2016


*INFORMATION FOR EMERGENCY MEDICINE TRAINEES – JUNIOR DOCTORS CONTRACT MAY/JUNE 2016*

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# EMTA JUNIOR DOCTORS CONTRACT SUMMARY JUNE 2016

This is a **summary** of the T&Cs published on the 27th May 2016, following the re-negotiations between the BMA and Department of Health. Trainees come to Emergency Medicine from a variety of backgrounds, with a variety of experience. There are certain to be specific circumstances for individual trainees that I won't cover, and indeed circumstances that I'm sure I won't have thought of.

This guidance is based on work by Dr Rebecca Lennon, an ST5 in Palliative Medicine currently working as a Medical Leadership and Management fellow, and I am extremely grateful to her for sharing her guidance for her trainees with me. This document reflects my personal understanding of the contract on offer, and discussions with other trainee representatives from different specialties and members of the BMA JDC. It has been fact checked by the BMA, and as of 9 June 2016 it is up to date. Some elements of the contract are still being finalized, particularly LTFT.

The aim is to inform your personal opinion on how you vote; the aim is not to attempt to sway you one way or the other. **There is no endorsement or otherwise of the contract.** I would strongly encourage you to attend a BMA roadshow if you are able, so that you can resolve any questions you have directly from those best placed to know the answers. NHS employers have sent a letter to all Trust Chief Executives ensuring they allow junior doctors time to attend, but this will require local negotiation on our parts. The **JDC have voted to not hold a position on the contract**, to allow the membership to form their own views based on the facts presented.

The BMA will be providing tools and materials to help you understand the impact this will have on your pay. Pay will be made up of your basic 40 hours, NROC allowance, weekend allowance, enhancements for night work, up to 8 additional hours from your work schedule, work done whilst on-call and exception reports. The BMA will be doing pay modelling for full-time and LTFT trainees, so you can see the differences in pay between the contracts and total pay over the whole F1-ST6/8 period. Clearly, some elements of the contract have no direct impact on Emergency Medicine, since we do not undertake NROC and don't operate an on call system in the sense of the new contract, even during core training in other specialties.

There will be no further **equality impact assessment**. This is because the Secretary of State feels he has already discharged his legal obligations with the previous contract and not enough has changed to warrant a further assessment – indeed many of the changes made were a direct response to the issues raised in the original EIA so are a clear improvement.

The **referendum** will open on the 17th June, after all the roadshows are complete, and close on the 1st July. This will be an online vote, backed up with a postal vote. Only one vote will count and if someone votes twice, their first received vote will be the one that counts. The result will be available on the 6th July, when the JDC will meet again to discuss the result before it is published. The vote will be decided on a majority verdict, i.e. 51%.

The BMA do not know **what will happen if there is a 'no' vote**. The most likely possibility is that the Department of Health impose a worse contract than this, as this has happened in the November and March offers; they went back on previously agreed aspects. However, technically, on both occasions where they have left negotiations, this would be similar to getting a 'no' vote, and both times when

they've re-talked the contract has improved. On returning, who has been negotiating with them has improved, i.e. it got closer to the real decision makers. During the last talks, the Secretary of State was there in person negotiating, so the feeling is they have got as much from him as he is currently willing to give. There is a risk with a 'no' vote that the BMA lose any of their negotiating power with the contract going forward because it will be difficult to engage with a contract their membership did not support. There are some aspects of the contract that they feel they could re-negotiate during the future reviews and improve on; LTFT pay and nodal point pay are just two examples. Currently the Department of Health or NHS Employers need to have the BMA involved in any changes to the contract in the future, as this is written into the contract. However, this will be taken out if there is a 'no' vote: there has to be a clause in the contract addressing how changes can be made to it – if there is collective agreement, all future changes must be through collective agreement, but if it is imposed, all future changes can be imposed.

## WORKING HOURS, BREAKS AND REST

A **shift** is when you are required to be present at work (resident). No Emergency Medicine work falls under the definition of on call or non resident, so a large section of the contract does not apply to us.

No doctor should be rostered for more than an average of 48 hours of actual work per week (up to 56 hours a week if opted out, which remains voluntary), as calculated over the reference period defined as the rota cycle, placement length or 26 weeks whichever is shorter. There is an absolute maximum of 72 hours in a 7-day period. Annual leave entitlement during the reference period is deducted.

No shift shall be rostered to exceed 13 hours in duration.

5 consecutive shifts longer than 10 hours will be followed by 48 hours rest.

4 consecutive shifts longer than 10 hours finishing after 2300hrs will be followed by 48 hours rest.

4 shifts where at least three hours of work are between 2300 and 0600 will be followed by 48 hours rest.

Unless longer due to the above, rest periods should be 11 hours between shifts. Any breaches of 11 hours' rest in a 24-hour period will be subject to time off in lieu, which must be taken within 24 hours or you get paid. A doctor will be paid for the additional hours worked that resulted in the shortening of the rest period, at a penalty rate, as set out in Annex A. Where this occurs, the doctor will not be expected to work more than five hours on the day following the day on which the breach occurred and pay will not be deducted for the time off.

If your shift is over 5 hours long, you get a 30-minute break and if over 9 hours long, you get 2 x 30 minute breaks. If you combine the two 30 minute breaks you have to take them in the middle of the shift, and it can't be taken within an hour of the shift commencing or held over to be taken at the end of the shift.

Weekends for the purposes of working hours limits are defined as Saturday 0001hrs to Sunday 2359hrs, and you cannot be rostered for more than **1:2 weekends**. Doctors paid at nodal point 2 are exempt from this requirement for one placement during their foundation year. For these doctors, there is a

requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2. This one exception was agreed to ensure the continued deliverability of A&E services within existing workforce restraints, but we aim to remove this provision in the contract review scheduled for 2018.

An enhancement of 37 per cent of the hourly basic pay rate shall be paid on any hours worked between 21.00 and 07.00, on any day of the week. Where a shift is worked which begins no earlier than 20.00 and no later than 23.59, and is at least 8 hours in duration, an enhancement of 37 per cent of the hourly basic rate shall also be payable on all hours worked up to 10:00 on any day of the week.

The number of hours in the rota for which an enhancement is paid will be assessed across the length of the rota, converted into equal weekly amounts by dividing the total number of hours to be paid at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure and the doctor will be paid 1/12th of the annual figure for each complete month, or a proportion thereof for any partial months worked. Average total hours, and average hours that attract an enhancement, will be assessed in quarter hours, rounded up to the nearest quarter hour.

How much impact this will have depends on the rotas you are working now, and whether or not they will need to change to comply with the new terms and conditions. Emergency Departments follow a peak hours staffing model, as per national recommendations, in the majority of cases. ED rotas are build around a need to deliver service more so than elsewhere in the hospital, which is why we work so many evenings and weekends already. The BMA has only one rota for Emergency Medicine amongst their pay calculators, which does not reflect the variability of ED rotas between hospitals.

If the new terms will mean changes for you, it would be a worthwhile exercise exploring how your rota may change where you work, as this will allow you calculate what theoretical pay for a future iteration of yourself may be under the new contract.

There is a worked example of how I have done this as an Appendix for reference. This has been done as I understand the contract, and is not intended as a definitive opinion.

## ANNUAL LEAVE

Annual leave remains the same previously: 27 days per annum up to 5 years, 32 days per annum at 5 years or more, plus 8 statutory days. Leave may not be taken from shifts attracting an enhanced rate of pay. Where a doctor wishes to take leave when rostered for such a shift or duty, the doctor must arrange to swap the shift or duty with another doctor on the same rota. It is the doctor's responsibility to arrange such swaps and the employer is not obliged to approve the leave request if the doctor does not make the necessary arrangements to cover the shifts.

## LOCUM WORK

For those working on the new training contract, any **locum shifts** you want to do must be initially offered to the NHS, via their staff bank. However, this only applies if you are offering work at the same

grade and skill set to which you currently work. If they do not have any locum shifts that fit your requirements, then you can work elsewhere. If you are offering to work at a level below your current grade though, there is no such requirement and you may work for an agency. This was a compromise suggested to push back against the previous much more restrictive 'first refusal' clause which limited you to doing locum work for your main employer.

These restrictions do not apply to those not working on a training contract, who it is presumed will remain free to offer their services as they do now.

## PAY

**Basic salary**

Basic pay is paid for 40 hours work per week, paid pro-rata for less than full-time (LTFT) trainees. The nodal pay points are in section 1 of Annex A. They are now front-loaded to mitigate the removal of automatic pay progression.

Automatic pay progression is never likely to come back, as this precedent has been set in other public sector jobs, and in sectors where it is yet to be applied it will likely be removed at the next available opportunity.

There are also guaranteed uplifts in basic pay for the next 3 years; 1%, 0.9% and 0.8%.

Every trainee's gross pay was calculated on the new nodal points and this amount subtracted from the total pay envelope of £3.3 billion, which only needs to be cost neutral for the first year after the contract implementation. This meant there was money left over and, in order to make the pay envelope neutral, the nodal points needed to be uplifted by 10-11% on average. The rise in basic pay of 10-11% does not apply to every trainee, as it varies by nodal point. The largest pay rise occurs at ST3 of 32% on basic pay, assuming you are at the lowest pay point for ST3 on the current contract. This % increase was calculated when the pay progression points were restructured into nodal points.

**Pensionable pay**

The following is pensionable:

- Basic pay
- Pay protection uplifts
- London weighting

The following is non-pensionable:

- Weekend allowance
- Availability allowance
- Pay for all work done whilst on-call
- Additional hours beyond your work schedule
- Flexible pay premia

**Weekend Allowance**

Weekends are defined at Saturday 0001 to Sunday 2359. Payment is as a percentage of basic pay only as per frequency of weekend work from the table below. If you are LTFT then it will be pro-rata for the

rota you are on, so if you are 50% of FTE working 1 in 4 weekends you get the same allowance as a FT colleague working 1 in 2 weekends. This has been confirmed after the publication of these T&Cs with further negotiation with the Department of Health, in an email at JDC. Please see section below for further details on LTFT trainees.

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

EM trainees will never undertake non-residential on-call during training, even during core (Anaesthetics, ICM, Acute Medicine, Paediatrics), subspecialty (Paediatrics and Pre-Hospital), and dual specialty (ICM), and will not receive the 8% of basic pay flat rate on call availability allowance during training.

## OTHER PAYMENTS

**Flexible Pay Premia**

You can be eligible for more than one flexible pay premium (FPP) and thus can be paid for more than one, but never for the same one twice. Any calculations for additional hours are based on basic pay and do not include FFP payments. They are pro-rata and paid until you exit the training programme for which they were applicable. The proposed FPP are set out in section 4 of Annex A.

For the Emergency Medicine FPP, once you start receiving it, you will continue to receive it. £20,000 over 3 years amounts to £6667 per annum. In addition, those who extend training for any reason will also continue to receive the average yearly premia for those additional years. I am not certain if this will apply to those doing additional years for subspecialisation.

For integrated clinical and academic pathways, the FPP is paid on completion of the higher degree and return to the same training programme. For other academic pathways whilst on run-through training/higher specialty training, or approved out of programme (OOP) for research experience, the FPP is paid when you complete the higher degree and return to the same training programme.

**Senior Decision Makers Allowance**

This will not come into effect until 2nd October 2019. The money for this has come from the removal of the previous 5th nodal point for ST7/8, which for EM is only reached by those taking OOPT or entering from outside the specialty. The term is very loosely defined at the moment, with no clear indication of what defines a senior decision maker nor what the value of payment for this role would be.

**London Weighting**
Is set out in section 8 of Annex A. They made no progress on re-modelling this during negotiations, but it was talked about being a work stream during implementation or afterwards, as it needs updating.

**Maternity or Parental Pay**
If you have come back into training, but the reference period falls within an OOP period and means that your occupational maternity pay would be nil, as long as the continuity of service provision is met, the reference period will move back to your placement immediately before OOP.

The maternity and parental leave T&Cs have not changed because they are pan-NHS and based on the Agenda for Change contract. However, in this contract there is a paragraph that may be of note to some of us that seems to have changed. It states that during maternity or parental leave your entitlement to study leave continues, including funding. You can take study leave as KIT days, otherwise it accrues.

## PAY PROTECTION

There will be a period of transitional pay protection, but this will differ depending on your grade. This will no longer be based on **31st October 2015** (the date the Secretary of State announced he was imposing the contract, but will be based on the basic pay you were earning the day before transition. If you transition in August 2017 you get the increments you would have received by then. The banding you get is based on the rota you were working the day before transition as well, but the banding that rota was earning at 31 October 2015.The period will end on the 3rd August 2022. However, this will be extended **pro rata** if your work LTFT or up to a maximum of 2 years if you have taken time out of programme for whatever reason. It will end when you CCT or the 3rd August 2022, whichever is the sooner. If you move from working **LTFT to full-time**, or vice-versa, your cash floor and work schedule will be recalculated on a pro-rata basis. If your pay includes **previous pay protection**, it will be honoured and included in your cash floor calculations. The final cut off point of August 2022 will be reviewed in the contract review scheduled for 2018, to see if there would be any trainees still seeing a pay cut at this point (mainly those LTFT), and if so the period may be extended.

**Leave or OOP**
If at the point of transition for your grade and specialty you will be on maternity, parental, adoption or sick leave, or OOP, but return to training before the 3rd August 2022, you will still be eligible. Your pay protection will be calculated on the basic and banding pay you would have been on had you not been absent.

**SAS**
SAS doctors will receive pay protection via the same mechanisms described above if they take up a training post.

**CT2**
You will be eligible for pay protection if you:

- Moved directly from core training to ST3 on the 3rd August 2016
- Complete core training on the 2nd August 2016, but due to a different start date do not start ST3 until later than 3rd August 2016

Pay protection will be calculated from what you were earning as a CT2 on 2nd August 2016 = Basic salary + banding. This will become what is known as your 'cash floor'. Your pay as an ST3 will be calculated

based on your work schedule and compared to your cash floor. If it is lower, then the difference will become your pay protection. If the pay from your work schedule is higher than your cash floor, then you will receive the higher amount. However, if you then move to a placement where the pay drops, you will still receive pay protection up to your original cash floor until the end of the transitional period. Essentially, you will always receive the cash floor amount until the end of the transitional period, but may be paid more in some placements.

**ST3 and above**

Pay protection will mean that there will be no change in the way you are paid compared to the current arrangements. You will still receive your basic salary, banding and yearly annual increments. You will receive a work schedule and comply with the new T&Cs. However, any work schedule reviews may result in a change of banding, which may increase or decrease. If you decide to re-train in a different training programme, your pay protection will be re-calculated at the grade which you are moving to.

**Non-transitional pay protection (or standard contractual pay protection when switching specialty)**

Pay protection will apply to doctors who:

- Change to hard to fill specialties, as long as there has been 6 months service and must take up the post within 12 months of appointment (can be extended if due to disability)
- Change to any specialty because of caring responsibilities or a disability. No qualifying period needed.

If a career grade doctor chose to train in a hard to fill specialty then they will be pay protected, but need to have had 13 months service in their SAS role and take up the post immediately. They will also be pay protected if choose to train in any specialty if the change is because of a disability. Only their basic pay will be protected.

## LESS THAN FULL TIME TRAINEES

Discussions at JDC were dominated by discussing the effects for LTFT trainees, and this area is rapidly evolving.

In the **current contract**, pay for LTFT trainees works out to be higher than a simple pro rata on basic pay and banding. For example, it is calculated on the basis that a full-time trainee works 48 hours/week. If you work 60%, this calculates to be 28.8 hours/week. Basic pay is then 28.8/40 (40 is derived from a normal working week) = 72%. LTFT trainees will therefore be paid twice for some hours worked. The Department of Health's aim was **pay parity**, so under the new contract, an hour worked carries the same payment for full-time and LTFT trainees.

**Automatic pay progression** helped to reduce the inequalities from working LTFT, but this has been removed. How it affects LTFT trainees will depend on when they become LTFT and for how long. The worst affected will be those that go LTFT before ST3. Those ST3 and above will be helped by the front-loading of the nodal pay.

The Department of Health has committed to continue to talk about other ways to help increase pay for LTFT trainees. One avenue is to review **fixed fees** to make them pro rata, such as GMC, exams, college subscriptions etc. Another option is to take some of the money that gets freed up from reduced locum

rates or when people CCT and their pay progression or the 5th nodal point is no longer being paid for, and create a **LTFT premium** to make up any losses in gross earnings.

## WORK SCHEDULING

This should reflect both your service and educational commitments. It will initially be **generic** and include:

- Expected learning outcomes matched against the curriculum
- Scheduled duties
- Time for quality improvement and patient safety activities
- Periods of formal study
- On-call and shift requirements

This is then **personalised** to take into account your learning needs and opportunities available. It will be reviewed by your educational supervisor. The review will be ongoing and it can be amended at any time to reflect any changes that are needed.

**Exception reports** should be submitted for breaches in:

- Working time regulations
- Minimum rest requirements or breaks
- Working pattern deviations
- Missed educational opportunities
- Reduced support during service commitments

They will be **electronic** and **copied** to the Director of Medical Education or the Guardian of Safe Working Hours. These must be addressed and an action plan produced by your educational supervisor, which will be reviewed by the Director of Medical Education and the Guardian of Safe Working Hours. Exception reports will inform the ongoing process of reviewing your work schedule. They will also lead to either remuneration or TOIL depending on the reason and severity of the exemption report. Remuneration is always the backstop – TOIL must be taken within agreed time limits (24 hours for breaches of rest requirements and 3 months for other breaches) or you get paid.

If there is a **substantive risk** to patient or doctor safety then the exception report should be **verbal** at the earliest opportunity, followed up by an electronic submission. This will lead to either TOIL or increased support. Your supervisor will assess whether it is substantive or not, but may down grade it to serious or significant, both of which will result in the submission of exception reports.

You can request a **review of your work schedule** at any time, which should then take place within 7 working days. This will either result in no change, prospective changes, remuneration/TOIL or organisational changes, which will take longer to achieve so either alternative arrangements are made or your pay increased.

There will be **quarterly reports** to the Board from the Director of Medical Education and the Guardian of Safe Working Hours on all work schedule reviews related to working hours and rota gaps. The Board have an obligation to report these to HEE, CQC, GMC, GDC and the Lead Employer.

## GUARDIAN OF SAFE WORKING HOURS

All doctors are responsible for making sure our hours comply with the working time requirements and are safe to do our jobs. The Guardian of Safe Working Hours will be employed to oversee this. It will be a **senior position**, but not in a management position. The term will be for a minimum of **3 years**. The person will be appointed by a panel that includes junior doctors, who will also be involved in their ongoing performance management. Any concerns about the Guardian of Safe Working Hours can be raised with the Medical Director or escalated to the senior independent executive on the Board of Directors.

**Fines** will be levied for breaches in working time regulations, rest and break requirements. Funds will be dispersed by the Trust's junior doctors forum. However, they should not be used for facilities, study leave, IT provision or other resources defined by HEE as fundamental training requirements. All fines will be published in the Trust's annual financial report.

## JUNIOR DOCTORS FORUM

This will be composed of elected junior doctors currently working at the Trust, along with the Local Negotiating Committee's (LNC) junior doctor representative and the Chair of the LNC.

It states that where the Guardian of Safe Working Hours covers small specialities or those that have specific employment requirements, the forum should include representatives of these groups.

## PRIVATE FEES

You will be required to tell your Educational Supervisor of any regular commitments to private clinical work. It will be our responsibility to ensure any private clinical work does not impact on our NHS work, you pay tax and arrange appropriate indemnity insurance; this is no different to now.

You can do private work during your NHS contracted hours, but you shouldn't be paid for the same time twice; this is no different now. If you do, your employer can either take your fees, charge you for using their premises, reclaim your salary or ask you to make up the time.

You will be allowed to publish papers and give lectures, but if you are paid for these then it will be classified as private work. This is no different now.

Private fees will include cremation form fees, but this work will cease before long with the introduction of the Medical Examiner role.

## RAISING CONCERNS

If have a duty to raise concerns, which should be done in line with your Trust's local policy and should not suffer any detriment, even if they regard a third party. If the concern would be in the public interest, you have a duty to speak out and would be protected under the Public Interest Disclosure Act 1998. There are local policies in place for both such disclosures and should be reviewed before raising concerns in order to ensure you are protected.

## OTHER REVIEWS

There has been an agreement for HEE to review:

- the inter-deanery transfer process
- joint applications for doctors who are married or in a civil partnership
- placements within a defined travel time for those with caring responsibilities

The BMA will be involved in regular reviews of the contract with NHS Employers. The first is likely to be in August 2018.

The option of accelerated training will be developed to allow anyone who has taken time out of training to catch up to their peers. This is still in its infancy, but it may include access to mentorship, additional study leave funding and special training opportunities.

## APPENDIX 1: IMPACT ON A DGH ROTA – IN CONJUNCTION WITH SPREADSHEET

The following example uses the current rota from Milton Keynes Emergency Department (MKED), which has been chosen purely on the basis that I have worked there, and have used this rota for the purposes of estimating the impact of the various iterations of the contract as they have evolved.

The current MK rota is not compliant only due to 9 day stretches caused by SPA days, see "1 Existing Rota"; moving SPA days renders the rota compliant, see "2 Compliant Rota". Hours are either normal time, or time plus 37%. These hours are noted on both sheets.

A summary of the hours worked on the rota during a 14 week cycle is shown in "3 Pay Example":

| | |
|---|---|
| Basic salary | £45,750.00 |
| Additional hours pay | £5,718.75 |
| Weekend allowance | £3,431.25 |
| Night pay | £6,453.61 |
| Total pay without FPP | £61,353.61 |
| FPP | £6,666.67 |
| Total pay | £68,020.28 |

This sum, with FPP, is higher than every point on the present pay scale with 50% banding. Without FPP, it is higher than all points except ST7 and ST8. This will not be true for those who have an increased pay progression from previous training in other specialties.

The BMA use Example 16: Emergency Medicine ST3+ as their reference for their modelling. This rota sees an average of 41 hours, with 13.25 of those hours at night, and a weekend frequency of <1 in 2 – 1 in 4. From this is derived pay of £62599 per annum. The figures from MK give an average of 45 hours, with 15.25 of those hours at night, and weekend frequency of <1 in 2 – 1 in 4. The MK pay estimate is therefore higher than the BMA estimate, by £5421.28 per annum.

The final sheet shows a comparison between current and proposed earnings, both year by year and summative, without the FPP. Even without this, from ST3 onwards summative pay is higher even for those subspecialising. The figures for the new contract for foundation and CT1 and CT2 are based on averages from the BMA's figures for foundation jobs and ACCS, and compared against 1.5 banded jobs throughout, placing current contract at an advantage in foundation years in particular – very few (if any) foundation doctors have all jobs banded at 50%.

Financially, and at this level of analysis, the new contract returns higher levels of pay when compared with the current contract. This may not be true for LTFT trainees, depending on how their pay is calculated.

The variability due to rotas, however, is significant, with substantial changes in pay possible for minimally different rotas, and I therefore invite you to examine your own rotas to see if they are compliant with the new contract, and if so what that might mean for those who will be working them in future.