be adjusted pro rata. Flexible trainees (and any other less than full-time juniors) should not be disadvantaged in terms of rest periods or work intensity.
The following factors should also be taken into account when assessing whether a working pattern fulfils the rest requirements:

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

**Summary**

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

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

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

In on-call rotas, if juniors get the same rest as is required for weekday on-call, plus compensatory rest to reach required amount of rest, this will comply with the New Deal rest requirements.
Impact of EWTD on periods of duty and rest

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

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

Posts which breach New Deal and/or EWTD limits

Contracted duty hours and frequency of out-of-hours work

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

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

Junior doctors should seek advice from our team of advisers on 0870 60 60 828, their regional action team or equivalent and, possibly, their consultant in order to try to resolve problems with hours and/or rest. The following should be considered in any effort to resolve New Deal/EWTD problems:

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

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 juniors on full shift; no juniors to be bleeped during organised training session.

Organisational changes
- Bringing more work back into daylight hours, eg emergency theatre lists, emergency admissions unit.
- Introduction of hospital at night arrangements.
- Encouraging moves towards a consultant-delivered service.

For example, evening ward rounds by consultants on-call can resolve many acute problems which might otherwise disturb juniors at night. Consultants working in an identified admissions unit can provide an instant focus for clinical input.
- Avoiding duplication of tasks, eg multiple clerking of patients by different grades.
- Use of bed bureaux to locate beds.
Skill mix initiatives
- Ensuring adequate staffing levels in support services, both daytime and out-of-hours.
- Sharing of tasks with other suitably trained staff, eg nurse practitioners.
- Working to identify which tasks can be appropriately delivered by other staff. Possible examples include administration of IV drugs, carrying out requested investigations (bloods, ECGs, arranging X-rays etc), and catheterisation. There must also be mechanisms in place to ensure that, in the event of staffing pressures, these jobs do not default back to juniors.

Reorganisation
- Increasing cross-cover of working patterns where appropriate so that, for example, doctors on a night shift may be able to relieve on-call doctors’ workload.
- More team working.
- Possible merging of services between smaller units.
- Introduction of the ‘Hospital at Night’ model.

New working patterns
- When all the above have been implemented, and as long as there is an appropriate number of doctors on the rota to facilitate a working pattern change, some alternative form of working pattern may be investigated.

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

The New Deal became a contractual obligation for all junior doctors from August 2003 and the EWTD took effect from August 2004. Many Trusts have needed to change working patterns for junior doctors in order to comply and this will continue to happen in the run-up to August 2009. Moves toward achieving compliance with the 48-hour week must not result in juniors being told, with little or no notice that their rotas will change and that they will be paid less as a result. This lack of notice is not allowed under the terms and conditions of service.

There are very specific rules about how a post can be rebanded. These are contained in the ‘Rebanding Protocol’ available from the DH website www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingpay/Juniordoctorcontracts/DH_4053873 A summary, taken directly from the pro forma is listed in the table below. The full pro forma must be signed off by all parties to indicate all steps have been followed. If not, then the post has not been rebanded properly and the salary should remain at the previous level.

If members have any concerns about proposed changes or pressure to agree to them, they should be raised with our team of advisers on 0870 60 60 828.

The stages necessary to reband a training post

<table>
<thead>
<tr>
<th>Stage</th>
<th>Evidence Required</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Consult post-holders on proposed changes and obtain agreement of the majority participating in the working arrangements*</td>
<td>Approval of majority of current/incoming post-holders**</td>
</tr>
<tr>
<td>1b</td>
<td>Submit details of the new working arrangements to the action team for information and invited comment</td>
<td>Full details of proposed working arrangements and/or rota summary</td>
</tr>
</tbody>
</table>
The requirement for the junior doctors’ approval of changes does not permit demands to remain in Band 3 but does allow junior doctors to ensure the rota is workable and agreed by those concerned.

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

If changes are to be introduced at the change of postholder, agreement should be obtained from both outgoing and incoming doctors. A clear indication of the proposed change should be detailed in the job advertisement and job description. Before starting a new post, juniors...
are advised to contact the previous postholder to clarify their current working arrangements, and then to check if they are being offered something different.

It should not be a condition of appointment that a prospective postholder agrees to a change resulting in him/her working longer hours than the present incumbent. If members have any concerns, they should seek advice from our team of advisers on 0870 60 60 828 before signing their contract.

**Monitoring of work and rest**

Employers are contractually obliged to monitor junior doctors’ New Deal compliance and the application of the pay banding system. It should also be stated in the individual doctor’s contract that they have an obligation to cooperate with those monitoring arrangements.

Monitoring will require the collection of a variety of different data, including contracted hours, hours of duty and when those hours occur, hours of actual work and when those hours occur, and total and continuous rest periods. Monitoring should occur under representative conditions of work intensity (ie not at exceptionally quiet or busy periods, not when many or no doctors are away on leave) and should usually occur once during every six-month post. Where juniors believe monitoring has taken place during an abnormal and unrepresentative period, they should request that their employers carry out a further round of monitoring.

The one exercise should cover both purposes, ie banding allocation of posts and New Deal compliance. A monitoring period of two weeks is usually sufficient but, if more representative, it should be carried out over a cycle of the rota pattern. Hours information must use the agreed local recording methods (eg diary cards, barcode readers). Hours should be recorded during the agreed monitoring period, preferably during or at the end of each duty period, rather than by less reliable methods. Junior doctors must be notified adequately in advance of the monitoring period. They should be informed where to send the information recorded and how to get feedback on the outcome of their
participation. Employers are obliged to publish the results of monitoring within 15 working days of the last day of the monitoring period.

**When monitoring does not occur**

If monitoring does not occur, or is felt to be unrepresentative, this should be brought to the attention of the Trust human resources department, our team of advisers on 0870 60 60 828 and the regional action team or equivalent. A Trust failing to meet its contractual requirement to monitor will be served with an improvement notice by the SHA. If it fails to implement an appropriate monitoring system within six months, it will be required to pay the junior doctors concerned at Band 3 rates until the SHA confirms that the Trust now meets its contractual requirement to monitor.

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

**Different working arrangements**

The pattern of work, the length of duty period and the frequency of out-of-hours work undertaken by a junior doctor are the key features in deciding whether the working arrangement should be a full shift, a partial shift, a 24-hour partial shift, an on-call rota, or a hybrid of the above. It is important to ensure that the correct working arrangement is adopted for the actual work involved and the amount of rest which can be taken during duty periods. When drawing up shift or rota arrangements, junior doctors should remember that colleagues will be taking annual and study leave. This must be taken into account particularly if prospective cover applies. See the JDC’s guidance on rota design for further information on the BMA website.
Full shifts
Full shifts are based on those used in other services and industry and other health professions, e.g. nursing. Shifts are usually of eight to 12 hours’ duration, but under the New Deal may be up to 14 hours (although the EWTD rest requirements mean that unless compensatory rest is given shift lengths must be a maximum of 13 hours). This means that there will be two or three shifts to cover 24 hours although there can, of course, be more than one doctor on duty at a time. The principles for planning full shifts are the same as those outlined above for partial shifts.

This type of shift pattern is appropriate for providing medical cover where the work is intensive and potentially continuous throughout the 24-hour period. In such situations the doctors on duty can be expected to spend virtually all of the duty period, except for natural breaks, working or being immediately available for work in the unit. Any shift system which does not achieve four hours’ rest overnight is of full shift intensity. All hours of the shift are counted as actual work for the purposes of banding.

As a result of the SiMAP/Jaeger rulings regarding time spent at the workplace, many resident on-call working patterns have been replaced by full-shift systems. This is not always appropriate and may lead to periods of inactive time, especially in the out-of-hours period, which will impact upon an individual’s overall training time. If junior doctors do not feel the rota is planned well, they should notify their medical staffing department and their education supervisor.

On-call rotas
The following guidance sets out the position for on-call arrangements under the New Deal. However, it is important to remember that the EWTD and, more importantly, the SiMAP and Jaeger rulings also impose limits on working hours and requirements for rest breaks (or compensatory rest in lieu of rest breaks). Resident on-call rotas are therefore unlikely to comply with the EWTD because all time spent resident counts towards the average weekly working hours limit of 56 hours (reducing to 48 hours in 2009).
On-call rotas are a suitable working arrangement where junior doctors work a normal day, Monday to Friday, and are ‘on call’ in rotation for the remainder of the 24-hour period and for weekends. Duty periods will be more than 24 hours in length. An arrangement where a junior doctor is on call for only part of the day, for example until midnight or 9am to 5pm at a weekend is not an on-call rota. It is a shift system, regardless of work intensity.

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

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

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

**Partial shifts**

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

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

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

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

**How to plan a partial shift**

- A workload study should be undertaken; this will also provide useful documentary evidence to justify a change in working practices.
- Other methods should be used first to reduce hours or intensity.
- Junior doctors should be involved in designing the shift. The regional action team (or equivalent) may be able to provide advice and examples of other partial shifts already operating.
- Consultants should be involved and their support is crucial.

A partial shift sometimes involves changing from a firm to a team approach. Other affected staff groups should be involved (eg nurses, managers).
• It is essential to build in teaching sessions and handover time.
• Any partial shift should comply with the rest periods outlined above.
• The planned shift should be piloted and then evaluated; often the final shift has to be redesigned several times.

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

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

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

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

As with all working patterns, care must be taken to ensure the requirements of the EWTD are met, and partial shifts must take into account the need for all shifts to be 13 hours or less, or for adequate compensatory rest to be built into the rota.

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

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

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

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

**Pay banding system**

The juniors pay banding system has been in place since December 2000, and aims to remunerate junior doctors fairly, according to the actual hours worked and the frequency of their out-of-hours work.

A full-time contract consists of 40 hours, plus such further contracted hours as are agreed with the employing authority (subject to the New Deal and EWTD controls) including:

- all out-of-hours work
- agreed prospective cover for annual/study leave of colleagues
- any other regular commitments, eg early starts and late finishes
- any duty hours necessary for continuity of patient care.
The pay bands reflect whether the post is compliant with the New Deal hours controls and rest periods, and also whether the doctor works up to 40, 48 or 56 hours a week, the type of working pattern, the frequency of extra duty and the unsocial nature of the working arrangements.

The new pay banding system covers both full-time and part-time doctors and dentists in training, in posts and placements in the Hospital and Community Health Service (HCHS), including public health medicine trainees. These posts or placements are in the training grades of F1 & F2, SHO, SpR, StR and StR(FT).

**How the system works**

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

There are four bands in the new system.

- Band 3 includes all juniors whose posts are non-compliant with the hours’ limits or the rest requirements of the New Deal, as stipulated in HSC 1998/240, modified by agreement on weekend rest periods for on-call rotas as detailed in HSC 2000/031
- Band 2 includes all juniors whose posts are compliant with the New Deal and who work over 48 hours and up to and including 56 hours of actual work per week
- Band 1 includes all juniors whose posts are compliant with the New Deal and who work up to and including 48 hours of actual work per week
- F bands includes all juniors who work less than 40 hours of actual work per week
- Band 2 is split into Bands 2A and 2B, Band 1 is split into Bands 1A, 1B and 1C, and Band F is split into Bands FA, FB and FC:
- Bands 2A, 1A include all juniors who, within their respective hours’ limits, work the most frequently and at the most unsocial times, as defined by the banding criteria
• Bands 2B, 1B include all juniors who, within their respective hours’ limit, work less frequently and at less unsocial times
• Band 1C includes all juniors who, within the 48-hour limit, work on a low frequency on-call rota from home.

The pay banding criteria flow chart can be found at Appendix 5.

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

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

**Flexible trainees**
Since 1 June 2005, new banding arrangements have applied to doctors in training who work less than 40 hours of actual work per week (flexible trainees). The new system was agreed between the JDC, NHS Employers, COPMeD and the Departments of Health in March 2005 with the aim of widening access to flexible training. The previous banding arrangements had been perceived by many employers as making flexible trainees too expensive to employ and, effectively, this had limited the number of flexible training placements available. Basic salary under the new system is determined by the trainee’s actual hours of work, and there is an additional banding supplement paid as a proportion of basic salary according to the frequency and anti-social nature of the trainee’s out-of-hours work.
Flexible trainees’ hours of actual work are divided into five discrete time categories and labelled F5-F9. Each category attracts a proportion of the full-time basic salary, as below:

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

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

<table>
<thead>
<tr>
<th>Band</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA</td>
<td>50%</td>
</tr>
<tr>
<td>FB</td>
<td>40%</td>
</tr>
<tr>
<td>FC</td>
<td>20%</td>
</tr>
</tbody>
</table>

Total salary therefore is calculated as follows:

\[
\text{Total salary} = \text{salary}^* + \text{salary}^* \times 0.4
\]

* salary = F5 to F9 calculated as above.

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

Pay protection applies to those already contracted to train flexibly at 1 June 2005 whose pay under the new system would otherwise be reduced. If flexible trainees believe they have a claim for pay protection...
they should contact our team of advisers on 0870 60 60 828 for further information and advice. Pay banding supplements for GP registrars are set at 65 per cent for those employed before 31 March 2007 and 55 per cent for those employed since then.

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

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

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

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

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

**Definition of out of hours**
Out of hours work is anything outside 7am – 7pm, Monday to Friday.
Definition of working patterns

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

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

*EWTD caveat: resident on-call rota will be unlikely to be EWTD compliant.*

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

*EWTD caveat: periods of duty can only be resident provided shifts are 13 hours or shorter (unless compensatory rest is given).*

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

*EWTD caveat: periods of duty can only be resident provided shifts are 13 hours or shorter (unless compensatory rest is given).*

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

*EWTD caveat: shifts must be no longer than 13 hours unless compensatory rest is given.*

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

**Definition of prospective cover**

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

**Allocating banding and the appeals process**

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

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

If either party does not accept the regional action team’s (or equivalent) opinion, there will be a right of appeal which will be the responsibility of the employer to operate fairly and transparently. Appeals will be heard by a local Trust committee which should be convened as soon as possible and Trusts are expected to do so while the doctors remain in post. The decision of the committee is final. The effect of the decision will be backdated to the date of the change, or to 1 December 2000, whichever is applicable. It is essential that members who are considering making an appeal contact our team of advisers on 0870 60 60 828 for advice and support. Joint BMA/NHS Employers guidance clarifies the arrangements for banding appeals.

**Pay protection arrangements for compliant posts**

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

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

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

**Pay protection arrangements for non-compliant posts**

All posts which are non-compliant with the New Deal will be paid at the Band 3 rates applicable at the time. Where such non-compliant posts become compliant, postholders will retain the overall salary protected at the Band 2A rate applicable at the time of rebanding for so long as it remains favourable and for the duration of the post/placement.

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

* Salaries will be increased only to take account of increments in the base salary.
Mechanism for reallocating posts to lower pay bands
To re-band a post a protocol, agreed between the Department of Health and the JDC, must be followed. It must be completed by the Trust before a post is formally rebanded.

A specimen of the protocol is attached at Appendix 6. See page 201 for further information.

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

Where routine monitoring shows that a higher banding is appropriate, even though there has been no formal change to the working pattern, pay at the higher band will be backdated to the point three months after the first day of the previous successful monitoring round except:
• where this is the first monitoring round of the post, in which case pay is backdated to the first day in post; or
• where there have been intervening attempts by the Trust to monitor but which have not been successful, in which case pay is backdated to the first day of the monitoring period that first showed a higher band was appropriate; or
• where valid monitoring at the request of the postholders showed a higher band, in which case pay is backdated to the date of the request to monitor if this is less than three months from the first day of the previous successful monitoring round
• where a previously non-compliant rota is shown on valid monitoring to fall into a compliant pay band, the Trust must write to the doctors to inform them of the change, and pay at the protected level of Band 2A must be paid from the first day of the following month.
Clinical academics and other junior doctors who work for more than one employer

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

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

**Prospective cover**

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

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

**When does prospective cover apply?**

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

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

**Fixed annual leave**

If annual leave is fixed, prospective cover applies.
**Introduction of prospective cover**

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

If an employer wishes to introduce prospective cover (or any other change) into the contract of an incoming junior, it must consult with both the incoming and outgoing doctors. Any unilateral change without proper consultation must be resisted and reported to our team of advisers on 0870 60 60 828.

**Principle of the PCA**

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

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

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Hours</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call</td>
<td>Day</td>
<td>Day</td>
<td>Day</td>
<td>On-Call</td>
<td>–</td>
<td>–</td>
<td>72</td>
<td>2</td>
</tr>
<tr>
<td>Day</td>
<td>Day</td>
<td>On-Call</td>
<td>Day</td>
<td>Day</td>
<td>–</td>
<td>–</td>
<td>56</td>
<td>3</td>
</tr>
<tr>
<td>Day</td>
<td>On-Call</td>
<td>Day</td>
<td>Day</td>
<td>Day</td>
<td>On-Call</td>
<td>On-Call</td>
<td>104</td>
<td>4</td>
</tr>
<tr>
<td>Day</td>
<td>Day</td>
<td>Day</td>
<td>On-Call</td>
<td>Day</td>
<td>–</td>
<td>–</td>
<td>56</td>
<td>5</td>
</tr>
<tr>
<td>Day/AL</td>
<td>Day/AL</td>
<td>Day/AL</td>
<td>Day/AL</td>
<td>Day/AL</td>
<td>–</td>
<td>–</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

Day = 9am to 5pm = 8 hours
On-Call = 9am to 9am = 24 hours

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

On average, in the first four weeks, the juniors work:

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

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

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

Each grade has its own pay scale. There are currently:
- three points on the foundation house officer 1 scale
- three points on the foundation house officer 2 scale
- seven on the senior house officer scale
- 10 on the specialist registrar scale
- 10 on the specialty registrar scale; and
- six on the specialty registrar (fixed-term) scale.

The top three points of the SpR scale are in theory ‘discretionary’. In practice the award of the points should be automatic unless, for example, an employer is already taking action in respect of unsatisfactory performance. Advice should be sought from our team of advisers on 0870 60 60 828 if problems occur in this area.

Starting salaries and retention of higher grade salaries

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

With the creation of the StR grade, associated transitional arrangements were developed to ensure that SHOs transferred to the new StR scale fairly. Our team of advisers on 0870 60 60 828 should be contacted, or the relevant pay circular consulted, for further information.
**Incremental dates**

The incremental date will usually be the date of taking up the post in a new grade, although there are some exceptions:

- where previous service is counted, the number of completed months service will determine the incremental date
- where doctors have been paid on one of points 1-5 of the SHO scale for a period of five months or more in their last appointment prior to promotion to specialist registrar; and
- since August 2007, where SHOs transfer to the new StR or StR(FT) scales.

**Counting of previous service**

**Regular appointments**

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

**Locum posts**

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

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

**Counting of service while on annual leave**

Absence on annual leave counts for incremental purposes.

**Counting of service while on maternity leave**

Absence on maternity leave counts for incremental purposes.
Service outside NHS hospitals

Equivalent service or service in a higher grade outside NHS hospitals including overseas service, other than locum service, may be considered for incremental purposes. Details are available to members from our team of advisers on 0870 60 60 828.

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

Practitioners in the training grades who are required as part of their approved training programme to work in non-NHS organisations shall be guaranteed continuity of service for employment purposes.

Promotion increase

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

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

If, prior to taking up a regular appointment as a specialist registrar, a doctor has undertaken a locum appointment in this grade, the incremental date will be brought forward, counting completed service at half rate or in full accordingly.
Increments on first appointment to a grade
Specialist/specialty registrar
On first appointment as a specialist registrar or specialty registrar, one increment and one only should be given for any more than two years’ service spent previously in the SHO grade.

Protection of higher grade salary
Where a practitioner takes an appointment in a lower grade for the purpose of obtaining approved training (which could include training to enable the junior doctor to follow a career in another specialty), the doctor, while in the lower grade, is eligible to receive pay protection provided they have been in the higher grade for 13 months or more. Such a practitioner will receive either their protected salary or the appropriate training grade salary including banding supplement, whichever is more beneficial. Total pay with respect to the protected salary will include payment for additional hours and duties as if those duties had been carried out under the terms of the previous (higher grade) contract.

On re-appointment to the higher grade, the starting salary should be assessed as if the period spent in the approved training grade had been continuous service in the previous higher grade. A junior doctor seeking to retain their higher grade salary should make an application to do so to the new employer prior to taking up the new post.

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

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

There may be occasions where salaries have either been over or under paid. In cases where overpayment has been established it would not be unreasonable to negotiate a repayment schedule rather than repayment in a lump sum to avoid any financial hardship. No monies should be deducted without consent and no interest should be charged on the monies owed. 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 on 0870 60 60 828.

**London weighting**

Junior doctors should be paid London weighting if their hospital is within a specified area. There are two zones – a London zone and a fringe zone – and different rates apply to each. Members may obtain further information or clarification on whether their hospital is within a particular zone by contacting our team of advisers on 0870 60 60 828. A reduced rate of London weighting is payable to resident staff who receive their accommodation free of charge or who are paying lodging charges. However, compulsorily resident doctors occupying free single accommodation who also maintain a separate home within reasonable daily travelling distance of the hospital should receive the full rate of London weighting.

Doctors on rotations moving from posts that do not attract London weighting to posts which do, or from posts attracting the fringe London weighting to posts attracting the inner London weighting, in their second or subsequent placement in a rotation, may exercise the option to receive the appropriate London weighting allowance in place of excess travelling expenses.

**Medical academic staff**

Provided junior doctors have an honorary NHS contract in addition to their university contract, they should be eligible for the above provisions. Those with university contracts only may find their conditions vary according to each university.
Private and category 2 fees for junior doctors

Junior hospital doctors can earn fees for their services to private patients in some circumstances. Where junior doctors attend private patients outside their contracted hours they are entitled to receive payment. In carrying out private work, junior doctors’ total hours of work should not exceed New Deal limits. If the attendance is arranged privately, the fee is negotiated between doctor and patient, although junior doctors should be aware that medical insurers will usually only pay for consultant services and all such income is taxable.

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

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

Advice for applicants – 2008
Applications to specialty training in 2008 will be unlimited. It is important to note that this may have a ‘crowding effect’ on interviews. This means that the small percentage of outstanding candidates may initially take up the majority of interviews. However, when these applicants accept a post this will leave many posts unfilled and therefore those who originally applied for the post may be called to interview.

In addition, with a local recruitment process in England and separate national recruitment processes in Scotland, Wales and NI, there is not a central UK coordination of interviews and so interview clashes are inevitable. The BMA raised this issue at the Programme Board and asked for deaneries to be lenient in this situation.

If applying, please ensure you:
• read the appropriate applicant’s guide thoroughly
• check the appropriate MMC/deanery/health department website regularly
• where possible, sign up via the appropriate MMC website to their email alerts and newsletters from the MMC communications team
• make ‘back up’ applications if you are applying in popular regions and/or specialties
• read and understand all person specifications.

If applying to posts in more than one country/deanery/specialty please ensure you are fully aware of the different application processes and timetables.

England
General information – www.mmc.nhs.uk

Deaneries
North Western – www.nwpgmd.nhs.uk/
London – www.londondeanery.ac.uk/
KSS – register with site, www.kssdeanery.ac.uk/
East Midlands Deanery – www.eastmidlandsdeanery.nhs.uk/
Specialties recruiting across England and Wales in 2008

- Cardiothoracic surgery (ST3 – led by West Midlands)
- Neurosurgery (ST3 – led by South Yorkshire and South Humber Deanery) – www.syshdeanery.com/
- Plastic surgery (ST3 – led by London Deanery) – www.londondeanery.ac.uk/
- Public health (all levels – led by East Midlands Deanery) – www.eastmidlandsdeanery.nhs.uk/
- Histopathology (all levels – led by London Deanery) – www.londondeanery.ac.uk/
- Paediatrics and child health (all levels) – www.rcpch.ac.uk/
- Obstetrics and gynaecology (all levels England and Wales) – www.rcog.org.uk/

Applicant’s guide

www.mmc.nhs.uk/PDF/Applicant%20guide.pdf
(including information regarding the offer process) – www.mmc.scot.nhs.uk/documents/applicants_guide.pdf

Additional information

Posts may also be advertised in BMJ Careers, soon to be a section within the BMJ – www.careers.bmj.com and on NHS jobs – www.jobs.nhs.uk
Northern Ireland
General recruitment information – www.nimdta.gov.uk/

Scotland
General recruitment information – www.mmc.scot.nhs.uk
Applicant’s guide –

Wales
General recruitment information – www.mmcwales.org/

2009 recruitment and beyond
‘Aspiring to Excellence’ – An independent inquiry into Modernising Medical Careers, led by Sir John Tooke
In 2007, Sir John Tooke was tasked with evaluating the merits of Modernising Medical Careers, the reform of the SHO grade that stemmed from Liam Donaldson’s (Chief Medical Officer) ‘Unfinished Business’ consultation.

The BMA submitted evidence to this report and commented on its initial findings –
www.bma.org.uk/ap.nsf/Content/Tookereview
www.bma.org.uk/ap.nsf/Content/Tookeresponse

The final version of the report can be found here –
www.mmcinquiry.org.uk/

MMC Programme Board England
The MMC Programme Board was set up in 2007; the Board was tasked with ensuring that 2008 recruitment would be a smoother process than 2007. There are representatives from all major stakeholders on the Board, including two members of the JDC. It is anticipated that the Board will also be required to advise on recruitment for 2009, due to the short-time constraints. For information on MMC Programme Board meetings please see here – www.bma.org.uk/mmcforum
**MMC Programme Board and Delivery Board Scotland**

In planning for selection and recruitment in 2008 the Scottish Government Health Directorates adjusted the Scottish governance arrangements and set up a new Specialty Training Programme Board and new Selection and Recruitment Delivery Board. The Programme Board determines overall policy and objectives for the selection and recruitment to postgraduate medical Specialty Training in 2008 and beyond, and agrees Scotland’s input to UK governance arrangements and policy development. The Delivery Board reports to the Programme Board and its remit is to produce a project definition, project plan and risk register for specialty training selection and recruitment in 2008 and implement speciality training selection and recruitment in 2008. There are representatives from all major stakeholders on the Boards, including SJDC.

**Future recruitment**

At the time of writing, the Tooke Report had not yet been commented on by the UK Government. Despite many of the recommendations being fully supported by the profession, the Government is not compelled to accept all (or any) of them. The future recruitment, selection and training of doctors in the UK will be dependent on the recommendations that are taken forward. The BMA website will be updated with details as soon as they become available.

Following the publication of the final Tooke report, on 8 January 2008, the Scottish Government published its consultation on the proposed action in Scotland to take forward Professor Sir John Tooke’s recommendations from the independent inquiry – www.scotland.gov.uk/Publications/2008/01/07144119/0.

The Scottish Government is undertaking a fundamental review to define the different roles of the consultant, registered specialist, general practitioner and doctor in training, taking as its starting point patient needs and the role to be played by doctors in meeting those needs.
Flexible training

Flexible (less than full-time) training allows doctors and dentists to work part-time in posts that are fully recognised for training, and have the educational approval of the postgraduate dean and the royal colleges. This does not necessarily mean simply working half the time of a full-time trainee. Rather, flexible trainees are able to train at 60 per cent, 70 per cent or 85 per cent of a full time junior doctor, for example, as appropriate. In some specialties it is possible to work flexibly for the whole of postgraduate training, whereas others require some of this training to be full time.

Junior doctors are able to train on a flexible (less than full-time) basis if they have ‘well-founded individual reasons’ (EC Directive 93/16/EEC) such as domestic commitments, disability or ill health which prevent them from working full time.

However, under the new arrangements for flexible training agreed in 2005, it is possible for junior doctors to seek flexible training for a number of other reasons. These include the undertaking of a particular religious role that requires a certain time commitment, training for a national/international sporting event or the holding of a short-term post with extraordinary responsibility.

Regardless of your reasons for wishing to train flexibly, it is the postgraduate dean, or associate dean with responsibility for flexible training, who confirms that an application by a junior doctor to train flexibly is well founded. If you are interested in training flexibly, you should discuss this first with your deanery.

The majority of flexible trainees are now employed on the flexible training new deal that was negotiated in June 2005. This was agreed by the JDC, NHS Employers, the UK health departments and the Conference of Postgraduate Medical Deans, to improve access to flexible training.
Application process
The application is a five-stage process, and can take up to three months. If you wish to train flexibly in a post, it is recommended that you start this process as soon as possible. Applications will follow this path:
1. Seek advice on eligibility for flexible training from the postgraduate deanery.
2. Unless already in a post where you wish to train flexibly, apply through the ordinary open recruitment procedures for a training appointment.
3. Agreement of training programme with deanery.
4. Approval of training programme by Regional Specialty Education Committee/Programme Director on behalf of postgraduate dean and Royal College.
5. Funding approval by deanery and employing trust.

When applying for a training post, be reassured that it is not part of an appointment committee’s job to consider whether a candidate wishes to train flexibly on taking up a post or in the future and candidates do not need to state in their application that they wish to train flexibly. However, it is suggested that potential applicants discuss with the postgraduate deanery their intention to train flexibly at the earliest opportunity.

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

Slot share
A training placement can be divided between two trainees, so that all duties of the full time post are covered by two trainees. In a slot share two flexible trainees are employed and paid as individuals (often for 60% or more) and work together. The two trainees share an educational post but not a contract and may overlap sessions. This arrangement is not to be confused with a ‘job-share’.
Supernumerary posts
Supernumerary posts can be offered when flexible trainees can not be placed in a slot-share because there is not a suitable partner or where flexible training is needed at short notice. Supernumerary posts are additional to a normal complement of trainees.

Job-shares
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. Job-shares can sometimes be confused with slot shares which are different.

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

Flexible Careers Scheme
The Department of Health launched the ‘Flexible Careers Scheme’ in England in 2002 as part of the Improving Working Lives initiative. The scheme is now administered by the Strategic Health Authorities, and provides doctors with an opportunity to work flexibly within the NHS while being supported in maintaining their careers. However, the posts are currently not recognised for training purposes as trainees are only able to work up to 50 per cent of a full-time commitment. Doctors can work from two to four sessions per week with no on-call or weekend commitments. Junior doctors interested in continuing their NHS employment in this way should contact their employer to find out how the Flexible Careers Scheme operates in their area.

Pensions for flexible trainees
It should be noted that any less than full-time working is scaled down to its whole-time equivalent in calculating the pension payable, although some out-of-hours work may be taken into account.

For instance, if a doctor worked half-time for 40 years, the pension would not be 40/80ths of final salary, but half of 40/80ths. Full details of
how the NHS pension is calculated can be found in the BMA guidance note *Salaried doctors*.

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

**Locum work in the NHS**

Junior doctors employed on a locum basis in the NHS are subject to the terms and conditions of service for hospital medical and dental staff, unless they are employed directly by a locum agency. This section explains the terms and conditions of service for locum doctors employed by the NHS. It is not possible to give advice on the terms which agencies may offer, as these vary between agencies. It should be noted that locum posts do not usually attract recognition for training except in certain circumstances. The situation should be ascertained before accepting a post.

Unless prospective cover arrangements are in place employers are obliged to obtain a locum to cover a junior doctor’s annual and/or study leave. Employers are also obliged to obtain a locum to cover sick leave and maternity leave, which can never be covered prospectively. Trusts should first try to arrange an external locum. Where this is not possible, and junior doctors agree to cover for colleagues as an internal locum, they should be paid according to the locum rates under the pay banding system.

**Responsibility for arranging locum cover**

It is the responsibility of the junior doctor to bring to the attention of the employer the need for locum cover. However, it is the responsibility of the employer to engage the locum.

**Locums and the New Deal**

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

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

**External locums**

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

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

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

**Internal locums**

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

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

Internal locum arrangements, unlike prospective cover arrangements, allow doctors to be paid at the locum rate of the grade of the doctor being covered. The hours can be claimed at the locum rate, or if the doctor wishes, leave may be taken in lieu.
When a junior doctor performs work on a locum basis for their employer, and the agreement of the employer is not secured in advance, the junior should claim payment at locum rates, using the retrospective claim form. Employers should designate a person responsible for authorising retrospective payments and ensure that the doctor is paid as quickly as possible.

**Part-time locums**
A junior doctor engaged as a locum for less than 40 standard hours per week without a regular appointment is paid on the same basis as internal or external locums above.

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

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

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

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

**Band LL**
For locums employed to cover a post for one week or more are paid at the following rate:
- 1.2 x total salary (basic salary + banding supplement) of the post being covered.
For specialty registrars, there are two basic hourly rates that such locums may be paid, the StR lower rate and StR higher rate. The lower rate is payable when the locum is covering a doctor working at levels ST1 or ST2. In all other cases, the higher rate is applicable.

For all other grades, the mid-point of the grade salary scale is the basic hourly rate.

**Locum appointments training (LATs)**

Junior doctors in locum appointments for training (LAT) are excluded from the pay arrangement detailed above. Doctors in LAT posts are paid at the incremental point to which they are entitled because of previous experience, not the mid-point.

**Other terms and conditions of service**

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

**Notice periods**

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

**Annual leave**

Junior doctors acting as locums are entitled to leave at the rate of five or six weeks per 12 months’ continuous locum service, depending on the grade being covered. ‘Continuous locum service’ means service as a locum in the employment of one or more employing trusts uninterrupted by the tenure of a regular appointment or by more than two weeks during which the junior doctor was not employed in the hospital service. Wherever possible, leave should be taken during the occupancy of the post.

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.

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.

The specialist registrar and specialty registrar grades
When vacancies arise in the specialist and specialty registrar grades, two types of appointment can be made:
- a locum appointment covering the service element of the post only (LAS)
- a locum appointment which not only covers the service element but which provides a training opportunity (LAT)

Further details of all of these can be found in the Department of Health publications *A guide to specialist registrar training* for specialist registrars, and *A guide to postgraduate specialty training in the UK* for specialty registrars. Advice is available to members from our team of advisers on 0870 60 60 828.

Medical indemnity
Since 1990 the NHS has had financial responsibility for negligence attributable to medical and dental staff of the hospital and community health services. Although it is not a contractual requirement for NHS employed doctors to hold indemnity insurance, such as that provided by the defence bodies, some work which does not fall strictly within the terms of the doctor’s NHS contract is not covered by the NHS indemnity scheme and there may be occasions where there is a dispute about liability between the doctor and the employer.
The BMA therefore advises all doctors to hold membership of a defence body or provide themselves with other personal indemnity insurance.

**NHS indemnity**

Further details of what is and is not covered by NHS indemnity are given below.

**Work covered**

- work which falls strictly under the doctor’s contract with their employer (this includes where junior doctors work in independent hospitals as part of their NHS training, as a requirement under their NHS contract)
- 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 junior’s contract
- private practice carried out by junior clinical academic staff on the same basis as above
- work in a hospice if the doctor is seconded from a contract with an NHS trust
- work in a prison if part of the doctor’s NHS contract.

**Work not covered**

- category 2 work, for example completing cremation certificates
- defence of medical staff in GMC disciplinary hearings stopping at a roadside accident or other ‘good Samaritan’ acts
- GP locum work
- GP registrars working in general practice
- clinical trials not covered under legislation
- work for other agencies on a contractual basis or work for voluntary or charitable bodies
- work overseas
- work where a crime has been alleged.
Junior hospital doctors need separate cover if they undertake any category 2 work, which includes completing cremation certificates, examinations and/or reports on patients for courts, insurance companies, Department for Work and Pensions etc and making court appearances. As a general rule, category 2 work is that which is not principally to do with the prevention, diagnosis and treatment of illness, and a fee can usually be requested from a body outside the NHS. Private practice or work in independent hospitals which is not covered above also requires separate insurance.

Junior doctors who are required either by their employer or by their consultant to perform work which takes them over the hours limits set down in the New Deal and EWTD, would be covered by NHS indemnity and defence union cover.

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

Junior doctors and data protection
Junior doctors who make personal manual or electronic records of patient data, for example for training logbook purposes, should be aware of the provisions of the Data Protection Act 1998. If patient data are recorded on, for example, personal computers, and that data can identify a patient, then the data must be held subject to the provisions of the Data Protection Act. This would require the doctor to be registered for this purpose. Further information on the Act can be found on the Information Commissioner’s website at www.informationcommissioner.gov.uk

The Information Commissioner enforces and oversees the Data Protection Act 1998, and has a range of duties including the promotion of good information handling and the encouragement of codes of practice for data controllers, that is, anyone who decides how and why personal data (information about identifiable, living individuals) are processed.
The BMA advises junior doctors not to record data that identifies a patient, for example a patient’s name, though data which can be matched to a patient only through use of a hospital record system or separate second data set is lawful on an unregistered computer. For example, a hospital number can only identify a patient if cross-referred with the hospital records system.

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

Making a choice of which career path to pursue requires considerable thought. Personal choice needs to be aligned with aptitude, strengths and interests as well as the extent of competition for, and the availability of opportunities. Personal choice involves a number of factors, for example job satisfaction, desire for direct patient contact, research opportunities, variety, freedom, and so on. Personality plays an important part in the final choice; some graduates may prefer to work in specialties such as pathology or public health medicine rather than the clinical disciplines which involve direct contact with patients.

BMA Careers Services
The BMA is committed to supporting doctors throughout their careers, and has established BMA Careers Services to give a wide range of impartial specialist careers services, offering comprehensive information, skills development, tailored expert guidance and individual career counselling.

The services currently range from free careers information and online guidance available 24/7, through to discounted career development workshops and one-to-one careers coaching.

Members should login to the website to benefit from exclusive access to guidance and workshops. For any further queries please email info.bmacareers@bma.org.uk

If you are not yet a member of the BMA you will be eligible for this and a wide range of other benefits if you join.

Free careers information
Members have free access to a wide range of medical careers information 24/7 from the BMA website including tips for choosing a specialty, guides and handbooks, MMC recruitment timings, a specialty training programme timeline and useful links to other sites.
Free Sci59 psychometric test
Members can benefit from exclusive access to the Sci59 online psychometric test (created by the Open University) for impartial guidance on the most appropriate specialties to match your needs and personality profile.

Career skills development workshops
Interactive workshops are available to ensure you have the skills you need to develop and progress your career. Workshops cover interview preparation, interview technique (through role-playing exercises), and presentation skills.

Careers coaching
Individual career advice is available through a confidential one-to-one coaching programme. Designed to meet your specific needs and provide practical solutions to complex career issues and challenges, our impartial, independent advisers will provide expert, in-depth analysis at significantly discounted rates.

British Medical Journal (BMJ) careers advice zone
The BMJ careers advice zone helps doctors and medical students in their quest for accessible, impartial careers advice. The advice zone can be used to submit a question to a panel of over 200 experienced advisers, search the database of existing questions and advice, and to share careers advice with other users. It can be accessed at www.bmjcareersadvicezone.synergynewmedia.co.uk

Choosing a specialty
The most obvious way of getting to know about a particular specialty is to talk to someone who is already practising in that discipline. Further guidance can be sought from regional postgraduate deans or clinical tutors in Trusts or from regional advisers in general practice. Each medical royal college has regional advisers from whom information is also available. The BMA and other organisations hold careers fairs from time to time to disseminate information on the various specialties and expert advice is available at these fairs. Details can be obtained from our team of advisers on 0870 60 60 828.
Choosing a career – top five tips

- research options carefully and use all sources of career advice available
- speak to a practitioner in the field
- consult postgraduate deaneries for advice
- contact the appropriate medical royal college
- read the BMA’s Board of Medical Education publication Medical specialties: the way forward (available on the BMA website www.bma.org.uk).

Think about options that will suit your personality and skills

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

Think about options that will suit your lifestyle

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

Don’t rush into making a decision

- consider taking flexible training pathways that keep options open.

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

- BMA members can contact our team of advisers on 0870 60 60 828 for employment advice and information.

It should be noted that competition in some specialties is immense. Some thought should be given to staffing numbers: the supply and demand of doctors and the resulting career opportunities. For many years too many doctors have wanted careers in some hospital specialties such as general medicine, general surgery and obstetrics and gynaecology, and fewer in, for example, radiology, geriatrics and psychiatry.
In England, the NHS Improvement Plan in 2004 proposed a move away from the centrally prescribed national targets on the number of doctors needed to support service delivery. Consequently, several new bodies have been established to provide workforce planning advice to make certain that the NHS has sufficient staff to meet patient demand and meet NHS targets. Of these the National Workforce Development Board (NWDB) is responsible for delivering the required numbers of training commissions that underpin the future development of the medical workforce. It is supported by the Workforce Numbers Advisory Board (WoNAB) which continues to oversee workforce planning at a national level. WoNAB brings together experts on workforce planning on a multidisciplinary basis to advise on numbers of future training places that should be made available and works in collaboration with workforce development confederations (WDCs) and care group workforce teams (CGWTs).

In Scotland, the National Workforce Planning Framework for NHSScotland was published in 2005 and set in place a workforce planning cycle to allow workforce projections to be made to deliver objectives for improved patient care that meet service requirements and are underpinned by clear and affordable service and financial plans. Medical specialty training numbers are controlled using a national supply and demand model. The model takes account of various pieces of information including projected demand from NHS Board workforce plans, current staff, the number of leavers, attrition and retirement rates. In addition to the evidence provided by the national model, advice is also sought from the NHS Education for Scotland (NES) Specialty Training Boards and NHSScotland employers to determine final numbers.

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

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

General practice or a hospital career?

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

Another difference between a career in general practice and hospital medicine is the pay structure. Whereas GPs may expect to have fairly uniform pay throughout their careers, hospital doctors will earn less during their training years.

Thinking of working abroad?

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

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

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

- Specialist/specialty registrar and specialty registrar (fixed-term) (third or higher incremental point) six weeks
- Specialist/specialty registrar and specialty registrar (fixed-term) (minimum, first or second incremental point) five weeks
- Senior house officer five weeks
- Foundation house officer five weeks

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

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

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

\[
\text{weeks’ leave } \times \text{ week length}
\]

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

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

This FHO’s average weekly contractual commitment is therefore 5.5 days.

The FHO’s annual leave entitlement is therefore:

\[ 5 \times 5.5 \text{ days} = 27.5 \text{ days pa} \]

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

\[ 6 \times 5.5 \text{ days} = 33 \text{ days pa} \]

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

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

- The five-day week. A complete week counts as five days, making the annual leave entitlement 25 or 30 days (depending on grade); weekdays including Fridays count as one day. Taking less than full weeks in this system may sometimes give a lower allowance than the recommended formula and should be brought to the attention of our team of advisers on 0870 60 60 828 (see page 175).

- The six- or seven-day week. A complete week counts as six or seven days, making the annual leave entitlement between 30 and 42 days depending on grade. This is usually achieved by counting Fridays as two or three days, the rationale being that this prevents the potential abuse of taking a large number of Fridays combined with requesting not to be on call at the weekend.
Daytime work cover
Some departments engage locums for daytime work, some expect juniors of the same grade to cover, some expect juniors of different grades on the same firm to cover, and some have ‘floating’ juniors. Whichever method is used, junior doctors should ensure that they do not feel exploited or overworked by their colleagues’ absence. If this is the case, members should consult our team of advisers on 0870 60 60 828.

Leave year
The leave year for all doctors in the training grades runs from each doctor’s incremental date.

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

Untaken leave
Where a junior doctor has been unable to take the full allowance of annual leave before the end of the ‘leave year’ they are allowed to carry over up to five days, subject to the exigencies of the service and authorisation from the employer. Employers often restrict leave such that only one doctor per rota can be on leave at any one time. If junior doctors wait until the end of the post to take leave, they may not be able to take it. In general it is more beneficial to take the leave than to be paid in lieu, since payment in lieu for a day’s leave is normally made at only 1/31 of a month’s salary.

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. Foundation house officers may only transfer up to four days’ leave. 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**
Junior doctors are required to notify their employer when they wish to take leave, and the granting of such leave is subject to approved arrangements having been made for cover. It is usual for employers to ask for a minimum period of six weeks’ notice of intention to take leave. Some employers have introduced planned leave arrangements in order to make it easier for them to provide locum or prospective cover. These arrangements are not well-liked but in some circumstances can be to the advantage of all junior doctors on a rota or shift. However, such schemes must be applied in a reasonable manner and command the support of the junior doctors locally.

**Sickness during annual leave**
If a junior doctor falls sick during annual leave and produces a statement to that effect at the time, (eg a self-certificate) the junior doctor should be regarded as being on sick leave from the date of the statement. Where the first statement is a self-certificate, that statement should cover the first and any subsequent days up to and including the seventh day of sickness. Medical statements should be submitted to cover the eighth and subsequent calendar days of sickness where appropriate. Further annual leave should be suspended from the date of the first statement.

**Public holidays**
Full-time junior doctors are entitled to eight paid statutory and public holidays each year as follows: New Year’s Day, Good Friday, Easter Monday, May Day, Spring Bank Holiday, Late Summer Holiday, Christmas Day and 26 December. A further two days, known previously as statutory (or ‘stat’) days, are available. These may either be specified by the employer or converted into annual leave. In Scotland, the statutory days consist of three public holidays at Christmas/New Year, with the remainder as determined by the employer in the light of local practice.

Part-time junior doctors are usually entitled to statutory and public holidays on a pro rata basis, although different arrangements may apply locally.
Working on public holidays
If a junior doctor is required to be on duty at any time, including between midnight and 9am on a statutory or public holiday they should receive a day off in lieu. If the junior doctor is required to continue working the normal day it may be possible to negotiate an additional day off in lieu. If it is not feasible to take these days in lieu, then pay in lieu can be given.

Prospective cover
See page 53.

Annual leave for locum doctors
See page 73.
Study and professional leave

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

JDC has long been calling for a thorough review of existing study leave arrangements which it views as inadequate and widely variable.

The Conference of Postgraduate Medical Deans (COPMeD) is undertaking a review of study leave provision with JDC’s recommendations in mind and this is welcomed.

Entitlement
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.

Section 15 of the A guide to specialist registrar training (the ‘Orange guide’) still applies for SpRs.

The Rough Guide to the Foundation Programme
(www.foundationprogramme.nhs.uk/pages/home) covers study leave allowances for F1 and F2 years:

Foundation Year 1
The foundation training programme director (FTPDP) should ensure access to a formal taught programme of education which addresses the professional elements of the curriculum.
FHO1s should have up to three hours per week of protected, bleep-free time set aside for a timetabled learning programme. Alternatively, this time may be aggregated to give you seven days of whole day release. In Scotland there is an understanding that FHO1s can ‘borrow’ up to five days study leave from their FHO2 allocation in order to complete a taster period prior to applying for specialty training.

**Foundation Year 2**
In F2, you are eligible for 30 days study leave per year. However, a minimum of 10 days (7 in Scotland) of your study leave will be used for a formal educational programme in generic professional training and other aspects of F2 training.

The terms and conditions of service recommend the following standards on entry to specialty training:

**Specialty training levels 1 and 2 and FTSTAs**
*Either*
Day release for the equivalent of one day per week during university terms
*Or*
Up to a maximum of 30 days in a year
*And*
Study leave to sit an examination for a higher qualification.

**Specialty training**
*Either*
Day release for the equivalent of one day per week during university terms
*Or*
Up to a maximum of 30 days in a year
*And*
Study leave to sit an examination for a higher qualification where it is necessary as part of a structured training programme (up to two occasions)
*And*
Study leave to sit other examinations for a higher qualification.
Senior registrars
One day per week for individual study and specified research projects, or its accumulated equivalent
And
Professional leave for up to 10 days per year cumulative over a three-year period.

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

Applications
Regional postgraduate deans (in Scotland the NHS Education for Scotland) have overall responsibility for managing study leave budgets. However, in most regions budgets have been devolved to clinical tutors (postgraduate deans in Scotland and Northern Ireland and postgraduate organisers in Wales) or the appropriate NHS Trust. Applications are usually required to be submitted locally before the leave is taken and all expenses that are likely to be incurred should be indicated on the application. The study leave application will normally require the approval of the junior doctor's consultant. It is not the responsibility of the junior doctor to find or arrange any locum cover during the study leave period. Junior doctors should contact the human resources department to find out the procedure for applying for study leave in their Trust.

Details about applying for study leave in the different deaneries in Scotland can be found at the following link:
www.nes.scot.nhs.uk/medicine/study%5Fleave/

Expenses
Employers should accept the natural consequences of granting study leave, so that all reasonable expenses associated with periods of approved study leave are paid. However, there are circumstances where this could be unreasonable, for example, where expenses are met wholly or partly by a sponsoring body or where a practitioner holds a contract with more than one employer.
In deciding what are ‘reasonable expenses’ employers have been told by the Department of Health that ‘it would not, in our view, be reasonable for an authority to pre-determine a given level of expenses which it was prepared to approve in connection with applications for study leave’. In other words, when employers grant study leave, they must grant pay and expenses.

Where study leave expenses are granted, the full rates of travel and subsistence set by the General Whitley Council should be paid. Examination fees are not paid.

Some deaneries also put a limit on the study leave budget allowed for each junior. For the reasons stated in the above paragraph, the JDC regards this as inappropriate.

**Professional leave for overseas conferences etc**

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

**Appeals**

If study leave is refused or granted without pay or expenses, junior doctors can take the following steps.

(i) Appeal to the regional study leave committee (if one exists). This is a regional committee, on which junior doctors are represented, whose job it is ‘to ensure consistent and uniform practices and to decide appeals’. If there is no study leave committee in your region you should contact your postgraduate dean. Further details of the local study leave policy may be also obtained from the postgraduate dean. It is important that junior doctors do appeal because referral of refused applications will not otherwise occur.

(ii) Small claims court. If study leave is granted but without pay and/or expenses, the matter may be pursued through the small claims court as long as the claim is under £5,000. Hearings are usually in private and less formal than proceedings in higher courts. However, it is
possible for a case to be referred, by the registrar hearing the case, to the full County court. Costs may then be payable.

(iii) Employer’s grievance procedure. In cases where pre-determined policies are being arbitrarily imposed, it may be worth appealing to the employer under the grievance procedure.

In Scotland, each postgraduate dean has an appeals procedure for study leave applications: www.nes.scot.nhs.uk/medicine/study_leave/

BMA members should seek advice from our team of advisers on 0870 60 60 828 before embarking on an appeal.

**Study leave for GP trainees**
The GP Trainees Subcommittee of the GPC has agreed policy on study leave for GP registrars. The guidance note *Study leave for GP registrars* is available on the BMA website www.bma.org.uk.
Sick leave

References are made throughout this section to paragraphs in the General Whitley Council handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the General Whitley Council has been replaced by a NHS Staff Council. At the time of writing, the GWC handbook was still in use for medical staff, but new arrangements may apply in due course. Check the BMA website for details.

Scale of allowance

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

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

Pay includes salary supplement.

Employers can extend these allowances in exceptional cases. Because these periods are relatively short, junior doctors should also seek independent financial advice on income protection.

Calculation of allowances

The amount of sick leave allowance and the period for which it is to be paid are worked out by taking the junior doctor’s sick leave entitlement as on the first day of sickness and subtracting the total sick leave taken in the 12 months prior to the current absence. In aggregating periods of
absence, no account is taken of any absence on unpaid sick leave. Specific conditions apply to absence due to injury resulting from a violent crime. For the purposes of calculation of the allowance, 26 working days are equivalent to ‘one month’.

**Previous qualifying service**
All previous NHS service, (including locum service), university, local authority or civil service employment without any break of more than 12 months, is aggregated for sick leave purposes. There are several exceptional circumstances in which a break of more than 12 months does not mean a break in previous qualifying service. Where a junior doctor has broken their regular service in order to go overseas on a rotational appointment, or on an appointment which is considered by the postgraduate dean or college or faculty adviser in the specialty concerned (if necessary, with the advice of the consultant) to be part of a suitable programme of training, or to undertake voluntary service, their previous NHS or other approved service should be taken fully into account in assessing entitlement to sick leave allowance, provided that:
- the junior doctor has not undertaken any other work outside the NHS during the break in service, apart from limited or incidental work during the period of the training appointment or voluntary service; and
- the employer considers that there has been no unreasonable delay between the training or voluntary service abroad ending and the commencement of the NHS post.

**Limitation of allowance when insurance or other benefit is payable**
Sickness allowance, when added to sickness benefit, severe disablement allowance, invalidity benefit, statutory sick pay, compensation payments or other social benefits receivable, may not exceed the junior doctor's normal salary for the period and the occupational sick leave allowance is restricted accordingly.
Notification of sickness
A junior doctor who is incapable of working because of illness should immediately notify their employer under the circumstances specified by the employer. If the sickness absence continues beyond the third calendar day, the doctor must submit a statement of the nature of the illness within the first seven calendar days of absence. Further statements must be submitted to cover any absence extending beyond the first seven calendar days. They should take the form of medical certificates completed by a doctor other than the sick doctor. Exceptionally, the employer may require statements to be submitted at more frequent intervals.

A junior doctor admitted to hospital must submit a doctor’s statement on entry and on discharge in substitution for periodical statements. However, if the period of absence is less than seven calendar days, only a self-certificate is required.

Injury sustained on duty
It is important to note that a period of absence due to injury that is sustained by junior doctors in the actual discharge of their duties, and is not their own fault, is not recorded for the purpose of the scheme. It is essential that all such injuries are recorded at the first opportunity in the accident book or other mechanism for recording adverse incidents that may be in place.

Termination of employment
When a junior doctor is receiving the sick leave allowance at the time of expiry of their contract in a regular appointment, the allowance continues to be paid during the illness, ie after the contract would have been terminated, subject to the maximum entitlements set out in the ‘Scale of allowances’ section. This is an important provision of the sick pay arrangements, which is often overlooked by employers.
Accident due to sport or negligence
Sickness allowance is not paid in a case of accident due to active participation in sport as a profession or in a case in which contributory negligence is proved, unless the employer decides otherwise.

Recovering damages from a third party
A junior doctor who is absent as a result of an accident is not entitled to an allowance if damages are recoverable from a third party, but the employer may advance to the junior doctor a sum not exceeding the sickness allowance which would have been payable, subject to the junior doctor undertaking to refund any damages received. Where a refund is made in full, the period of absence does not count against the sick leave entitlement. These provisions do not apply to compensation awarded by the Criminal Injuries Compensation Authority.

Medical examination
The employer may at any time require a junior doctor who is unable to perform their duties as a result of illness to submit to an examination by a doctor nominated by the employer.

Forfeiture of rights
If it is reported to the employer that a junior doctor has failed to observe the conditions of this scheme or has been guilty of conduct prejudicial to their recovery, and the employer is satisfied that there is substance in the report, the payment of the allowance can be suspended until the employer has made a decision. Before making a decision, the employer must advise the doctor of the terms of the report and provide an opportunity for the doctor to submit their observations and appear or be represented at a hearing.

Statutory sick pay (SSP)
SSP is paid by the employer to employees. The sick pay paid by an employer will usually include both SSP and occupational sick pay entitlements.
Information

Employment Relations Act 1999

Maternity and Parental Leave Regulations 1999 amended by Maternity and Parental Leave (Amendment) regulations 2002 and 2001

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

Advance Letter (GC) 1/2003

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.

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

Special leave

References are made throughout this section to paragraphs in the General Whitley Council handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the General Whitley Council has been replaced by a NHS Staff Council. At the time of writing, the GWC handbook was still in use for medical staff, but new arrangements may apply in due course. Check the BMA website for details.

Parental leave

After 12 months’ continuous service within the NHS, each parent has the right to take at least 13 weeks’ unpaid leave in respect of children under 14 years, and 18 weeks for disabled children or adopted children under 18 years. Leave with pay may be granted by local agreement.

Notice periods for taking such leave should not be unnecessarily lengthy. Parental leave can be added to periods of paternity or maternity leave.
Special leave for domestic, personal and family reasons

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

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

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

Employment break scheme

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

Other special leave

Special leave with pay is also available in certain circumstances, by local agreement, eg attendance at court as a witness, or training with the reserve and cadet forces.
Leave for trade union duties and activities

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

Professional leave

Reasonable paid leave should be granted to enable doctors to attend meetings of their college or professional body, eg BMA. In case of difficulty, members should contact our team of advisers on 0870 60 60 828.

Leave for candidates for appointments

Paid leave for attending interviews is at the discretion of the employer, but is good practice and is referred to as such in *A guide to specialist registrar training*.

Maternity leave

Eligibility

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

- she has 12 months’ continuous service with one or more NHS employers at the beginning of the 11th week before the expected week of childbirth
- she notifies her employer in writing before the end of the 15th week before the expected date of childbirth (or if this is not possible, as soon as is reasonably practicable thereafter) of her intention to take maternity leave and of the date she wishes to start her maternity leave; and that she intends to return to work with the same or another NHS employer for a minimum period of three months after her maternity leave has ended
- and provides a MATB1 form from her midwife or GP giving the expected date of childbirth.
Changing the maternity leave start date
If the employee subsequently wants to change the date from which she wishes her leave to start she should notify her employer at least 28 days beforehand (or, if this is not possible, as soon as is reasonably practicable beforehand).

Confirming maternity leave and pay
Following discussion with the employee, the employer should confirm in writing:
• the employee’s paid and unpaid leave entitlements under this agreement (or statutory entitlements if the employee does not qualify under this agreement)
• unless an earlier return date has been given by the employee, her expected return date based on her 52 weeks’ paid and unpaid leave entitlement under this agreement; and
• the length of any period of accrued annual leave which it has been agreed may be taken following the end of the formal maternity leave period
• the need for the employee to give at least 28 days’ notice if she wishes to return to work before the expected return date.

Keeping in touch
Before going on leave, the employer and the employee should also discuss and agree any voluntary arrangements for keeping in touch during the employee’s maternity leave including:
• any voluntary arrangements that the employee may find helpful to help her keep in touch with developments at work and, nearer the time of her return, to help facilitate her return to work
• keeping the employer informed of any developments that may affect her intended date of return.

Keeping in touch days
Keeping in touch (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: 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 without bringing her 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 statutory maternity pay (SMP) or maternity allowance (MA) (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, for example a combination of full pay and half pay or a fixed amount spread equally over the maternity leave period.

**Calculation of maternity pay**

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

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

- in the case of an employee on unpaid sick absence or on sick absence attracting half pay during the whole or part of the period used for calculating average weekly earnings in accordance with the earnings rules for SMP purposes, average weekly earnings for the period of sick absence shall be calculated on the basis of notional full sick pay.

**Unpaid contractual maternity leave**
Employees will also be entitled to a further 13 weeks’ unpaid leave, bringing the total leave to 52 weeks.

**Comment and duration of leave**
An employee may begin her maternity leave at any time between the 11th week before the expected week of childbirth and the expected week of childbirth provided she gives the required notice.

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

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

**Pre-term birth**
Where an employee’s baby is born alive prematurely the employee will be entitled to the same amount of maternity leave and pay as if her baby was born at full term.
Where an employee’s baby is born before the 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 her maternity leave entitlement, taking a minimum period of two weeks’ leave immediately after childbirth and the rest of her leave following her baby’s discharge from hospital.

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

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

**Health and safety of employees pre and post birth**
Where an employee is pregnant, has recently given birth or is breastfeeding, the employer should carry out a risk assessment of her working conditions. If it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties the employer should provide suitable alternative work for which the employee will receive her normal rate of pay. Where it is not reasonably practicable to offer suitable alternative work the employee should be suspended on full pay.
These provisions also apply to an employee who is breastfeeding if it is found that her normal duties would prevent her from successfully breastfeeding her child.

**Return to work**
An employee who intends to return to work at the end of her full maternity leave will not be required to give any further notification to the employer, although if she wishes to return early she must give at least 28 days’ notice.

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

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

If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period this will not affect the employee’s right to return to her job under her original contract at the end of the agreed period.

**Sickness following the end of maternity leave**
In the event of illness following the date the employee was due to return to work normal sick leave provisions will apply as necessary.

**Failure to return to work**
If an employee who has notified her employer of her intention to return to work for the same or a different NHS employer in accordance with the regulations fails to do so within 15 months of the beginning of her maternity leave she will be liable to refund the whole of her maternity
pay, less any SMP, received. In cases where the employer considers that to enforce this provision would cause undue hardship or distress the employer will have the discretion to waive their rights to recovery.

**Fixed-term contracts or training contracts**

Employees subject to fixed-term or training contracts which expire after the 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.

If there is no right of return to be exercised because the contract would have ended if pregnancy and childbirth had not occurred the repayment provisions set out above will not apply.

Employees on fixed-term contracts who do not meet the 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, she shall have the right to return to work in the same post or in the next planned post irrespective of whether the contract would otherwise have ended if pregnancy and childbirth had not occurred. In such circumstances the employee’s contract will be extended to enable the practitioner to complete the agreed programme of training.

**Contractual rights**

During maternity leave (both paid and unpaid) an employee retains all of her contractual rights except remuneration.
Increments
Maternity leave, whether paid or unpaid, shall count as service for annual increments and for the purposes of any service qualification period for additional annual leave.

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

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

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.

Post-natal care and breastfeeding mothers
Women 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 women with suitable private rest facilities, and should consider requests for flexible working arrangements to support breastfeeding women at work.

Employees not returning to NHS employment
An employee who satisfies the required eligibility conditions but who does not intend to work with the same or another NHS employer for a minimum period of three months after her maternity leave is ended, will be entitled to pay equivalent to SMP, which is paid at 90 per cent of her average weekly earnings for the first six weeks of her 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 she may still be entitled to SMP. SMP will be paid regardless of whether she satisfies the eligibility conditions above. If her earnings are too low for her to qualify for SMP, or she does not qualify for another reason, she should be advised to claim MA from her local Job Centre Plus or social security office.

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 Trusts and the Northern Ireland Health Service; a break in service of three months or less will be disregarded (though not count as service).

The following breaks in service will also be disregarded (though not count as service):

- employment under the terms of an honorary contract
- employment as a locum with a general practitioner for a period not exceeding 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 her return
- absence on a 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.

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.

**Further information about maternity rights and SMP**
Information about all maternity rights can be found on the Department for Business, Enterprise and Regulatory Reform (BERR) and the Department for Work and Pensions websites.

**Unfair dismissal**
Regardless of length of service or hours of work it is unlawful for an employer to dismiss an employee or to select her for redundancy, solely or mainly because she is pregnant or has given birth, or for any other reason connected with her pregnancy or childbirth.

If you feel that you are being denied your employment rights contact our team of advisers on 0870 60 60 828 in the first instance. They will assess your circumstances and where necessary arrange for local representation.

**Defence body subscriptions**
Doctors who take maternity leave should contact their defence body as special beneficial arrangements should apply.

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

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

**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
There will be an entitlement to two weeks’ occupational maternity support pay. Full pay will be calculated on the basis of the average weekly earnings rules used for calculating occupational maternity pay entitlements. The employee will receive full pay less any statutory paternity pay receivable. 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 where they consider it necessary or 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 his or her 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.

Employees who are not eligible for the occupational scheme may be entitled to the statutory scheme.

Statutory scheme
Eligibility
Employees must satisfy the following conditions in order to qualify for paternity leave. They must:
• have or expect to have responsibility for the child’s upbringing
• be the biological father of the child or the husband or partner of the mother
• have worked continuously for their employer for 26 weeks ending with the 15th week before the baby is due.

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

**Length of paternity leave**
Eligible employees can choose to take either one week or two consecutive weeks paternity leave (not odd days). They can choose to start their leave:
• from the date of the child’s birth (whether this is earlier or later than expected); or
• from a chosen number of days or weeks after the date of the child’s birth (whether this is earlier or later than expected); or
• from a chosen date later than the first day of the week in which the baby is expected to be born.

Leave can start on any day of the week on or following the child’s birth but must be completed:
• within 56 days of the actual date of birth of child; or
• if the child is born early, within the period of the actual date of birth up to 56 days after the expected week of birth.

Only one period of leave is available to employees irrespective of whether more than one child is born as the result of the same pregnancy.

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

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 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 BERR website. Employers can also request a completed self-certificate as evidence of entitlement to paternity leave. The self-certificate must include a declaration that the employee meets certain eligibility conditions and provide the information specified above as part of the notice requirements.

By providing a completed self-certificate, employees will be able to satisfy both the notice and evidence conditions for paternity leave and pay. Employers will not be expected to carry out any further checks.

Contractual benefits

Employees are entitled to the benefit of their normal terms and conditions of employment, except for terms relating to wages or salary (unless their contract of employment provides otherwise), throughout their paternity leave. However, most employees will be entitled to SPP for this period. If the employee has a contractual right to paternity leave as well as the statutory right, he may take advantage of whichever is the more favourable. Any paternity pay to which he has a contractual right reduces the amount of SPP to which he is entitled.
**Return to work after paternity leave**
Employees are entitled to return to the same job following paternity leave.

**Protection from detriment and dismissal**
Employees are protected from suffering unfair treatment or dismissal for taking, or seeking to take paternity leave. Employees who believe that they have been treated unfairly can complain to an employment tribunal.

**Employers recovery of payments**
Employers can recover the amount of 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**
Information about all paternity leave rights can be found on the Department for Business, Enterprise and Regulatory Reform (BERR) and the Department for Work and Pensions websites.
Accommodation and catering

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

In July 2007, the requirement for pre-registration doctors to be resident at the hospital was removed from the Medical Act 1983. This means that there is no longer a statutory requirement for pre-registration doctors (first year foundation house officers (FHO1s) to be resident, which in turn means that hospital accommodation no longer needs to be provided without charge to FHO1s. However, in August 2007 NHS Employers wrote to Trusts to encourage them to continue to provide free accommodation to FHO1s for 2007/08. From August 2008 it is unlikely that many Trusts will continue to provide accommodation for these doctors without charge. Details of this issue are available on the BMA website at www.bma.org.uk/ap.nsf/Content/fhoaccom1207

Resident practitioners

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

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

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

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

The NHS Executive advance letter and the equivalent Scottish circular on lodging charges for voluntary resident practitioners specifies that the ‘level of lodging charges set locally must be agreed with local junior doctors’ representatives… eg the BMA’s local negotiating committee where one exists’. It is extremely important that junior doctor representatives are involved in negotiations to increase or set lodging charges and this will usually be through the local negotiating committee (LNC) (see page 6). Advice should be sought from our team of advisers on 0870 60 60 828 if there has not been junior doctor involvement in the negotiations or if there is not a junior doctor representative on the LNC.

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

**Overnight accommodation when on call**

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

If a doctor is working a full-shift pattern but is not required by condition of appointment to be statutorily or compulsory resident at the hospital then they are not eligible for free accommodation. If a doctor is required to stay overnight as part of an on-call or partial-shift pattern one night in seven or more then they are required to pay a proportion of accommodation charges if they are not eligible for free accommodation.

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

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

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

A recent judgement in the European Court of Justice (ECJ), known as the Jaeger judgement, ruled on the way in which on-call work should be regarded. It notes the specific case of removal of accommodation during duty periods and permit of sleep while on duty on the hospital site. The JDC recognises that accommodation facilities are frequently conducive to restful sleep and also 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 he is able to attend properly to patients.
Accommodation between duty periods

In circumstances where intervals between duty periods make it unreasonable for the junior doctor to travel to their home or usual residence, for example between shift duties. Trust employers do have a duty of care to ensure the safety of their employees and as best practice should offer to provide free accommodation. This decision is at their discretion. For those doctors who are too tired to travel home following a late handover in the morning and who feel too tired to drive an adequate rest facility should be made available in order for the practitioner to recuperate before driving home.

Many Trust 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.

Abatement of voluntary lodging charges

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

<table>
<thead>
<tr>
<th>Required to stay overnight</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>One night in three</td>
<td>0%</td>
</tr>
<tr>
<td>One night in four</td>
<td>35%</td>
</tr>
<tr>
<td>One night in five</td>
<td>55%</td>
</tr>
<tr>
<td>One night in six or seven</td>
<td>75%</td>
</tr>
</tbody>
</table>

Due to the increasing tendency for Trusts to hand over responsibility for their rented accommodation to housing associations, junior doctors may find difficulty in claiming these abatements. If a housing association just manages the accommodation the abatements should still apply. If a separate body owns the accommodation the position is less clear. In such cases, advice should be sought from our team of advisers on 0870 60 60 828.
Often in such circumstances, junior doctor accommodation is situated off site requiring the doctor to travel to the hospital. In order that a doctor is able to meet his clinical commitments on time consideration should be given that adequate parking is available at the accommodation. If this is not possible then a suitable transport system should be set in place by the Trust employer.

**Inadequate standard of accommodation**

Charges made for accommodation should reflect the standard and amenities provided. Should standards fall below the minimum stated in Annex A of HSC 2000/036 or HDL(2001)50 in Scotland, employers must provide the accommodation free of charge until improvements have been completed. Should the accommodation fall below the HIMOR standards (Annex A) Trusts should provide alternative accommodation until the HIMOR notice has been lifted or the juniors contract comes to an end. Should Trusts provide sub-standard accommodation the following penalties will apply.

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

Standards falling below the minimum stipulated in HSC 2000/036 or HDL(2001)50 in Scotland Living and working conditions for hospital doctors in training – accommodation must be free until improvements are completed (within an agreed timescale) and training posts should be advertised accordingly.

Standards still falling below the minimum stipulated in HSC 2000/036 or HDL(2001)50 in Scotland after an agreed date for improvement – no training posts can be advertised until the Trust has reached minimum standards. Trusts would also be required to find alternative accommodation for any trainees in post, and to provide transport to and from hospital if necessary.
Self-contained accommodation

The provision of self-contained and married accommodation varies from hospital to hospital. All accommodation must meet the minimum standards set out in HSC 2000/036 or HDL(2001)50 in Scotland. There is no requirement for employers to provide this accommodation and where such accommodation is provided the quality tends to vary. Junior doctors requiring married accommodation should check that such accommodation is available from the Trust before taking up the post.

Rent rebates

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

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

Tenancy agreements

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

- an assured tenancy agreement
- an assured shorthold tenancy agreement
- a licence agreement.
A licence agreement offers no security of tenure and merely licenses the occupation of the premises. An assured tenancy is the most common form of agreement between private landlords and their tenants. It cannot be used for properties which are not let as separate dwellings or are the individual’s only or main home. Junior doctors are therefore most likely to be offered assured shorthold tenancies.

An assured shorthold tenancy offers the landlord a guaranteed right to repossess the property at the end of the agreed period of the tenancy. The first assured shorthold tenancy must not be for less than six months and at least two months’ notice is required to bring it to an end. A model fixed term tenancy agreement, which was agreed with the NHSE is available from our team of advisers on 0870 60 60 828.

Rents under this type of tenancy should not be increased during the term of the tenancy, though they are exclusive of service charges, which may be added on (see below).

**Service charges**

Employers usually arrange for the installation of a meter for each unit of accommodation to assess the consumption of gas and electricity. The charge is laid down by the local gas or electricity company and paid directly by the individual. In some cases, where meters are not installed, the employer may include these charges in the accommodation charge. Employers are also required to add to the assessed rent a sum equivalent to the cost of any services such as central heating, which they provide, though this must reflect a reasonable level of consumption and take account of the difficulty usually encountered by individual residents in controlling their own heating.

Employers may also add a sum to cover the cost of ‘furniture and fittings’ based on the gross value of the furniture when new.

**Council tax**

The BMA has a factsheet: *The council tax: implications for junior doctors*. This is available from the BMA website.
Standards of accommodation

HSC 2000/036 Living and working conditions for hospital doctors in training or HDL(2001)50 in Scotland sets out the minimum standards of accommodation and catering for junior doctors. These agreed minimum standards are the result of discussions between junior doctors’ representatives, regional New Deal task force officers, representatives from postgraduate deaneries, NHS managers, NHS Estates staff and other interested parties. The agreement stipulates the following minimum standards:

**On-call rooms**

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

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

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

**Bedrooms**

Each bedroom (one per occupant) should have the following:

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

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

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

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

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

table; at least one chair per occupant.

Living rooms
Living room (one between four occupants):

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

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

Incorporating five of the following items = one star
Incorporating 10 of the following items = two star
Incorporating 15 of the following items = three star
This will encourage Trusts, for just a small extra investment, to attract junior doctors to their hospital by providing accommodation and other facilities of a high standard.

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

**Kitchen**
- Filter coffee machine
- Automatic washing machine
- Tumble dryer
- Dishwasher

**Living room**
- TV and video recorder
- IT/internet access

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

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

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

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

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

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

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

Junior doctors are no longer required to remain on site and therefore many Trust employers do not provide extended meal times after 11pm. If the canteen is closed then it is important that food is available in the Mess through a supply of microwaveable meals.

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

Serving and dining areas must be situated away from facilities provided for patients, relatives and other non-employees.
**Monitoring and complaints**
There should be a designated named Trust officer to whom junior doctors can address complaints and concerns about facilities.

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

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

Strategic Health Authorities have devolved the role of the Regional Action Team to Trust employers. In such circumstances, there should be a designated Trust employer responsible to ensure that standards are met and are in accordance with HSC 2000/036.

Information regarding supporting the New Deal in Scotland, including contact information for New Deal Support Officers, can be found at the following link: www.newdealsupport.scot.nhs.uk/

**Recreational and other facilities**
There should be a doctors’ mess easily accessible from wards and departments. In large hospitals this may require more than one mess. In small Trusts a joint mess for all clinical staff may be acceptable.

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

Secure, communal cycle store.

Laundry with an adequate number of washing machines and dryers (reasonably priced and well maintained).
Exercise/sporting facilities for all staff – where this is not possible, employers should make arrangements with local sports centres and swimming pools and should inform juniors of these facilities.

**Guidance on hospital accommodation and catering**

The JDC has produced guidance on hospital accommodation and catering based on HSC 2000/036 Living and working conditions for hospital doctors in training or (HDL(2001)50) in Scotland. A copy of the guidance is available via the BMA website.

**Removal expenses**

The scheme for reimbursement of removal expenses gives employers discretion on the scope and level of removal expenses which they may reimburse. However, training grade doctors remain entitled to reimbursement of their removal or excess daily travelling expenses, and employers have been asked to take particular account of the circumstances of those who have to move frequently to satisfy their training needs, so that they are not disadvantaged by these moves.

Before accepting an appointment, doctors who would have to move to take up that appointment should contact the new employer as early as possible to check their eligibility for removal expenses. This is very important because of the discretion which has been given to employers to determine eligibility. It should be made clear that employers must reimburse removal expenses for junior doctors who are required to relocate in the interests of the service or to satisfy their training requirements.

As much information as possible should be obtained from the Trust human resources department before the interview stage. Negotiation of removal or travel expenses should take place before the post is accepted, and confirmation of any agreement should be obtained in writing.

Junior doctors may find that their employer has negotiated a removal expenses agreement covering all staff within the Trust. The BMA has issued guidance to its LNCs on negotiating such a package.
Nevertheless, individual doctors may now have to play a greater role in negotiating their own expenses. In addition, some regions have established removal expenses policies covering all Trusts in the region and this will often include setting a limit on expenses, usually of about £8,000.

**Rotational appointments**

Doctors who have to move during a rotational training appointment can choose to travel the greater distance between their home and their place of work on a daily basis instead of moving house. The mileage that may be paid under these circumstances is the difference between the mileage from home to their designated base place of work and the mileage from home to the new place of work, as set out in paragraph 315 of the Terms and Conditions of Service. In most cases the base place of work is where the majority of time and/or work is spent.

**Flexible training**

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

**GP registrars**

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

The scheme for payment of removal expenses for GP registrars in the GP part of their training is broadly similar to the old scheme for hospital doctors but reimbursement is made to the registrars by the health authority (health board in Scotland).

**Honorary contract holders**

A doctor moving from a post with a university, the Medical Research Council (MRC) or the Wellcome Trust where they held an honorary NHS contract will probably be eligible to receive removal expenses on return to the NHS.
Doctors moving from the NHS to MRC or university appointments will receive whatever removal expenses are payable by the MRC or individual university.

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

**Agreement to remain in service**
As a condition of receiving removal expenses, employers may require some groups of doctors to sign an undertaking that they will not leave the service of that employer within two years unless the circumstances justify the release of the doctor from this undertaking. If this is broken, the doctor may be required to refund all or part of the expenses.

Doctors in training should be wary of signing a contract containing an agreement to remain in service as it is often the case that they will leave the employer’s service within two years for training reasons. Our team of advisers on 0870 60 60 828 can advise on the best course of action if this occurs.

**Level of expenses payable**
Under the GWC agreement employers should, prior to the post being accepted and in agreement with the employee, determine the scope and level of financial assistance to be provided. The provision of removal expenses will form part of the contract of employment. Employers have been asked to ensure equity between different categories of staff, and should take into account both their own interests and the needs of prospective employees. The employer must also ‘clearly indicate the aspects of removal costs that will be reimbursed, and, where applicable, the upper limit of payment in all usual circumstances’.

This implies that there may be considerable variation in expenses offered according to factors such as area, ease of recruitment in a particular specialty etc. Employers must, however, also take the following into account when considering the level of expenses:
• all the individual’s circumstances
• the need to re-house dependants
• comparability of old and new accommodation.

Doctors will need to be aware that expenses offered may vary, although expenses should be based on costs actually incurred. There should be a clearly set out appeals procedure to cover cases of disagreement.

Legal and other services
Employers are given discretion to establish, in negotiation with the employee, the procedure to be followed and costs to be reimbursed where an employer has entered into an agreement with solicitors or other agencies to provide house purchase, conveyancing or removal services at preferential cost.

The BMA is opposed to the concept of employers imposing their choice of legal or other services on an employee. Doctors who wish to choose their own solicitor etc should establish at an early stage whether this is acceptable, and should note that if they use their own solicitor, the employer may impose an upper limit on reimbursable expenses based on their own agency’s charges.

Making a claim
Step 1: the agreement
• Contact the human resources department of the prospective employer and find out in detail how they plan to calculate and pay removal expenses.
• Contact our team of advisers on 0870 60 60 828 to check that the offer is in line with any local agreement on removal expenses, and that it is reasonable.
• Use the list as a guide to the possible costs which should be covered in the offer.
• Do not accept an appointment until agreement is reached on the range and level of expenses.
• Get the employer’s agreement in writing and check whether there is a time limit on submitting a claim.
• Keep all receipts, and check whether those are needed for all expenses or whether miscellaneous expenses can be claimed without them.

Step 2: what to claim
The GWC scheme states that any reasonable costs incurred in relocation may be met, including those incurred in:
• the search for accommodation in the new area
• the purchase and sale of property
• removal of furniture and effects
• continuing commitments in the old area
• general/miscellaneous removal costs
• additional housing costs in the new area
• other expenses, at the employer’s discretion.

Step 3: what to avoid
• Loans, offered as an alternative to removal expenses.
• Undertakings to repay if moving within a fixed period.
• Lump sum settlements: new tax rules mean that tax may be payable.
• Overall ceilings on expenses: the BMA is opposed to these.

Tax
Removal expenses can be paid tax-free up to a ‘qualifying limit’, which is revised annually. Currently, the limit stands at £8,000. Further information can be obtained in a guidance note from our team of advisers on 0870 60 60 828. Your local tax office will also be able to help.

Removal expenses: what to claim
The following are offered as example only and are neither inclusive or exclusive.

Expenses during search for accommodation
• Preliminary visits to new area (paid leave and expenses, including immediate family).
• Subsistence allowance for a maximum of four nights away while seeking accommodation.
• Return travel expenses (including immediate family).
• Travel expenses for weekly visits home or by the immediate family to the practitioner until new accommodation has been found (for a maximum of 12 months).
• Allowance for retention of accommodation in new area while absent (for a maximum of 12 months).

Expenses of house purchase and sale
• Advance of salary for house purchase (ensure repayment terms are clear).
• Legal and other expenses (eg stamp duty, legal fees, surveys, wiring/drain test).
• House sale (eg solicitors’ fees, agents’ fees, costs relating to a purchase which falls through).

Expenses of moving house
• Journey from old to new home, with immediate family.
• One return visit to superintend removal.
• Storage and/or removal of furniture/effects (three quotes must be sought).
• Tenancy agreements.
• Miscellaneous (eg plumbing, telephones, replacement of school uniform, TV aerial, etc).

Continuing expenses in old area
The employing may reimburse any reasonable continuing commitments in the old area, eg:
• child’s lodging costs (where they remain behind)
• rent and rates payable on the old property concurrently with the new one.

Additional expenditure in new area
The employer may make allowances towards additional housing costs where the cost of accommodation is higher than in the old area, eg:
• increased expenditure in new area compared with similar expenditure in old area for:
  • rent/rates
  • property insurance
  • other (covering rent or imputed equivalent, council tax, water rates, etc).
Travelling and other expenses

References are made throughout this section to paragraphs in the General Whitley Council handbook. With the introduction of the Agenda for Change pay arrangement for non-medical staff in the NHS, the General Whitley Council has been replaced by a NHS Staff Council. At the time of writing, the GWC handbook was still in use for medical staff, but new arrangements may apply in due course. Check the BMA website for details.

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

Payment of mileage allowances

The circumstances under which juniors may receive mileage allowances are set out in paragraphs 277-89 of the Terms and Conditions of Service. The following is a brief summary of the provisions. Further advice should be sought from our team of advisers on 0870 60 60 828.

Full-timers

Full-time junior doctors working in the NHS who are required by their employer to travel on official business receive mileage allowances for the following journeys:

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

The mileage payable for such journeys is usually subject to a maximum allowance. Paragraphs 284 and 285 of the terms and conditions of service set out the entitlement in detail.
Part-timers
For part-time junior doctors, the following journeys are classified as official business:

- principal hospital to any destination on official business
- home to any destination other than the principal hospital, on official business
- home to principal hospital when there is a subsequent official journey (subject to a maximum)
- home to principal hospital, when the junior doctor is called out in an emergency.

See paragraph 286 of the terms and conditions of service for further details.

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

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

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

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

Insurance
Junior doctors who use their own car on NHS business should ensure that the car is insured for business use.
Public transport rate
The standard or regular user rates will not apply if a junior doctor uses a private vehicle in circumstances where travel by a public service (e.g. rail or bus) would be appropriate. For such journeys an allowance at public transport rate will be paid unless this is higher than the rate that would be payable under standard or regular user rates. It is important to note that public transport rate should only be paid where the use of public transport is not unreasonable i.e., it is convenient and would not prolong the journey excessively. If it is not possible, or reasonable, to use public transport, standard or regular user rates should be paid.

In all other circumstances, the standard or regular user rates apply. Employers should use the following criteria in deciding whether the public transport rate should apply:
• the nature of the practitioner’s duties
• the length and complexity of journeys (including the number of changes and likely waiting times)
• the availability of public transport
• personal safety
• the time of day
• relative journey times (public transport compared with private vehicle)
• any other relevant factors, for example, equipment or luggage to be carried.

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

If a practitioner needs to use private transport because public transport does not provide a reliable or reasonable way to get to or from work (or is in some other way inappropriate) or because they are travelling on an official journey, the standard or regular user mileage rates should apply. According to agreed guidance, as a general guide a journey by public transport which takes over one hour or which requires three or more changes would be considered unreasonable and the standard or regular user mileage rates shall apply. More detailed guidance on when the standard or regular use rates should be used is available in NHS
Employers’ Pay Circular MD 3/2006. For Scotland this is circular PCS(DD)2006/6.

The changes to the mileage rates in Scotland were issued under PCS(DD)2008/1.

Mileage paid at the public transport rate does not count towards the number of miles for which payment is made at higher rates under the standard and regular users mileage schemes. For example, a doctor who had to drive 3,000 miles and was paid at the appropriate standard rate for 2,000 miles and public transport rate for 1,000 miles would still be entitled to a further 1,500 miles at standard rate (ie the higher level paid up to 3,500 miles).

**Carriage of official passengers**

A junior doctor carrying passengers who are employed by an NHS employer on NHS business, is entitled to receive a passenger allowance, at national rates.

**Car out of use**

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

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

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

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

**Loans for car purchase**

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

The maximum amount of the loan cannot exceed the cost of the car less the net amount realised by the sale or part exchange of a vehicle used on NHS business within the preceding 12 months. The loan is repayable over a maximum of five years or the estimated life of the car, if shorter. If a junior doctor changes employer while repaying a loan the new employer will purchase the loan from the former employer.

**Garage expenses, tolls and ferries**
Garage and parking expenses, and charges for tolls and ferries, will be reimbursed to junior doctors using their cars on official business on the production of vouchers wherever possible. Overnight parking charges will only be reimbursed if the junior doctor is receiving night subsistence allowance for overnight absence or is receiving mileage expenses paid at public transport rates.

**Pedal cycles**
Official journeys undertaken by pedal cycle attract expenses at national rates.

**Railway fares**
Junior doctors are expected to take the fullest possible advantage of any cheap fares available.

**Air fares**
Payment for travel by air may not exceed the cost of travel by appropriate alternative means of transport, together with an allowance equivalent to the amount of any saving in subsistence expenses consequent on travel by air, provided that where the employer decides that the saving in time is so substantial as to justify payment of the fare for travel by air, they may pay an amount not exceeding:
- the ordinary, or any available cheap fare for travel by regular air service; or
where no such service is available or in case of urgency, the fare actually paid by the doctor.

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

Eligibility
Junior doctors are not automatically entitled to a Crown car, but will be offered one if the employer considers it economic or in the interest of the service to do so.

Types of car
For junior doctors, a base vehicle of at least 1,100cc and no more than 1,800cc can be provided. A larger vehicle may be chosen but any excess costs compared with the use of the base vehicle are met by the individual junior doctor.

Petrol costs
Junior doctors who have been allocated Crown cars are responsible for purchasing all petrol, whether for business or private mileage. Reimbursement for NHS business mileage should be claimed by submitting a signed claim form. The rate per mile is determined according to the following formula:

\[
\text{Cost of one gallon of LRP} \times \frac{\text{Base vehicle's mileage on urban cycle}}{\text{Base vehicle's mileage on urban cycle}}
\]

The price of petrol is as notified from time to time by the Department of Health or devolved equivalent based on the price of lead replacement petrol as published in Petroleum Times. The mileage on the urban cycle is as quoted by manufacturers from officially approved tests under the Passenger Car Fuel Consumption Order 1983.
Private charges
A Crown car user will be required to reimburse the employer for the private use element of the car. This will take the form of a composite annual charge to cover payment for the road fund licence, insurance for private use, a handling charge, VAT and a fixed amount per 1,000 miles of estimated private driving. Further details are given in the BMA guidance note *NHS official travel* – available from the BMA website.

Implications of declining a Crown car
A junior doctor may be requested to have a Crown car by an employer as it is more economical for them to provide a car rather than reimburse travelling expenses at standard or regular user rate. If the request is declined the junior doctor will be reimbursed at a ‘special rate’ equivalent to the current 9,001 to 15,000 miles rate for over 2,000cc for regular and standard users, regardless of the vehicle’s engine size. There is no entitlement to claim standard or regular user lump sum payments and allowances.

Taxation
As far as HM Revenue & Customs is concerned, private use of Crown cars constitutes a tax benefit and their treatment is therefore the same as a company car given to any employee.

Junior doctors interested in Crown cars should be aware that the scheme will only be economically advantageous to some individuals, depending on variables such as private and business mileage, size of car, and the tax position. They are therefore advised to proceed with caution. BMA members should seek advice from our team of advisers on 0870 60 60 828 and/or their accountant.

Subsistence allowances
Subsistence allowances are payable in addition to travelling and other expenses when junior doctors are required to be away from their home. For example, they can claim in relation to periods of approved study leave, interview expenses, or in connection with removal expenses during a search for suitable permanent accommodation in a new area, subject to the terms of the removal expenses policy.
At the time of writing a review of subsistence allowances was under way in the NHS Staff Council. The BMA website should be checked for the latest figures. However, the following allowances are currently payable.

**Night subsistence – commercial accommodation**

When a junior doctor stays overnight in a hotel or other commercial accommodation, the overnight costs will be reimbursed as follows:

- the actual receipted cost of bed and breakfast up to a normal maximum limit of £55; plus
- a meal allowance of £20 to cover the cost of main evening meal and one other daytime meal.

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

**Night subsistence – non-commercial accommodation**

Where a junior doctor stays for short overnight periods with friends and relatives or in caravan accommodation, a flat rate of £25 is payable. This includes an allowance for meals. No receipts are required.

Junior doctors staying in accommodation provided by the employer or host organisation are entitled to an allowance to cover meals which are not provided free of charge up to £20.

Where accommodation and meals are provided without charge, an incidental expenses allowance of £4.20 is payable. All payments of this allowance are subject to the deduction of income tax and National Insurance (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 junior doctor is absent from home and more than five miles from headquarters, by the shortest practical route, on the business of the employer. The rates are as follows.

Lunch allowance – £5
(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 junior doctor spends more on a meal/meals than would have been spent at the junior doctor’s headquarters. A junior doctor is required to certify accordingly on each occasion for which a day meal allowance is claimed, but a receipt is not required.

Junior doctors may qualify for both lunch and evening meal allowance in some circumstances. There will be occasions where, due to the time of departure, it will be necessary to take a meal but the conditions relating to the time absent from the base are not met. This, and any other exception to the rules, may be met at the discretion of the employer.

Late night duties expenses
A junior doctor may also receive in addition to a day meal allowance, an evening meal allowance of £3.25. This is paid at the discretion of the employer and is subject to income tax and NI contributions.
Receipts
The subsistence rates above are payable in full when junior doctors are away from home on official business. There is no requirement under the General Whitley Council agreement that staff should produce supporting vouchers/receipts, except in the case of claims for very long absence allowance, overnight bed and breakfast costs, train meal allowances or for abnormally high expenses. However, local policies (which do exist) may require receipts, and the position should be checked before claiming.

Telephone expenses
Resident medical staff
Under HSC 2000/036 Living and working conditions for hospital doctors in training (HDL(2001)50 in Scotland), resident junior doctors should be provided with a telephone connected, using a standard BT or cable socket, to the internal hospital telephone system and for there to be access to the facility for making external calls at no higher than relevant BT rates. It is BMA policy that junior doctors should not be charged more than the actual charge of the call made by the telephone company.

Official business calls
Junior doctors may claim the cost incurred of outgoing calls made on official business.

Telephone installation and rental costs
It is sometimes a contractual requirement for SpRs and StRs to possess a telephone. Employers should pay for the cost of installation and rental of telephones where they are satisfied that the following conditions apply:

- it is essential for the efficiency of the service that the junior doctor should be on call outside normal working hours; and
- the telephone is the only practicable method of communication with the junior doctor; and
- the possession of a telephone is a contractual requirement. However, contract holders are also entitled to reimbursement of the cost of calls by the employer.

The payment of installation and rental costs is usually taxable.
**Interview expenses**

Where an employer invites a junior doctor to appear before a selection board or invites a shortlisted junior doctor to attend in connection with an application for appointment, reimbursement of eligible expenses is made by the prospective employer. For specialty training interviews in Scotland, candidates offered an interview who are based in Scotland are advised to claim from their current employer, i.e. their local health board.

Trainees from outside Scotland are advised to claim from the lead board dealing with recruitment for the specific specialty. The applicant is entitled to travelling expenses and subsistence allowances at the appropriate rates. A candidate will not be reimbursed for more than two attendances, except that a candidate for a consultant appointment may be reimbursed up to three attendances. If an employer invites such a candidate to attend prior to shortlisting, it may reimburse the expenses provided that the candidate is subsequently shortlisted.

A junior doctor who is requested to appear before a selection board while on holiday is reimbursed for:

- travelling expenses from the holiday address, but limited to travelling expenses from the port of entry if the junior doctor is abroad, and provided they return to the holiday address after the interview. Travel from Northern Ireland, the Isle of Man and the Channel Islands is not regarded as travel from abroad, and therefore travelling expenses should be met in full
- subsistence allowances at the appropriate rate, unless the junior doctor is able to stay at home and it is reasonable to expect them to do so.

Expenses may be reimbursed for pre-interview or pre-application visits for specialty registrar appointments. The prior agreement of the prospective employer should be obtained.

Reimbursement is not made to a junior doctor who refuses the offer of an appointment as advertised on grounds which the employer considers inadequate.
Postage
Any expenditure incurred by a junior doctor in postage in the service of an employer is reimbursed by the employer.
NHS pension scheme

The NHS pension scheme compares well with other occupational pension schemes in the public and private sectors and can help doctors plan for a good standard of living in retirement. In addition to the basic pension and lump sum entitlement, there are a number of other valuable benefits including insurance and family benefits.

The benefits provided by the NHS pension scheme (NHSPS) have been under review. An Agreement has been reached by the NHS Employers and the NHS Staff Side at the Pensions Review Steering Group.

From 1 April 2008 the NHSPS will become two schemes; with new entrants joining the new NHSPS (new scheme) and existing members and deferred members who rejoin the scheme before 1 October 2008 remaining in an amended version of the current NHSPS (current scheme). Other members of the current NHSPS will not be affected by these changes unless they re-enter NHS pensionable employment after 1 April 2008.

Who can remain in the current NHSPS?
- Members in pensionable service as at 1 April 2008.
- Members in pensionable service as at 1 April 2008 who subsequently defer their benefits and then rejoin the NHSPS within five years of leaving.
- Deferred members as at 1 April 2008 who rejoin the NHSPS prior to 1 October 2008 or after 1 October 2008 but within five years of leaving Those leaving the scheme with less than two years’ service (ie no deferred benefits) and returning to the NHS within a year will have the option of which scheme they rejoin.

Who will join the new NHSPS?
- Members who join the NHSPS for the first time on or after 1 April 2008.
- Members in pensionable service as at 1 April 2008 who defer their benefits and then rejoin the NHSPS more than five years after leaving.
- Members of the current NHSPS who elect for all of their past and future service benefits be transferred to the new scheme during the choices exercise which begins in July 2009.
Full details of the changes being made to the NHSPS on 1 April 2008 can be found on the BMA website.

**Why be a member of the scheme?**
In the past, a number of people have been persuaded to opt out of their occupational pension schemes and to take out personal pension plans (PPPs) instead. Fortunately, very few doctors have chosen to do so. The BMA has taken actuarial advice on this question and it is clear that for the vast majority of doctors opting out of the NHS pension scheme would be financially unwise.

Doctors who are members of the current NHSPS or the new NHSPS will receive guaranteed final salary pension benefits at retirement.

**Contributions**
Presently the employee contribution rate is 6 per cent of superannuable income.

From 1 April 2008 pension contributions may increase dependent on the level of your income. Members of both the current NHSPS and the new NHSPS will be subject to the new agreed contribution structure shown below:

<table>
<thead>
<tr>
<th>Annual pensionable pay (Full time equivalent)</th>
<th>Current contribution</th>
<th>New contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £19,165</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>£19,166 - £63,416</td>
<td>6%</td>
<td>6.5%</td>
</tr>
<tr>
<td>£63,417 - £99,999</td>
<td>6%</td>
<td>7.5%</td>
</tr>
<tr>
<td>£100,000 plus</td>
<td>6%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Your pension contributions attract tax relief. Scheme members also pay a reduced rate of national insurance contribution (because the NHSPS is contracted out of the state earnings related pension scheme, SERPS).
The real cost is considerably less than 6 per cent as the following example of an SHO on the third point of the scale in 2003 shows:

<table>
<thead>
<tr>
<th></th>
<th>Non member</th>
<th>Scheme member</th>
<th>Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic salary</td>
<td>27,150</td>
<td>27,150</td>
<td>-</td>
</tr>
<tr>
<td>Banding supplement</td>
<td>21,720</td>
<td>21,720</td>
<td>-</td>
</tr>
<tr>
<td>(assumed band 2A [80%])</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total salary</td>
<td>48,870</td>
<td>48,870</td>
<td></td>
</tr>
<tr>
<td>Tax</td>
<td>11,977</td>
<td>11,325</td>
<td>652</td>
</tr>
<tr>
<td>NI</td>
<td>3,075</td>
<td>2,654</td>
<td>421</td>
</tr>
<tr>
<td>Net salary</td>
<td>33,818</td>
<td>34,891</td>
<td>1,073</td>
</tr>
<tr>
<td>Employee’s contribution</td>
<td></td>
<td>1,629</td>
<td>-1,629</td>
</tr>
<tr>
<td>(6% of £27,150)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saving on tax and NI</td>
<td></td>
<td>1,073</td>
<td></td>
</tr>
<tr>
<td>Real cost</td>
<td></td>
<td>-556</td>
<td></td>
</tr>
<tr>
<td>Real cost as % of basic salary</td>
<td></td>
<td>2.05</td>
<td></td>
</tr>
</tbody>
</table>

NB Based on salary, tax and national insurance rates applicable from April 2003

The employer contribution is 14 per cent of salary in England, Wales, and Scotland and 7 per cent in Northern Ireland.

**Pensionable income**
This includes basic salary, London weighting allowance and domiciliary consultation fees. It does not include pay supplements beyond whole-time basic salary (1.0), temporary additional NHDs or income above the earnings cap (£112,800 for 2007/08) for doctors who joined the NHS after 1 June 1989.
On retirement, pensionable salary will be the notional whole-time salary rate for the position (part-time working is ignored) during the best of the last three years. In most cases this will mean the salary rate applicable during the last 12 months of service. This method will continue to apply to members of the current NHSPS (as amended).

For members of the new NHSPS, pensionable salary is the best three years consecutive average pensionable pay years, in the last 10 years.

**Pensionable service**

The period actually worked in the NHS will count as reckonable service, irrespective of whether it was whole time or part time. Reckonable service is used for a number of calculations, including the following:

- maximum service limits (40 years at age 60; 45 years at age 65 and in total)
- number of added years which can be purchased (see below).

In calculating pension, any part-time working must be scaled down to its whole-time equivalent, eg 10 years working an 8/10 contract would result in eight years’ scaled service.

From 1 April 2008 the current service limits detailed above will be replaced with a new service limit of 45 years.

**Calculation of pension**

The two essential elements in calculating pension are pensionable salary and scaled service.

For member of the current NHSPS (as amended), the formula used is as follows:

\[
\text{Pension} = \frac{\text{scaled service}}{80} \times \text{pensionable salary}
\]

A consultant retiring with 35 years’ scaled service would have pension calculated as follows:
Pension = \frac{35}{80} \times £78,097 = £34,166

For members of the new NHSPS, the formula used is as follows:

Pension = \frac{\text{scaled service}}{60} \times \text{pensionable salary}

A consultant retiring with 35 years’ scaled service would have pension calculated as follows:

Pension = \frac{35}{60} \times £78,097 = £45,556

The method of calculating a general practitioner’s pension is different. Details can be found in the BMA factsheet entitled General practitioners.

**Index linked pensions**

NHS pensions in payment are increased in April each year in line with the Retail Prices Index (RPI).

**Lump sum**

For members of the current NHSPS (as amended) the lump sum is automatically provided and for most doctors is three times the pension (or \frac{3}{80} of pensionable salary for each year of service). The lump sum is tax free. In the example above, the lump sum would be as follows:

\[ £34,166 \times 3 = £102,498 \]

For married male doctors with service before 25 March 1972, and for female doctors who opted for a bigger widower’s pension, the lump sum will be less than three times pension. The BMA’s NHS pension scheme: an overview gives details.

For members of the new NHSPS no lump sum is automatically provided. Members are not required to take any lump sum but they can choose how much lump sum they wish to take up to the limits permitted by the Inland Revenue for tax free lump sums. This will be achieved by the commutation of £1 of annual pension to provide £12 of tax free lump sum.
Retirement age
Normal retirement age in the current NHSPS is age 60 and at that age any doctor may retire and claim the pension. However, it is possible to stay in the scheme up to age 65 and even beyond then, up to age 70, if a contract is extended (subject to a maximum of 45 years in total in the scheme).

Doctors who remain in the current NHSPS (as amended) will retain their normal pension age of 60.

Doctors who are members of the new NHSPS will have a normal pension age of 65.

After 1 April 2008 members of both schemes will be able to continue in the NHSPS until age 75.

Early retirement
A number of options are available.

• Voluntary early retirement
Doctors in the current NHSPS may retire from age 50 with an actuarially reduced pension and lump sum. Doctors who remain in the current NHSPS (as amended) and satisfy certain qualifying conditions will retain the current minimum pension age of 50. All other doctors will move to a minimum pension age of 55 on 6 April 2010.

Doctors who are members of the new NHSPS may retire from age 55 with an actuarially reduced pension.

Voluntary early retirement without actuarial reduction is possible if the employer is willing to pay for the extra cost involved.

• Redundancy or organisational change
Early retirement with an enhanced pension may be possible in these circumstances from age 50 onwards. Redundancy arrangements in the NHS have been reviewed and doctors who are made redundant after 1 October 2006 will be subject to the revised redundancy procedures.
Details of these arrangements can be found in the BMA factsheet entitled *Redundancy* which can be found on the BMA website.

- **Ill health retirement**
  For doctors permanently incapable of carrying out their duties as a result of ill health, an enhanced ill health pension and lump sum may be payable.

  There is a review into the ill health retirement process which will affect members of the current NHSPS (as amended) and the new NHSPS. Details of this review can be found on the BMA website at www.bma.org.uk/pensions These changes are due to be implemented on 1 April 2008.

**Breaks in service**
Doctors who work or study abroad for a period or have a break in service for any other reason will need to consider their pension position. If they have been in the NHS scheme for less than two years, and have a break of more than one year, then a refund of contributions is normally payable. This should be avoided if at all possible because pension entitlement accrued to date will be lost and the refund will be significantly reduced by taxation and the need to repay national insurance contributions. There are a number of possible ways of avoiding a refund. Please see the BMA factsheet entitled *Leaving the NHS* for further information.

Doctors with more than two years in the NHS scheme cannot take a refund and will have a preserved benefit in the scheme. If eligible they may therefore wish to consider buying additional service in the scheme to make up for time lost as a result of a break in service (see below).

**Additional benefits**
There are a number of methods available to increase the benefits payable under the NHS pension scheme.
Added years – this facility is being withdrawn from the NHPS from 1 April 2008

By paying extra contributions it is possible to buy added years in the NHS scheme so that the maximum service entitlement has been achieved by age 60 (or age 65). This is particularly useful for doctors because they do not qualify until at least age 23 and therefore cannot achieve 40 years at age 60 without buying extra years.

Added years produce benefits in exactly the same format as the scheme generally, ie an extra index linked pension and a tax free lump sum of three times that extra pension.

Existing added years contracts will be honoured for doctors who remain in the current NHPS (as amended).

Doctors who do not currently have a contract to buy added years must elect by 31 March 2008 and contributions will commence on the doctor’s next birthday in 2008/09.

Doctors who are members of the new NHPS will not be able to purchase added years and doctors who were previously members of the current NHPS who transfer all their membership to the new NHPS will not be able to complete their added years contracts.

After 1 April 2008 members of both the current NHPS (as amended) and the new NHPS will be able to access an additional pension purchase facility to ‘buy’ up to £5,000 per annum of additional pension.

Members of the current NHPS (as amended) will be able to buy additional pension to be taken without reduction at age 60.

Members of the new NHPS will be able to buy additional pension to be taken without reduction at age 65.
**Additional voluntary contributions (AVCs)/Free standing additional voluntary contributions (FSAVCs)**

AVCs/FSAVCs are money purchase arrangements. This means that the extra contributions paid are invested and, at retirement, will produce a sum of money which is used to purchase extra pension (in the form of an annuity). The benefits will depend upon the success of the investment and the interest rates prevailing at retirement (which affect the cost of an annuity).

AVCs are an in-house scheme organised by the NHSPS with Equitable life, Prudential and Standard Life (however Prudential is not available to doctors in Scotland or Northern Ireland). Because this is an in-house arrangement, administrative charges are likely to be lower than for an FSAVC as no commission is payable.

FSAVCs may be purchased from a company of your choice. The BMA has concerns about the way in which FSAVCs are marketed, particularly to junior doctors. Please take care and contact BMA Pensions if you are concerned that you may have been mis-sold an FSAVC.

From 6 April 2006 you are allowed to pay up to 100 per cent of your annual pay into tax effective pension arrangements providing you do not exceed Inland Revenue limits. The tax simplification regulations also permit you to take up to 25 per cent of your AVC/FSAVC fund as tax-free cash.

**Unreduced lump sum**

Any doctors who would not otherwise receive the full lump sum (eg married male doctors with service before 1972) may pay extra contributions in order to purchase the unreduced lump sum and thereby ensure that their lump sum is three times pension.

**Contribution limits**

In addition to the basic NHS scheme contribution of 6 per cent of salary, it is possible to pay up to 9 per cent in extra contributions to purchase additional benefits, making 15 per cent of salary in total. Tax relief is provided on the full 15 per cent.
From 1 April 2008 the current contribution limit of 15 per cent is being removed from the NHSPS. Members of both the current NHSPS (as amended) and the new NHSPS will be able to receive full tax relief on pension contributions to the NHSPS up to 100 per cent of their NHS pensionable income.

**Personal pensions/stakeholder pensions**
Any private income can be pensioned separately in the form of a personal pension plan, or a stakeholder pension arrangement.

**Choice of additional benefits**
The BMA factsheet *Improving benefits* provides additional details on the choices available. Having read that, if still in doubt, doctors may wish to seek independent financial advice.

**Mental health officer (MHO) status**
Prior to 6 March 1995 (1 April 1995 in Scotland and Northern Ireland), MHO status was granted to whole-time or maximum part-time doctors who spent the whole or substantially the whole of their time caring for mentally disturbed people.

After 20 years as an MHO, each year thereafter counts as double for pension purposes and it is possible to retire at age 55.

Following legal action by the BMA, MHO status was extended to part-time doctors, backdated to 1976, provided they met the usual criteria. The BMA factsheet Salaried doctors provides details.

MHO status was withdrawn on 6 March 1995, but is retained by doctors who had it at that time.

MHO status is being protected for members of the current NHSPS who remain in the current NHSPS (as amended).
Family benefits
After 1 April 2008 dependents benefits will be payable to married partner, a registered civil partners or to a nominated partner. Please refer to the BMA factsheet entitled Death benefits for further information.

Further advice
There are many other changes to the NHSPS on 1 April 2008. Some of these changes affect both schemes and others are specific to one particular arrangement. Full details of the changes are available from BMA Pensions and can be found on the BMA website at www.bma.org.uk/pensions.

Further advice on the NHS pension scheme can be obtained from the following bodies which are responsible for administering the scheme:

England and Wales
NHS Pensions Agency
Hesketh House
200-220 Broadway
Fleetwood, Lancashire
FY7 8LG
Tel: 01253 774774
www.nhspa.gov.uk

Scotland
Scottish Public Pensions Agency
7 Tweeside Park
Galashiels
TD1 3TE
Tel: 01896 893100
www.sppa.gov.uk
Northern Ireland
Health and Personal Social Services
Superannuation Branch
Waterside House
75 Duke Street
Waterside, Londonderry
BT47 6FP
Tel: 01504 319000
www.dhsspsni.gov.uk

Easy to read leaflets on the scheme are available from these authorities or the employer or health authority/board.

Occupational pension schemes, such as the NHS scheme, are required to provide members with benefit statements upon request (no more than once a year).

Doctors who wish to obtain an estimate of their pension should write to their in the first instance, or direct to the NHS Pensions Agency or equivalent in Scotland or Northern Ireland (see above). Members should give details of their date of birth and national insurance number. They should also ask for a full service record (and dynamising sheet for general practitioners) and check it carefully upon receipt.

If there are any problems or difficulties with the estimate provided, members should contact BMA Pensions at BMA House on 020 7387 4499.

The BMA produces a number of factsheets on the NHS pension scheme in addition to those mentioned above, which are available from our team of advisers on 0870 60 60 828 (some are also on the BMA website). Individual advice on occupational pension schemes can be obtained from BMA Pensions at BMA House.

The BMA is not registered under the Financial Services Act and therefore cannot provide financial advice.
Tax for junior doctors
The following factsheets are available from the BMA and on the BMA website:

- Tax for the newly qualified doctor
- Income tax and the employed doctor
- Income tax and partnerships
- Income tax for general practitioners
- Income tax for consultants
- Capital gains tax
- Personal pensions
- National Insurance contributions

Frequently asked questions on the existing and new NHS pension schemes (after 1 April 2008)

Introduction
These FAQs are intended to address queries that are often put to us by members. Throughout the FAQs reference is made to the ‘existing’ and ‘new’ NHS pension scheme. The existing NHSPS applies to anyone who is a contributing member of the scheme before 1 April 2008 and in some cases current deferred members of the scheme.

Anyone who joins the NHSPS for the first time after 1 April 2008 will join the new NHSPS.

If you require any further information then please refer to the guidance which can be found at www.bma.org.uk/pensions or contact BMA Pensions on 0207 383 6138.

How is my pension calculated?
If you are a GP then your pension benefits are based on your total career dynamised income. Each year a record of your pensionable income is sent to the NHS Pensions Agency and the total of this pensionable income at retirement is the basis for the calculation of your pension. In order to increase previous years’ income to ensure that it
does not devalue for pensions purposes the income is increased by the dynamising factor. The dynamising factor has two roles. Firstly, it increases the previous year’s income by that factor. So if the dynamising factor for a certain year were 5 per cent then the previous year’s income would be increased by 5 per cent for pensions purposes. The second role of the dynamising factor is to increase all the previous years’ dynamising factors. So if the dynamising factor for a particular year is 5 per cent then it increases all the previous years’ dynamising factors by 5 per cent. These increased dynamised factors are applied to the actual earnings from that year and so all previous years’ pensionable income is constantly uprated. The dynamising factor has had several methods of calculation and until 31 March 2008 it will be based on the percentage annual increase in the GP profession’s income (please refer to the separate FAQ below for more information on the imposed cap and judicial review application). After 1 April 2008 the dynamising factor will be based on the RPI plus 1.5 per cent. When you get to retirement your total career dynamised income is multiplied by 1.4 per cent to calculate your pension and by 4.2 per cent to calculate your lump sum.

If you are a salaried doctor (NB not a salaried GP) then your pension is based on a final salary method of calculation. For each year of service that you have in the scheme you accrue 1/80th of your final pensionable pay as pension. So for example if when you come to retire you have 30 years of service and your final pensionable pay is £75,000 then your pension will be calculated as being $30/80 \times \£75,000 = \£28,125$. It is important to note that whilst the whole-time equivalent salary is always used for the calculation of your benefits, working part time will mean that you accrue less service than you would do if you worked whole time. For example, if you work half time for 10 years then at the end of that 10-year period you would have accrued five scaled years.

**How is my final pensionable pay calculated?**

For members of the existing NHS pension scheme final pensionable pay is calculated as being the best of the last three years’ notional whole-time pay. On retirement the Pensions Agency will count back three calendar years and the best 12-month period (generally the last 12
months) will be used for the calculation of final pensionable pay. Part
time doctors or doctors who switch from working full time to part time
close to retirement should note that it is always the notional whole-time
pay figure which is used in the calculation of their benefits. Therefore
regardless of whether you are doing one Programmed Activity or 10, the
same whole-time equivalent pay figure is used.

For members of the new scheme final pensionable pay is calculated as
being the average of the best three consecutive years in the last 10.
Points about whole-time equivalent explained above will still apply.
Doctors should also note that the three years of salary which are the
best consecutive in the last 10 will be increased in line with RPI.

General practitioners should note that their benefits are based on their
total career income and therefore final salary does not apply.

How is my tax free lump sum calculated?
For most doctors retiring from the existing NHS pension scheme the tax
free lump sum will simply be three times the annual pension. The tax
free lump sum is paid at the same time as the first pension payment and
is always tax free. There are two exceptions to the lump sum being three
times the pension.

The first is where a male member has service in the scheme prior to 25
March 1972 and is, or ever has been married. In this instance a lump
sum of one times the pension is accrued in respect of service prior to
this date. Normal retirement lump sum accrual of three times pension
applies after this date. The second exception concerns female members
who opted to take a smaller lump sum in respect of widowers’ benefits
based on service prior to 6 April 1988. This is an extremely rare
occurrence and female doctors who took this option should either refer
to the BMA’s factsheet entitled Salaried doctors or should contact BMA
Pensions for further information.
Doctors retiring from the new NHS pension scheme should note that due to the higher rate of accrual no automatic lump sum is payable on retirement. Instead, doctors have flexibility in commuting part of their pension for a lump sum of up to 25 per cent of the pension value at the commutation rate of £12 of lump sum for every £1 of pension. Please see the separate FAQ on taking a larger tax free lump sum after 1 April 2008.

How do you commute part of your pension in exchange for a bigger lump sum after 1 April 2008?

It will be possible for anyone retiring after 1 April 2008, from either scheme, to commute part of their pension in exchange for a tax free lump sum up to the maximum of 25 per cent of their pension value.

The calculations behind this are quite complex but essentially the extra lump sum that you can take from the current scheme (on top of the automatic lump sum payable at retirement) is 33/14 x the annual rate of the pension.

The new NHS pension scheme does not provide an automatic tax free lump sum. Members of the new scheme will therefore have the opportunity to commute part of their pension for a lump sum of up to 25 per cent of the pension value as described above or take no lump sum at all as they wish.

The maximum lump sum available from the new scheme is approximately 5.36 x the annual rate of the pension.

Please go to www.bma.org.uk/ap.nsf/Content/FlexTxFrLS for a lump sum calculator.
What happens if I work past the normal pension age of 60 in the existing NHS pension scheme?
Doctors who work past the normal retirement age of 60 in the NHS pension scheme will simply continue to accrue normal benefits, that is to say that there is no further enhancement to benefits if you work beyond the normal pension age. Please note that it is not possible to accrue more than 40 calendar years service at 60 or more. Please note that after 1 April 2008 it will be possible to accrue a maximum of 45 calendar years service at any age.

How do I apply for added years?
You should in the first instance approach the pensions officer at your Trust or PCT and request an added years quotation. The added years quotation will tell you exactly how many added years you can buy and at what cost. The pensions officer is generally found in the HR or payroll department. If you decide that you wish to proceed with the purchase of added years then you should return the application form for buying added years to the pensions officer and they will liaise with the NHS Pensions Agency on your behalf. Please note that new added years contracts will not be able to be taken out after 1 April 2008. However, all doctors have the opportunity to buy added years between 1 April 2008 and 31 March 2009. If you wish to do this, then you must send your completed added years application form to the NHS Pensions Agency via your pensions officer so that they receive this by 31 March 2008. The added years contract will then begin on your birthday between 1 April 2008 and 31 March 2009.

How do added years increase my benefits?
If you are a GP then the benefit of added years is based on your average annual dynamised income during the period that you purchase the added years. For example if you were to begin buying five added years from age 40 to age 60 and your average dynamised income during this period was £100,000 then the benefit of the added years would be $5 \times £100,000 = £500,000 \times 1.4\% = £7,000$ per annum. Additionally, you would receive a tax free lump sum of three times the additional pension amount provided by added years. The value of added years is
therefore based entirely on income for GPs regardless of FT or PT work. If you are a salaried doctor then buying one added year is exactly the same as working for one year in the NHS pension scheme. Every added year that you buy will provide you with an extra 1/80th of your final pensionable pay as pension and 3/80ths of your final pensionable pay as tax free lump sum. If you work part time then this will reduce the value of the added years that you purchase. For example if you are working half time throughout the period that you buy added years then you would pay half the contribution that someone who is working whole time would pay and you are credited with half of the purchase. There is no way of buying added years to bridge the gap between part-time and full-time work.

**Are added years good value?**

Added years are seen by independent financial advisers as generally being a secure benefit. However please note that BMA Pensions is unable to provide independent financial advice and as such the decision on whether you should buy added years or improve your benefits in any other way should be made following consultation with a suitable independent financial adviser. You may wish to contact BMA Services, who are the BMA’s independent financial advisers and deal only with BMA members. If you wish to be put in contact with a BMA Services adviser then you should call 0845 609 2008.

**What will replace added years after 1 April 2008?**

New added years contracts will not be able to be taken out after 1 April 2008 except where an application to do so has been received by the NHS Pensions Agency prior to 31 March 2008. After 31 March 2008 it will be possible for members to pay additional contributions and secure extra blocks of annual pension at retirement. These blocks will be available in £250 units of annual pension and it will be possible to increase your annual pension by up to £5,000 per year. Please note that the value of the additional pension purchased will increase in line with inflation each year. Details on how to make the additional pension purchase have not yet been publicised and will be made available on the BMA website in due course.
What happens to the added years that I am buying if I transfer to the new scheme?

Added years will not be a feature of the new NHS pension scheme and therefore any doctor who wishes to transfer to the new scheme during the choice exercise between July 2009 and June 2010 will have to transfer their added years to the new scheme in the form of a service credit. It will not be possible to continue paying added years in the new scheme. Therefore, doctors who wish to complete their added years purchase must, by definition, remain in the existing NHS pension scheme.

What is the maximum amount of service that I can accrue in the scheme?

At present the maximum amount of service that you can accrue at age 60 is 40 calendar years and at age 65 and thereafter it is 45 calendar years. The exception to this rule is if you have MHO status (see separate FAQ). From 1 April 2008 it will be possible for members of both existing and new schemes to accrue the maximum of 45 calendar years at any age. Please note however that that it is not possible to buy added years that would mean that you exceeded the maximum service levels that are currently in place.

What is the earliest age at which I can retire?

Members of the existing NHS pension scheme, provided that they were in service on 5 April 2006 will retain the right to take voluntary early retirement from age 50 onwards. The minimum age for voluntary early retirement increases to 55 in the new scheme. Doctors who are forced to retire on ill health grounds may retire at any age if their application is accepted. Please note that pension and lump sum benefits on voluntary early retirement are actuarially reduced to reflect the fact that they have come into payment prior to the normal pension age.

Can I rejoin the NHS pension scheme or return to work after retirement?

Members of the existing NHS pension scheme should note that the only situation where they can rejoin the NHS pension scheme following retirement is on returning to work after ill health retirement under the age of 50. For existing scheme members there is the opportunity to pay
into a personal pension in respect of earnings received on returning to work after retirement should they wish.

Members who retire from the existing NHS pension scheme prior to the choice exercise in July 2009 may exercise pensionable re-employment in the new NHS pension scheme after a two-year period.

Members of the new NHS pension scheme are able to rejoin the scheme on return to work after retirement.

**What are the restrictions on returning to work after retirement?**

Doctors are able to return to work after retirement provided that they firstly take a 24-hour break in service and secondly do not work any more than 16 hours per week for the first calendar month following re-employment. At the end of this period there is no limit on earnings or pension (assuming that the doctor is age 60 or over or retiring on voluntary early retirement grounds with actuarially reduced benefits) although doctors may wish to consider the tax implications.

Abatement (which used to apply more widely and is the reduction in pension if earnings plus pension on re-employment exceed pre-retirement earnings) is now only applied to the benefits of doctors who return to work following retirement on the grounds of ill health or redundancy. It also applies to mental health officers returning to work before age 60. Even in these situations abatement can only apply until age 60.

Doctors who do return to work after ill health or redundancy retirement should obtain what is known as their ‘earnings margin figure’ from Paymaster (who are responsible for the payment of pensions). This is the amount that doctors may earn before their benefits are abated. Doctors who do not take the necessary break in service of 24 hours (or one month if they wish to return to full time work immediately) will have their pension benefits suspended until they have taken the necessary break.
What is abatement?
Abatement is the reduction of pension on return to work if earnings plus pension exceed pre-retirement earnings. For example if a doctor were to retire with a pensionable salary of £80,000 and then receive a pension of £40,000 then they would be able to earn up to an extra £40,000 on re-employment. Please note abatement only applies to doctor who return to work after ill health retirement or retirement on the grounds of redundancy. Additionally, doctors with MHO status who retire between the age of 55 and 60 and then return to work prior to age 60 would also potentially be affected by abatement.

What benefits are payable to my family if I die?
A death gratuity is payable on the death of a member of the NHS pension scheme and represents twice actual annual salary, or for practitioners twice annual average dynamised earnings. This applies to members of the existing and new pension schemes. One slight difference with regard to the existing and new NHS pension schemes are that members of the existing scheme are only able to nominate one person to receive this benefit; however the default position is that the legally married husband or wife or civil partner is the default payee. After 1 April 2008 members will be able to nominate more than one beneficiary should they wish.

Benefits are also payable to the legally married husband, wife or civil partner on the death of a member of the existing NHS pension scheme. The benefits are 50 per cent of the notional ill health retirement benefits that would have been payable to the member on the date of death. In this instance the NHS Pensions Agency will undertake a notional calculation of the enhanced ill health retirement benefits and 50 per cent of these will be payable to the legally married husband or wife or civil partner. Please note that in respect of spouse’s benefits payable from the existing NHS pension scheme prior to 1 April 2008 these benefits will stop if the spouse subsequently remarries or cohabits with another partner.
The dependants benefits payable are essentially calculated in the same way, regardless of which scheme you are in, as the enhanced accrual in the new scheme does not affect dependants benefits. These will still be calculated as per the existing scheme rules.

What benefits are payable to me if I have to retire on health grounds? If you are retiring on health grounds from the existing pension scheme then you will usually expect to receive an enhanced pension and lump sum. The size of the pension and enhancement depends upon your age and length of service. Pensions cannot be enhanced beyond the age of normal retirement age of 60. Ill health retirement is granted if medical evidence can be provided to prove that you are permanently incapable of undertaking your current job due to an illness of body or mind. In order to apply for ill health retirement it is necessary to obtain the form AW33E from your Trust or PCT pensions officer and to enclose a report from the consultant and/or GP who have been treating you. If you require any assistance in applying for ill health retirement then please contact BMA Pensions.

Please also see the separate FAQ on proposed changes to the NHS pension scheme from 1 April 2008.

**How do I apply for ill health retirement?**

If you wish to apply for ill health retirement you should request the form AW33E from the Trust or PCT’s pensions officer. We would also suggest that you enclose medical evidence in the form of a report from the consultant and/or GP who has treated you. The current rules on ill health retirement require you to prove that you are permanently incapable of undertaking your current job due to your illness. ‘Permanently incapable’ means up to the normal retirement age of 60.

If your ill health retirement application is turned down you have several opportunities to appeal and BMA Pensions would be happy to assist in this process.

Please also refer to the FAQ below regarding the review of the ill health retirement scheme.
What is happening to ill health retirement benefits?
There has recently been a review of ill health retirement benefits in the NHS pension scheme as part of the overall pension scheme review. In order to fund the continuation of the existing benefits in the NHS pension scheme it was necessary for the ill health retirement review to provide some cost savings and this is reflected to an extent by the proposals. The consultation period on ill health retirement proposals runs until January 2007 and BMA urges members to look at the consultation document and provide comments to the dedicated email address info.ihreview@bma.org.uk The consultation document can be found here www.bma.org.uk/pensions

What happens if I am made redundant?
If you are made redundant and you are under age 50 then you may be eligible to receive a compensation payment which will depend upon your length of service. If you are over aged 50 then it may be possible for you to received an enhanced pension under the transitional arrangements or under the new arrangements to use part of your compensation payment to pay for the actuarial reduction to your pension. If you are under threat of redundancy then you should in the first instance contact our team of advisers on 0870 60 60 828. For assistance regarding the pension element of redundancy then please contact BMA Pensions.

I am deferred member of the NHS pension scheme; can I re-join the existing scheme on re-employment in the NHS?
Deferred members of the NHS pension scheme as at 1 April 2008 can rejoin the existing NHS pension scheme provided that they take up an NHS pensionable post prior to 30 September 2008, regardless of when they last worked in the NHS.

Deferred members who rejoin after 1 October 2008 can rejoin the existing NHS pension scheme provided they take up an NHS pensionable post within five years of last working in the NHS. Deferred members who fall outside of these two categories will be compelled to join the new NHS pension scheme.
What will the contribution rates increase to after 1 April 2008?

Contribution rates will increase in both schemes from 1 April 2008. The rates of contribution are tiered and will depend upon earnings:

- Up to £19,165: 5.0%
- £19,166 - £63,416: 6.5%
- £63,417 - £99,999: 7.5%
- £100,000 +: 8.5%

The tiered contribution rates are not graduated, in the same way as for example, income tax. This means that a doctor earning £99,999 will pay 7.5 per cent on their whole salary and a doctor earning £100,000 will pay 8.5 per cent on their whole salary. The staff side negotiators did look at a graduated system but the rates of the top tiers would have gone in to double figures and we did not feel that this would be acceptable to members. An increase in contributions is never a popular change to the scheme rules however this was necessary to maintain the benefits of the scheme at the current level and to retain the normal pension age of 60 in the current scheme. The BMA feels that the scheme still offers excellent benefits to members.

Due to the fact that pension contributions are tax-free, even an increase from 6 per cent to 8.5 per cent is only a net increase of 1.5 per cent (£1,500pa to a doctor earning £100,000pa).

What are the interim arrangements for tiered contributions in 2008/09?

Due to the size of the task and the short timescale involved it will not be possible to implement the tiered contribution system in full from 1 April 2008, this will not be introduced until 1 April 2009.

For the first year (2008/09) doctors will be allocated to a tier based on previous year’s earnings. For salaried/hospital doctors this will be based on their earnings from 2007/08 and for GPs, 2006/07.
While there will be some winners and losers on the periphery most doctors will find that they have been allocated to the appropriate tier. It is important to note that there will be no balancing at the end of this period – contributions will stand, regardless of pay increases or reductions during 2008/09.

**How do the contributions apply to part-time doctors?**
If you are a salaried/hospital doctor then you will be allocated to a tier based on whole-time equivalent pay. This is because benefits at retirement are also based on whole-time equivalent pay.

There is no concept of whole-time equivalent pay for GPs and their tier will be allocated according to actual earnings (in the same way as their pension benefits are).

**Aren’t doctors essentially paying for the benefits of the lower paid under this system?**
The actuarial valuations showed that those employees with higher pay progression through their careers receive much better value for their contributions than groups with a flatter pay progression. This is due to pensions being based on final earnings and contributions having been paid on comparatively much lower levels of pay in the earlier years of employment. Because the NHS is a mutually funded scheme employees pay the same rate of contributions as a percentage of pay, currently 6 per cent but this does not reflect the differential gains that are achieved. In essence there is a cross subsidy between the lower paid and the higher paid at the moment. Because the employers pick up around two-thirds of the cost it is not as simple as saying that nurses pay for doctors’ pensions but this is the underlying principal. The proposed tiers do not reverse or completely remove this but they do reduce the extent of the subsidy.
GPs don’t get final salary pensions though. Why should they pay the higher rates?
It is true that tiered contributions are perhaps less appropriate in a career average scheme such as the one which applies to GPs. However, the actuaries have calculated that to provide GPs (and dentists) with a scheme that is comparable to salaried/hospital doctor colleagues, the contributions required are also broadly the same.

What is the earnings cap?
The earnings cap applies to anyone who joined a pension scheme after 1 June 1989. Anyone affected by the earnings cap will have their pensionable pay capped at the level that applies in each tax year. This means that the salary on which pension contributions can be deducted are capped, as is the final salary on which benefits can be based. The earnings cap for the tax year 2007/08 is £112,800. From 1 April 2008 the earnings cap will be removed in respect of benefits accrued after that date. Benefits that were capped between the period 1 June 1989 and 31 March 2008 will remain capped.

What is the lifetime allowance?
The Finance Act 2006 brought in legislation that limited the total value of pension scheme benefits. The initial limit to the value of lifetime benefits was set at £1.5 million and this increases annually. The pension is valued by multiplying its annual rate by 20 and adding the lump sum. For example somebody retiring with a pension of £50,000 per year would have the value of their lifetime benefits calculated as being £1.15 million. For doctors who exceed the lifetime limit penalties and taxation charges can apply unless steps have been taken to protect the excess benefits using either primary or enhanced protection. Initially only doctors with very large amount of service allied with high salaries in the NHS will exceed the lifetime limit based solely on their pension benefits. However doctors with substantial private practice should note that the fund value of personal pensions as well as additional voluntary contributions, and free standing additional voluntary contributions are also included in the valuation. Any doctor concerned that they may be exceeding the limit should take independent financial advice.
What is the current situation regarding dynamising factors?
Lord Warner wrote to the Chairman of the GPC in December 2006 advising the Chairman of GPC that the Government had decided to renge on its agreement with GPs contained in the GMS contract. Under the contract dynamising factors were to be based on the percentage annual increase in the GP profession’s profits. However, Lord Warner announced that these increases to dynamising factors would be capped as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
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<tbody>
<tr>
<td>2003/4</td>
<td>12.9%</td>
</tr>
<tr>
<td>2004/5</td>
<td>6.9%</td>
</tr>
<tr>
<td>2005/6</td>
<td>7.3%</td>
</tr>
<tr>
<td>2006/7</td>
<td>6.9%</td>
</tr>
<tr>
<td>2007/8</td>
<td>6.9%</td>
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The BMA felt that this was extremely unfair as GPs had signed a contract expecting their pension benefits to be increased by the method explained in that contract. In order to represent our GP members, the BMA applied for and have received permission for a judicial review of Lord Warner’s decision. This judicial review will be heard in the early part of 2008 and further updates will be published on the BMA website when they become available.

I am a GP, how long will I have to wait to receive payment of arrears of my pension and lump sum?
Some GPs who retired between 2004 and 2006 have yet to have their pension benefits paid based on the latest dynamising factors. The BMA continues to liaise with the NHS Pensions Agency on this issue and the Pensions Agency are confident that all arrears of what they refer to as ‘GP sub-awards’ will be completed by 31 March 2008.

Will the changes to the NHS pension scheme affect me?
The answer to this question depends on whether you are already a member of the NHS pension scheme or whether you are going to join for the first time after 1 April 2008 (or following a long break in service). Anyone who is a contributory member of the NHS pension scheme and
is in service prior to 1 April 2008 will be able to remain in the existing NHS pension scheme but should note that certain amendments will apply to this scheme. New joiners after 1 April 2008 will have to join a new NHS pension scheme with different rules and regulations. Deferred members of the scheme (those members who have previously worked in the NHS and have a preserved pension within the scheme) are able to rejoin the existing NHS pension scheme as long as they take up an NHS pensionable post prior to 30 September 2008. If they return to NHS pensionable re-employment after 1 October 2008 then they can only rejoin the existing NHS pension scheme if their break in service has been for less than five years. After this time rejoiners will be compelled to join the new NHS pension scheme. There is a large volume of information on the existing and new NHS pension schemes on our website www.bma.org.uk/pensions

How do I transfer to the new NHS pension scheme?
All members of the existing NHS pension scheme will be able to transfer to the new pension scheme between 1 July 2009 and 30 June 2010. Please note that if you do transfer over to the new scheme then all of your benefits will be transferred and there will no option to reverse this decision. The transfer basis has not yet been agreed or announced but it is likely that the transfer will be done on a cost neutral basis, in other words the value of your benefits in the existing scheme will be replicated in the new scheme. It is important to note that there are a number of differences between the two schemes, in particular the normal retirement age of the existing scheme is 60 but has increased to age 65 in the new scheme. Similarly, there are differences in the accrual rate which increases to 1/60th of final salary per year of service for salaried doctors and 1.87 per cent of total career earnings for general practitioners. There is no automatic lump sum from the new NHS pension scheme; instead members will have the flexibility to give up part of their pension for a lump sum of 25 per cent of the pension value. Doctors may wish to consider taking independent financial advice before making a decision on whether or not to transfer to the new scheme from the existing scheme.
Should I transfer to the new scheme from the existing scheme between July 2009 and June 2010?

BMA Pensions cannot provide financial advice and therefore you should refer to an independent financial adviser for assistance in making decisions on whether to transfer. BMA Services offers such advice to members and can be reached on telephone number 0845 609 2008.

The new NHS pension scheme looks better than the existing one because the accrual rate is higher.

It is true to say that the accrual rates in the new NHS pension scheme are higher than in the existing scheme. The accrual rate for salaried doctors in the existing scheme is 1/80th of final salary per year of service and in the new scheme it is 1/60th of final salary for each year of service. For general practitioners in the existing scheme their pension is based on 1.4 per cent of total career dynamised earnings and in the new scheme this will increase to 1.87 per cent. However whilst the accrual rates themselves are higher it should be noted that the normal retirement age in the new scheme is 65 rather than 60 as is in the case in the current scheme. Doctors who retire voluntarily prior to the age of 65 in the new scheme will have their pension and lump sum actuarially reduced to reflect the fact that it is coming into payment prior to the intended age. In addition, the new scheme does not offer an automatic lump sum on retirement. Annual pension has to be given up (commuted at a rate of £1 pension for £12 of lump sum) if a lump sum is to be taken. Please see the FAQ below for more information.

Should I retire now or after 1 April 2008 and what difference will this make?

Some doctors may wish to delay their retirement slightly in order to take advantage of the option to commute part of their pension for extra tax free lump sum. It will also be possible after 1 April 2008 to protect your pension benefits if you are stepping down from a higher paid job to a lower paid job. This does not include changing to a part time post as pension benefits are always based on the whole-time equivalent salary. If for example you were to step down from being a consultant and to take
up post as a associate specialist then you are able to protect the pension benefit earned in the higher paid post and to continue to accrue pension benefits in the lower paid post. It should also be noted that pension scheme contributions will increase from 1 April 2008.

I have MHO status, what does this mean and will the changes on 1 April 2008 affect this?

MHO status is a benefit which applies to doctors who work in the field of psychiatry and took up their post prior to 25 March 1995. It only applies to posts where the doctors spent substantially all of their time in the care of mental health patients. The benefits of MHO status are that after 20 calendar years spent working as a MHO there is the option to retire with unreduced benefits from the age of 55 and also every complete year worked after 20 years doubles for pension purposes. For this reason, it is possible for MHOs to accrued a maximum of 40 calendar years at age 55 and 45 calendar years at age 58.

MHO status has been preserved for existing MHOs after 1 April 2008. The benefits will continue to apply in exactly the same way as they do now.
BMA website – www.bma.org.uk

The BMA website provides all the latest information on professional issues, with continually updated news summaries and BMA press releases. It can be used generally as a comprehensive source of information and also provides specific services to all BMA members. The dedicated junior doctors’ section of the website includes feedback on the latest developments in JDC issues and activity. JDC reports, including this handbook, and are posted along with guidance on pay and conditions and useful tools such as an interactive calculator to determine which pay band junior doctors’ posts should be allocated to, and advice about what to do if your post is banded or re-banded incorrectly. The website also provides a base for JDC’s ongoing information campaigns.

There are also webpages for the SJDC, WJDC and NIJDC.

There is a simple online registration process to gain a password which will give you access to all areas of the website. Register today and get the most from the BMA.

www.bma.org.uk
The BMA website also provides links to sites such as major medical organisations and satellite sites such as the BMI, BMJ Careers and the national BMA websites of Scotland, Wales and Northern Ireland. The junior doctors’ section of the Department of Health website is also a useful location to access official documents such as the terms and conditions of service for hospital doctors, health circulars outlining the regulations on living and working conditions for junior doctors, and the protocol for the rebanding of training grade posts. In Scotland, this information is available on the NHS Scotland SHOW website. The SJDC also has a webpage of useful links for junior doctor representatives which includes links to the relevant Scottish circulars: www.bma.org.uk/ap.nsf/Content/usefulweblinks. The NHS Education for Scotland is also as useful resource with details regarding study leave and contact details for each of the deaneries in Scotland: www.nes.scot.nhs.uk/default.asp
Other pages
Other pages of the BMA website include:
• latest information on all professional issues
• career guidance
• BMA’s policy and reports on major issues
• details of BMA work, for instance in science and in ethics
• membership information
• virtual access to the BMA Library.

Sources of further information for junior doctors
Terms and conditions of service
Hospital and medical and dental staff (England and Wales): terms and conditions of service; Department of Health/Welsh Office (July 1994).

This is available for reference in trust medical staffing offices, together with related documentation and on the NHS Employers website at www.nhsemployers.org/pay-conditions/pay-conditions-357.cfm

Hospital medical and dental staff and doctors and dentists in public health medicine and the community health service (Scotland) terms and conditions of service (July 2007):

The gold guide and Modernising Medical Careers (MMC)
Information and documents relating to MMC, including information about selection to specialty training can be found at the following links:

England: www.mmc.nhs.uk
Northern Ireland: www.nimdta.gov.uk/
Scotland: www.mmc.scot.nhs.uk
Wales: www.mmcwales.org/

A guide to postgraduate specialty training in the UK (The gold guide) can be accessed at the above MMC websites.
BMA guidance available to members
All BMA guidance is updated regularly and is available to members only, free of charge, from our team of advisers on 0870 60 60 828 and the BMA website (www.bma.org.uk).

Members should take advice on individual problems from our team of advisers on 0870 60 60 828. There may have been changes since publication of the guidance notes and in Scotland and Northern Ireland circumstances may differ and the guidance notes may not apply.

Help, support and local services
BMA members needing employment advice and information or members who feel they need representation should contact our team of advisers on 0870 60 60 828 or at support@bma.org.uk

Our advisers are trained in doctors employment issues and will mostly be able to deal with an enquiry immediately. However, advisors are also able to assess whether or not individual members need direct representation from the BMA’s advisory staff or from a national office (Northern Ireland, Scotland and Wales).

So, no matter whether you need a guidance note or have a serious problem at work you should contact our team of advisers on 0870 60 60 828 first.

As well as providing individual representation BMA centres and national offices support local junior doctors representatives and LNCs.

The BMA is unable to help non-members or assist members if their problem predates membership of the association.

When contacting our team of advisers on 0870 60 60 828, members should quote their current membership number. Members seeking advice on individual or local problems should call 0870 60 60 828 in the first instance.
Department of Health guidance
Copies of Department of Health publications are available online at www.dh.gov.uk/publicationsandstatistics/fs/en

Copies of the Scottish Government Health Directorates publications are available on the NHS Scotland SHOW website under the publications section: www.show.scot.nhs.uk/

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Tel: 020 7383 6613
Fax: 020 7383 6360
Email: info.jdc@bma.org.uk

General enquiries
020 7387 4499

The Medical Royal Colleges
- College of Emergency Medicine www.emergencymed.org.uk/CEM
- Royal College of Anaesthetists www.rcoa.ac.uk
- Faculty of Dental Surgery www.rcseng.ac.uk
- Royal College of General Practitioners www.rcgp.org.uk
- Royal College of Obstetricians and Gynaecologists www.rcog.org.uk
- Faculty of Occupational Medicine www.facoccmded.ac.uk
- Royal College of Ophthalmologists www.rcophth.ac.uk
- Royal College of Pathologists www.rcpath.org www.rcpch.ac.uk
- Royal College of Paediatrics and Child Health www.rcpch.ac.uk
- Faculty for Pharmaceutical Medicine www.fpm.org.uk
- Royal College of Physicians of Edinburgh www.rcpe.ac.uk
- Royal College of Physicians of Ireland www.rcpi.ac.uk
- Royal College of Physicians of London www.rcplondon.ac.uk
- Royal College of Physicians and Surgeons of Glasgow www.rcpsglasg.ac.uk
- Royal College of Psychiatrists www.rcpsych.ac.uk
- Faculty of Public Health www.fphm.org.uk
- Royal College of Radiologists www.rcr.ac.uk
- Royal College of Surgeons of Edinburgh www.rcsed.ac.uk
- Royal College of Surgeons of England www.rcseng.ac.uk
- Royal College of Surgeons of Ireland www.rcsi.ac.uk
- Academy of Medical Royal Colleges www.aomrc.org.uk
Appendix 1

Offer and acceptance of a training post

Note: the model contract for Scotland takes account of different terminology and circular references for Scotland.

STATEMENT OF PARTICULARS OF EMPLOYMENT FORMING PART OF THE CONTRACT FOR HOSPITAL MEDICAL AND DENTAL STAFF IN THE GRADES OF SPECIALTY REGISTRAR, SPECIALIST REGISTRAR, SENIOR HOUSE OFFICER, FOUNDATION HOUSE OFFICER, HOUSE OFFICER AND PRE-REGISTRATION HOUSE OFFICER AND DOCTORS IN PUBLIC HEALTH MEDICINE AND THE COMMUNITY HEALTH SERVICE

For Specialist and Specialty Registrars it will be necessary to incorporate into the model contract below, paragraphs as appropriate from the previous model contract required specifically for SpRs as per AL(MD)2/96 or its successor.

[Insert: Name and address of employing authority/Trust]
Date ..............................
Dear ..............................

Offer of appointment

1. (a) I am instructed by the [insert name of employing authority/Trust] to [offer you]* [confirm the offer of]* an appointment as [insert job title and grade] at [insert name of hospital(s)] commencing on ....... [for a period of ....... terminating on ....... ].*

(b) The date of the start of your period of continuous employment is ....... . For these purposes, your employment with [insert name of previous employer] [is]* [is not]* included in the period of continuous employment.

Applicable collective agreement

2. Your appointment will be subject to the Terms and Conditions of Service of Hospital Medical and Dental Staff and doctors in Public Health Medicine and the Community Health Service (England and Wales) as amended from time to time [and any reference in those Terms and Conditions to an employing Authority shall be construed as if it were to include a reference to an employing Trust].*
Duties
3. (a) Your hours and duties are as defined in the attached job description (For rotations, the job description may differ for each individual post/placement). You will be available for duty hours which in total will not exceed the duty hours set out for your working pattern in paragraph 20 of the Terms and Conditions of Service.

(b) Your working pattern is described as [full shift]* [partial shift]* [24-hour partial shift]* [on-call rota]* [hybrid comprising [full shift]* [partial shift]* 24-hour partial shift]* [on-call rota]*]

with controls on hours as defined in the Terms and Conditions of Service paragraph 20.

[For staff contracted as full-time staff

(c) You will receive a base salary as detailed in Table 1, Appendix 1 of the Terms and Conditions of Service.]*

[For staff contracted as part-time staff

(c) You will receive a basic salary determined by your actual hours of work as a proportion of the full-time basic salary as detailed in Table 1, Appendix 1 of the Terms and Conditions of Service, using the principles set out in ‘Equitable Pay for Flexible Medical Training’ (NHS Employers, 2005).]*

(d) A non pensionable supplement at payband [insert payband]

will be payable in accordance with paragraph 22 of the Terms and Conditions of Service (for rotations, banding supplements may differ for each individual post/placement).

(e) Banding supplements may be altered (in accordance with paragraphs 6(e) and 7(c) below) in the light of changes in working patterns in order to make posts compliant with the New Deal and the Working Time Regulations as amended. If the payband changes, you will be issued with a letter of variation (in accordance with paragraph 7 below). Pay protection will apply in accordance with paragraph 21 of the Terms and Conditions of Service.
Pay
4. (a) Your base salary will be £ [insert figure] per annum, paid monthly [and will progress by annual increments to £ [insert figure] per annum] in accordance with the current national agreed salary scale for your grade. (These rates are subject to amendment from time to time by national agreement.) See Note 1.

[(b) Your incremental date will be [insert date]]*

[(c) You will receive, in addition to your base salary a supplement at the rate of . . . . . . . % of your base salary for duty contracted at [Band 1 A/B/C]* [Band 2 A/B]* [Band 3]* [Band FA/FB/FC]* as set out in Paragraph 3(d) above, which will be payable monthly. (These rates may be amended from time to time by national agreement).]*

[(d) In addition, you will be paid the following allowances: eg peripheral allowances, London Weighting]*

Pension
5. (a) Your appointment will be pensionable and your base salary will be subject to deduction of superannuation contributions in accordance with the NHS Pension Regulations 1995 unless you opt out of the scheme. (Any supplement payable to you is not pensionable.) Details of the NHS scheme are given in the scheme guide, which is enclosed.

(b) There [is]* [is not]* a contracting out certificate in force for the purposes of section 3(5) of the Employment Rights Act 1996 (Employment Rights (NI) Order 1996 in Northern Ireland).

(c) Pay supplements over and above base salary are non-pensionable.

For staff contracted to work 40 or more hours of duty per week:
(d) Your pensionable pay for contributions purposes must be based on your actual whole-time basic pay (1.0) only.

For staff contracted to work less than 40 hours of duty per week:
(e) Your pensionable pay for contributions purposes will be the appropriate proportion of actual whole-time basic pay (1.0). However, your contributions must also be paid on any
additional hours of duty you work between your contracted hours and a maximum of 40 hours per week.

(f) Your employer must make arrangements to track and record these additional hours (see Paragraph 5(e) above) for pension purposes.

**Monitoring of working patterns**

6. (a) The Trust is contractually obliged to monitor junior doctors’ New Deal compliance and the application of the banding system, through robust local monitoring arrangements supported by national guidance. You are contractually obliged to co-operate with those monitoring arrangements.

(b) These arrangements will be subject to:
   • review by the regional improving junior doctors working lives action team (or equivalent); and
   • for the Trust, the performance management systems.

(c) The Trust must collect and analyse data sufficient to assess hours’ compliance and/or to resolve pay or contractual disputes. Therefore, when the Trust reasonably requests you to do so, you must record data on hours worked and forward that data to the Trust.

(d) The Trust is required to ensure that staff in all training grades comply with the controls on hours of actual work and rest detailed in sub-paragraph 22.a of the Terms and Conditions of Service, and with the requirements of the Working Time Regulations as amended from time to time.

(e) You are required to work with your employer to identify appropriate working arrangements or other organisational changes in working practice which move non-compliant posts to compliant posts and to comply with reasonable changes following such discussion.

**Revision to pay banding**

7. (a) The Trust will notify you in writing of its decision on banding.

(b) Full details of the procedure for appealing against banding decisions are in the Terms and Conditions of Service sub-paragraph 22.l.
(c) Full details of the procedure for rebanding posts are in the Terms and Conditions of Service sub-paragraph 22.m.

Notice
8. You are entitled to receive . . . . . notice of termination of employment and are required to give [insert name of employing authority/Trust] . . . . . notice. See also Note 2.

Registration and insurance
9. You are required to be registered with the [General Medical Council]* [and]* [General Dental Council]* throughout the duration of your employment. See also Note 3.

Additional work
10. You agree not to undertake locum medical or dental work for this or any other employer where such work would cause your contracted hours (or actual hours of work) to breach the controls set out in paragraph 20 of the Terms and Conditions of Service.

Residence
11. [The appointment requires you to be resident at [insert name of hospital]. No charge will be made for lodgings, in accordance with the Terms and Conditions of Service. See also Note 4]*
   [The appointment requires you to be resident in [insert name of hospital house or flat]. The terms of your occupation are set out in the enclosed tenancy agreement/licence. See also Note 4]*
   [The appointment does not require you to reside in hospital, but you have chosen to do so; and a deduction from salary for lodgings will accordingly be made, in accordance with the Terms and Conditions of Service. See also Note 4]*
   [The appointment does not require you to reside in hospital, but you have chosen to do so; and the terms of your occupation of [insert address of hospital house or flat] are set out in the enclosed tenancy agreement/ licence.]
See also Note 4]*

[It is your responsibility to ensure that when on call you will be available by telephone and able to reach your hospital in time to meet your clinical commitments]*

**Leave**

12. (a) You will be entitled to . . . . . . weeks’ annual leave with full pay each year. The Trust’s leave year runs from . . . . . . .

(b) In the current leave period [insert dates] your entitlement will be . . . . . . weeks.

(c) Full details of both annual leave and sick leave allowances and the conditions governing those allowances and study leave, are set out in the Terms and Conditions of Service.

**Property**

13. (a) [Insert name of employing authority/Trust] accepts no responsibility for damage to or loss of personal property, with the exception of small valuables handed to their officials for safe custody. You are therefore recommended to take out an insurance policy to cover your personal property.

(b) Notwithstanding (a) above, [Insert name of employing authority/Trust] undertakes, so far as is reasonably possible, to ensure that lodgings are maintained in a secure condition.

(c) You should, through the exercise of normal diligence, also seek to maintain the security of your lodgings.

**Deductions**

14. The [insert name of employing authority/Trust] will not make deductions from or variations to your salary other than those required by law without your express written consent.

**Sickness Absence**

15. The provisions relating to absence by you because of sickness appear in paragraph 225-244 of the Terms and Conditions of Service.
Grievance procedure

16. (a) Should you have any grievance relating to your employment you are entitled to discuss the matter in the first instance with the consultant (or consultants) to whom you are responsible, and where appropriate to consult, either personally or in writing, with [insert name of the appropriate Personnel Officer], at [insert address of Personnel Officer].

(b) The agreed procedure for settling differences between you and [insert name of employing authority/Trust] where the difference relates to a matter affecting your Conditions of Service is set out in Section 42 of the General Whitley Council Conditions of Service (or in any replacement provision which may come into force from time to time).

Disciplinary procedure

17. The provisions relating to disciplinary procedure appear in section 42 of the General Whitley Council Conditions of Service as incorporated by paragraph 189 of the Terms and Conditions of Service.

Acceptance

18. If you agree to accept the appointment on the terms specified above, please sign the form of acceptance on the following page and return it to me. A second signed copy of this is attached, which you should also sign, and retain for your future reference.

Yours faithfully

Signature ........................................
On behalf of .................................
Notes

[]*: A square bracket followed by an asterisk indicates “delete as necessary”.

1. Your salary gives ............. years’ incremental credit for previous service. If you have any enquiry about how this has been calculated, please contact [insert name and address of Personnel Officer].

2. (a) The Departments and the profession have agreed that minimum periods of notice should be applied as follows, unless there is agreement by both parties to a contract that a different period should apply:

   House Officer ...................... 2 weeks
   Foundation House Officer 1 ........... 2 weeks
   Foundation House Officer 2 .......... 1 month
   Senior House Officer ................. 1 month
   Specialty Registrar (Fixed Term) ........ 1 month
   Specialty or Specialist Registrar ........ 3 months

   (b) The Employment Rights Act 1996 (Employment Rights (NI) Order 1996 in Northern Ireland) provides entitlement to minimum periods of notice, dependent upon an employee’s length of continuous employment, as follows:

<table>
<thead>
<tr>
<th>Period of continuous employment</th>
<th>Notice entitlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month or more but less than 2 years</td>
<td>Not less than 1 week</td>
</tr>
<tr>
<td>2 years or more but less than 12 years</td>
<td>Not less than 1 week for each year of continuous employment</td>
</tr>
<tr>
<td>12 years or more</td>
<td>Not less than 12 weeks</td>
</tr>
</tbody>
</table>

3. Copies of HC(89)34 and the leaflet on indemnity arrangements issued in December 1989 (are enclosed)* [may be obtained on request]* You are normally covered by the NHS Hospital and Community Health Services indemnity against claims of medical negligence. However, in certain circumstances (especially in services for which you receive a separate fee) you may not be covered by the indemnity. The Health Departments therefore advise that you maintain membership of your medical defence organisation.
4. Copies of the enclosure to HSC2000/036 relating to standards of residential accommodation [are enclosed] [may be obtained on request]*.

5. Copies of HSC 2000/031 – Modernising Pay and Contracts for Hospital Doctors and Dentists in Training, [are enclosed] [may be obtained on request]*.

PLEASE DO NOT DETACH

I hereby [accept]* [confirm my acceptance of]* the offer of appointment mentioned in the foregoing letter on the terms and subject to the conditions referred to in it.

Signature  Date

This offer, and acceptance of it, shall together constitute a contract between the parties.
Appendix 2

Guidelines for training grade job descriptions

Job descriptions for training grade posts which must be attached to contracts should include information on the following areas:

The post
1. The job description should include:

   a) a brief statement of the reason why the vacancy has arisen

   b) a description of the hours and duties of the post, including a provisional list of daily commitments and the arrangements for emergency duty

   c) a person specification. This should be a statement of the key attributes the appointee should possess, covering both previous clinical experience and personal qualities which are felt desirable. Any criteria should be capable of use at the appointment committee.

   Job descriptions and person specifications should be couched in non-sexist language. Requirements about age, qualifications and length or nature of experience should not be included unless specifically required for the post. Employee/person specifications should not include requirements on marital status nor include references to marriage plans or domestic arrangements.

The training scheme
2. There should be a description of the training opportunities offered by the post, including, where applicable, a description of the training scheme and rotation of which the post forms part. This section can take the form of a uniform brochure or prospectus produced for all posts in a particular training scheme.
People
3. This section should set out the names of those with whom the postholder will have most contact. The list should include the consultant(s) to whom the doctor will be clinically accountable, the person in charge of training, both in the district or unit and in the overall training scheme, and the person in the medical personnel department who will be the postholder’s main contact point.

Terms and conditions
4. This section should detail the terms and conditions of service of the post, including remuneration, and state if the post is compulsorily resident. This could be a separate, standard leaflet.

The district, unit and service
5. This section, which could be presented in a format for use in many different posts, should describe the service, including an overall description of the district and unit.

Facilities
6. Information should be provided on accommodation and other facilities available, eg doctors’ mess, catering facilities, car parking.

[Source: Junior doctors, the New Deal: living and working conditions of doctors in training; NHS Management Executive 1991]

All training posts should have deans and educational approval, and this should be clearly stated in the advertisement. It is strongly advised that junior doctors should be extremely wary about applying for non-approved or non-standard posts which could be seriously disadvantageous to future career prospects and are unlikely to be recognised by medical royal colleges. Junior doctors who have any concerns about a post should seek advice from their postgraduate dean’s office.
Appendix 3

Retrospective claim form for payments as on a locum basis
To Claimant:
(i) This claim form has been agreed by the Joint Negotiating Committee for Hospital Medical and Dental Staff. Its purpose is to allow junior hospital medical and dental staff to claim payments for work performed as on a locum basis with their own employing authority for which prospective agreement was not obtainable in time.
(ii) Please read the notes overleaf before completing the claim form.

Personal details
Surname: .........................................................
Forenames: .......................................................  
Address for correspondence: ................................  
Grade: Specialty: ................................................  
Location of post held .........................................  
(a) name of hospital .........................................  
(b) name of department .......................................
Claim for payments: Please enter hours claimed at locum rate.  
(a) the time, date and number of hours claimed; (b) the basis of the claim.
<table>
<thead>
<tr>
<th>Hours</th>
<th>Date</th>
<th>Time from</th>
<th>Basis of claim</th>
</tr>
</thead>
</table>

Total hours claimed: ........................................

I have read and accept the notes overleaf and have performed the above duties outside my regular contractual commitment:

Signature of claimant ........................................

Date ....................

Signature of authorised signatory ........................

Date ....................

(to be signed by a person designated to authorise payment)

For office use

Please pay the above named for ............ hours at locum rates.

Checked by .......................... 

Date ....................

Authorised by ............

[Source: HSG(93)1 Doctors and dentists in training: TCS/model contract guidance, appendix C]
Notes
1. Paragraph 111a and paragraph 111c of the Terms and conditions of service of hospital medical and dental staff (TCS) are as follows:

Paragraph 111a:
Practitioners in the training grades of may be employed on a locum tenens basis by their own employing authority but not within the hours for which they are already contracted and provided that such employment does not cause their average weekly hours to exceed the limits set out in paragraph 20 (except in circumstances where they are acting up as a consultant).

Paragraph 111c:
A practitioner employed in a training grade (except Locum Appointments for Training) accepting an appointment as on a locum basis (cf. sub-paragraph 110.f) in any of these grades, in a hospital identified in the job description applicable to the practitioner’s main employment, will contract for each hour in such appointments at the standard hourly rate in accordance with the pay banding arrangements with effect from 1 December 2000 as set out in table 2 of appendix I, or shall be entitled to receive a day’s leave for each week night (the night of Friday/Saturday being classed as a week night) or complete Saturday (including the night of Saturday/Sunday) or Sunday (including up to the start of normal duty on Monday morning) of additional duty. The taking of such leave shall be subject to the needs of the service and to the authority’s approval. Any such leave which has not been taken within twelve months or by the end of the practitioner’s contract, whichever is the earlier, shall be relinquished. Payment shall then be made retrospectively under the terms of this sub-paragraph for the actual amount of additional duty undertaken at the time and for which the practitioner has not otherwise been paid and has been unable to take leave in compensation.
2. It has been agreed that the effect of these two paragraphs is to allow an employing body to contract prospectively with one of its own employees, in any of the training grades for duty in circumstances defined by paragraphs 110 and 111 of the Terms and conditions of service which the employing body would otherwise seek to cover by appointment of a locum not already in its employment, and that payment should be at the standard locum rate. In these circumstances the above claim form is not required.

3. It has also been agreed that a practitioner in one of the training grades may seek retrospective authority for payment for duty performed as on a locum basis for his or her own employing body when, exceptionally, the prospective agreement of the employing body was not obtainable in time. In these circumstances the above claim form should be completed, and signed by the claimant and a person designated by the employing body as responsible for authorising payments, within 10 days, wherever possible, of the completion of the duty.

4. Where it is thought desirable to continue an arrangement entered into as in paragraph 3 above, the agreement of the employing body must be obtained at the earliest possible moment. The arrangement must not continue for more than three days without the agreement of the employing body.
Appendix 4

Protecting your pay
Pay protection is a difficult issue. It is important that you get written confirmation from your employer of the banding that you will be paid for the job you have accepted.

In order to have the best chances of ensuring that your pay on graduation is the correct amount with the correct banding applied, the BMA has devised a letter for you to send to your future employer once you are notified of the post(s) you will take up.

Please feel free to edit the attached letter to suit your own personal requirements. If you do not receive a response from the Trust it is important to pursue this without delay. Contact our team of advisers on 0870 60 60 828 for further details or information (see page ***).

Template letter

Deanery address
<insert>

Doctors Address
<insert>

Date

Dear <insert trust deanery contact name>

Acceptance of <insert position>

Thank you for your letter offering me the position of <insert position> in <insert specialty> in the <insert region> Deanery region. I should like to accept this offer and inform you that my earliest start date will be <insert date>.

Please find enclosed the relevant completed documents you requested.
I should be grateful if you can write to me by return of post and provide me with a list of each possible post that I may take up during this entire rotation, together with the current pay banding applicable to each of these posts.

I look forward to hearing from you as soon as possible.

Thank you

Yours sincerely

<insert name>
Appendix 5

Doctors doing out-of-hours work
Appendix 6

Approval to change band

Trust: Hospital: ...................................................
Specialty(ies): ...................................................

Numbers of Doctors in Working Arrangement by Grade
PRHO: SHO: SpR: Other: ...........................................
Working Pattern: ..................................................
Current Banding: ........ Proposed Banding: .... Effective Date: ....

<table>
<thead>
<tr>
<th>Stage</th>
<th>Evidence Required</th>
<th>Documentation</th>
<th>Confirmed Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Consult post-holders on proposed changes and obtain agreement of the majority participating in the working arrangements.</td>
<td>Approval of majority of current/incoming post-holders</td>
<td>Template signed by trust junior doctor representative confirming agreement of majority of current/incoming post-holders</td>
<td></td>
</tr>
<tr>
<td>1b. Submit details of the new working arrangements to the action team for information and invited comment.</td>
<td>Full details of proposed working arrangements and/or rota summary (eg from ND2000 software)</td>
<td>Letter signed by action team chair or delegated authority confirming theoretical compliance of working arrangements</td>
<td></td>
</tr>
<tr>
<td>1c. Obtain agreement from clinical tutor for education purposes.</td>
<td>Full details of proposed working arrangements Comments of action team</td>
<td>Letter signed by dean or delegated authority confirming educational acceptability of working arrangements</td>
<td></td>
</tr>
</tbody>
</table>

If exceptionally and because of the impracticality of full implementation of new working arrangements a trust wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the regional action team (or its equivalent) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Evidence Required</th>
<th>Verification</th>
<th>Confirmed Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Submit request for provisional approval of working arrangements to action team</td>
<td>Signed letter from trust giving reasons for inability to fully monitor before rebanding. Evidence of full or partial testing/monitoring of proposed arrangements</td>
<td>Letter signed by action team chair or delegated authority authorising an offer of provisional banding.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Banding:</th>
<th>Provisional New Banding:</th>
<th>Implementation Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Team Signatory Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage</th>
<th>Evidence Required</th>
<th>Verification</th>
<th>Confirmed Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Monitoring of working pattern and confirmation of banding</td>
<td>Completed monitoring returns from 75 per cent of doctors on rota over full two week period Summary of monitoring results</td>
<td>This signed template</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous banding:</th>
<th>Verified New Banding:</th>
<th>Effective Date:</th>
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</thead>
<tbody>
<tr>
<td>Trust Signatory (Designation)</td>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td>Rota Signatory (Junior Doctor LNC representative)</td>
<td></td>
<td>Date:</td>
</tr>
<tr>
<td>Action Team Signatory (Designation)</td>
<td></td>
<td>Date:</td>
</tr>
</tbody>
</table>

For the Scottish form and guidance, please see HDL(2002)33.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAC</td>
<td>Advisory Appointments Committee</td>
</tr>
<tr>
<td>ACCEA</td>
<td>Advisory Committee on Clinical Excellence Awards</td>
</tr>
<tr>
<td>AL</td>
<td>Advance Letter</td>
</tr>
<tr>
<td>AVC</td>
<td>Additional Voluntary Contribution</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>CHRE</td>
<td>Council for Healthcare Regulatory Excellence</td>
</tr>
<tr>
<td>CCSC</td>
<td>Central Consultants and Specialists Committee</td>
</tr>
<tr>
<td>CCST</td>
<td>Certificate of Completion of Specialist Training</td>
</tr>
<tr>
<td>CCT</td>
<td>Certificate of Completion of Training</td>
</tr>
<tr>
<td>CEA</td>
<td>Clinical Excellence Award</td>
</tr>
<tr>
<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CGWT</td>
<td>Care Group Workforce Teams</td>
</tr>
<tr>
<td>DCC</td>
<td>Direct Clinical Care</td>
</tr>
<tr>
<td>DDRB</td>
<td>Doctors and Dentists Review Body</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EL</td>
<td>Executive Letter</td>
</tr>
<tr>
<td>EPP</td>
<td>Exposure Prone Procedure</td>
</tr>
<tr>
<td>EWTD</td>
<td>European Working Time Directive</td>
</tr>
<tr>
<td>FSAVC</td>
<td>Free Standing Additional Voluntary Contribution</td>
</tr>
<tr>
<td>GDC</td>
<td>General Dental Council</td>
</tr>
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<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GWC</td>
<td>General Whitley Council</td>
</tr>
<tr>
<td>HA</td>
<td>Health Authority</td>
</tr>
<tr>
<td>HC</td>
<td>Health Circular</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMSO</td>
<td>Her Majesty's Stationery Office</td>
</tr>
<tr>
<td>HSC</td>
<td>Health Service Circular</td>
</tr>
<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>HSG</td>
<td>Health Service Guideline</td>
</tr>
<tr>
<td>ICO</td>
<td>Information Commissioner's Officer</td>
</tr>
<tr>
<td>ISTC</td>
<td>Independent Sector Treatment Centre</td>
</tr>
<tr>
<td>JMCC</td>
<td>Joint Medical Consultative Council</td>
</tr>
<tr>
<td>JNC(S)</td>
<td>Joint Negotiating Committee (Seniors)</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
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<tr>
<td>JWCCC</td>
<td>Joint Welsh Consultants Contract Committee</td>
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<tr>
<td>LAC</td>
<td>Local Awards Committee</td>
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<td>LNC</td>
<td>Local Negotiating Committee</td>
</tr>
<tr>
<td>MAC</td>
<td>Medical Advisory Committee</td>
</tr>
<tr>
<td>MHO</td>
<td>Mental Health Officer</td>
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<td>MRC</td>
<td>Medical Research Council</td>
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<td>Medical Staff Committee</td>
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<tr>
<td>NCAS</td>
<td>National Clinical Assessment Service</td>
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<td>NCSSD</td>
<td>National Counselling Service for Sick Doctors</td>
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<tr>
<td>NHD</td>
<td>Notional Half Day</td>
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