

# Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016

## Version 1

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# Introduction

1. This document sets out the Terms and Conditions of Service (TCS) for doctors and dentists (hereafter referred to as doctors) in approved postgraduate training programmes under the auspices of Health Education England (HEE). It supersedes the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002<sup>1</sup> and the provisions currently contained in Schedules to the directions to HEE with regard to GP specialty trainees (GP registrars) when employed in practice settings. These TCS will also apply to a doctor employed in a relevant training post during a period of grace approved by the postgraduate dean.
2. These terms and conditions are not intended to apply to any doctor or dentist not in training on a General Medical Council (GMC)/General Dental Council (GDC) approved training programme, or to a dentist training on a dental foundation training programme.
3. These TCS do not apply to any doctor undertaking a period of shadowing immediately prior to commencing work as a foundation doctor. Separate arrangements should be used for this shadowing period.
4. Sections of the *NHS Terms and Conditions of Service Handbook*<sup>2</sup> which apply to doctors employed under these TCS are listed in Schedule 13.
5. This TCS document, the principle statement of terms and conditions (contract of employment), and any local employer-level agreements (including employment policies), contain the entire terms and conditions of employment, such that all previous agreements, practices and understandings between the employer and the employee (if any) are superseded and of no effect. Where any external term is incorporated by reference, such incorporation is only to the extent so stated and not further or otherwise.
6. The standards of training and education for doctors are agreed between the employer and HEE, and are subject to an annual agreement (the Learning and Delivery Agreement) between the parties.

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<sup>1</sup> Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002, [http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Terms\\_and\\_Conditions\\_of\\_Service\\_NHS\\_Medical\\_and\\_Dental\\_Staff\\_300813\\_bt.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Terms_and_Conditions_of_Service_NHS_Medical_and_Dental_Staff_300813_bt.pdf)

<sup>2</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

## Abbreviations

F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
StR	Specialty Registrar
SpR	Specialist Registrar
CCT	Certificate of Completion of Training
COGPED	Committee of General Practice Education Directors
CQC	Care Quality Commission
DME	Director of Medical Education
FPP	Flexible pay premium / premia
GDC	General Dental Council
GMC	General Medical Council
HEE	Health Education England
LNC	Local Negotiating Committee
LTFT	Less Than Full Time
NIHR	National Institute for Health Research
OOP	Out Of Programme
OOPC	Out Of Programme (Career Break)
OOPE	Out Of Programme (Experience)
OOPR	Out Of Programme (Research)
OOPT	Out Of Programme (Training)
PIDA	Public Interest Disclosure Act 1998
TCS	Terms and Conditions of Service
WTR	The Working Time Regulations 1998 (as amended)

## Definitions

Allocated leave	Allocated leave is residual leave which is allocated to an individual doctor after requests for leave have been accommodated as best as possible.
Clinical academic programme	An integrated academic training programme combining both clinical and academic components (for example, those defined under the auspices of National Institute for Health Research (NIHR)).
Director of Medical Education (DME)	<p>The DME is a member of consultant medical staff and an employee of the employer / host organisation who leads on the delivery of postgraduate medical and dental education in the Local Education Provider (LEP), ensuring that doctors receive a high quality educational experience and that GMC/GDC standards are met, together with the strategic direction of the organisation and Health Education England (HEE). The DME is responsible for delivering the educational contract between the LEP/ lead provider (LP) and HEE local team.</p> <p>For the purposes of these terms and conditions, where reference is made to the DME, the responsibilities described may be discharged by a nominated deputy to the DME.</p>
Doctor	Wherever 'doctor' is used in these terms and conditions, it is intended to mean a doctor or dentist in an approved postgraduate training programme under the auspices of HEE.
Doctor or dentist in training	A doctor or dentist in postgraduate medical or dental education undertaking a post of employment or a series of posts of employment in hospital, general practice and/or other settings.
Educational review	An educational review is a formative process which enables doctors to receive feedback on their performance and to reflect on issues that they have encountered. Doctors will be able to raise concerns relating to curriculum delivery and patient safety. This will include regular discussions about the work schedule.
Educational supervisor	A named individual who is selected and appropriately trained to be responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time. The educational supervisor may be in a different department, and occasionally in a different organisation, to the trainee. Every trainee should have a named educational supervisor and the trainee should be informed of the name of the educational supervisor in writing.
Employer	The organisation by which the employee is employed and which holds the contract of employment.
Fixed leave	Fixed leave is leave built into the construction of the rota with days or weeks blocked out for each doctor in advance.

Form B	Form B is a GMC document which approves a training post at a specific point in time. It provides an outline of the educational and service activities and the expected learning outcomes from the post.
Guardian of safe working hours	A senior appointment in the employer / host organisation who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.
Host organisation	An organisation where a doctor is deployed to work in a post for a fixed period of time under a lead employer arrangement. The employer can also be, but is usually not, the host organisation.
Integrated clinical academic pathway	Integrated clinical and academic pathway refers to academic clinical fellow/clinical fellow programmes for the development of career academics.
Lead employer	An organisation that issues and holds the contract of employment throughout a doctor's training programme, during which the doctor may be deployed into one or more host organisations.
Long shift	For the purposes of these TCS, a long shift is any shift that exceeds 10 hours in duration.
Night shift	For the purposes of these TCS, a night shift is any shift where a minimum of three hours of actual work falls within the period 23.00 to 06.00.
On call	A doctor is on call when they are required by the employer to be available to return to work or to give advice by telephone but are not normally expected to be on site for the whole period. A doctor carrying an 'on-call' bleep whilst already present at their place of work as part of their scheduled duties does not meet the definition of on-call working.
On-call frequency	The on-call frequency is defined by the recognition of commitment to the on-call rota.
On-call period	An on-call period is the time that the doctor is required to be on call (as defined above) by their employer.
Placement	For the purposes of these TCS, a placement is a setting into which a doctor is placed to work for a fixed period of time in a post or posts in order to acquire the skills and competencies relevant to the training curriculum, as described in the work schedule.
Post	For the purposes of these TCS, a post has approval by the GMC/GDC for the purposes of postgraduate medical and dental education. Each approved post is located within an employer or host organisation.

Professional leave	Professional leave is leave in relation to professional work.
Professional work	Professional work is work done outside of the requirements of the curriculum and/or the employer/host organisation for professional bodies such as Royal Colleges or the GMC/GDC.
Public holiday	Holidays recognised by the NHS in England. Currently, these are: New Year's Day; Easter Friday (otherwise also known as Good Friday); Easter Monday; the two May bank holidays; the August bank holiday; Christmas Day and Boxing Day.
Rota	The working pattern of an individual doctor or group of doctors.
Rota cycle	The number of weeks' activity set out in a rota, from which the average hours of a doctor's work and the distribution of those hours are calculated.
Rotation	A rotation is a series of placements made by the HEE local office into posts with one or more employers or host organisations. These can be at one or more locations.
Shift	The period which the employer schedules the doctor to be at the work place performing their duties, excluding any on-call duty periods.
Special leave	Special leave for any circumstances will be defined by the employer's local policy.
Study leave	Study leave is leave that allows time, inside or outside of the workplace, for formal learning that meets the requirements of the curriculum. This will include regional educational events where the time is protected.
The regulator	General Medical Council/ General Dental Council.
Training programme	Training programmes and training posts are approved by the GMC or GDC. Learning environments and posts used for training are recommended for approval by HEE for the purpose of postgraduate medical/dental education. Time spent in those posts/environments allows the doctor to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificates of Completion of Training (CCT).
Unsocial hours	For the purposes of these TCS, unsocial hours are any hours that fall between 21.00 and 07.00, and any hours that fall between 17.00 and 21.00 on a Saturday, and between 07.00 and 21.00 on a Sunday.
Weekend	A weekend is Saturday and Sunday. For the purposes of these TCS, a weekend worked is defined as any weekend that contains

	any shift or duty period that either begins or ends (or both) at any time on Saturday (midnight to midnight) or Sunday (midnight to midnight).
Work schedule	A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.
Work schedule review	<p>A work schedule review is a formal process by which changes to the work schedule may be suggested and/or agreed.</p> <p>A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.</p> <p>A work schedule review should consider safe working, working hours, educational concerns and/or issues relating to service delivery.</p>
WTR reference period	Reference period as defined in the Working Time Regulations 1998 (as amended), currently 26 weeks.

## References

The *Gold Guide* as referenced in these TCS, refers to the document entitled *A reference guide for postgraduate specialty training in the UK*<sup>3</sup> as amended from time to time.

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<sup>3</sup> A Reference Guide for Postgraduate Specialty Training in the UK, The Gold Guide, Sixth Edition, <http://specialtytraining.hee.nhs.uk/files/2013/10/Gold-Guide-6th-Edition-February-2016.pdf>



# SCHEDULE 01

## GENERAL DUTIES AND RESPONSIBILITIES

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1. Doctors have clinical and professional responsibility for their patients (for doctors in public health medicine, this is for their population) as set out in the General Medical Council (GMC) guidance *Good Medical Practice*<sup>4</sup> or any successor documents, as amended or substituted from time to time. It is the duty of a doctor:
  - a. to maintain professional standards and obligations as set out by the GMC and the General Dental Council (GDC), as appropriate
  - b. to keep patients (and/or their carers, if appropriate) informed about their condition
  - c. to involve patients (and/or their carers, if appropriate) in decision-making about their treatment
  - d. to maintain the required level of skills and knowledge, and
  - e. to protect patients and colleagues from any risk posed by their own health or fitness to work.
2. A doctor is responsible for carrying out any work related to, or reasonably incidental to, the duties set out in their work schedule, such as:
  - a. the keeping of records and the provision of reports
  - b. the proper delegation of tasks, and
  - c. other related duties.
3. Doctors will be expected to be flexible and to cooperate with reasonable requests to cover for their colleagues' absences where the doctor is competent to do so, and where it is safe and practicable for the doctor to do so. Where doctors carry out work in accordance with this paragraph and such work takes place outside of their contracted hours, they will receive either an equivalent off-duty period in lieu or appropriate remuneration at the rates described in Schedule 2.
4. A doctor will be prepared to perform duties in occasional emergencies and unforeseen circumstances. Commitments arising in such circumstances are, however, exceptional and the doctor should not be required or expected to undertake work of this kind for prolonged periods or on a regular basis.
5. A doctor is expected to engage fully with the training programme
6. A doctor is expected to engage constructively with the employer in the design of services and of safe working patterns to support that service delivery.
7. A doctor will make all reasonable efforts to achieve agreed training and service delivery objectives.
8. A doctor employed under these TCS must continue to hold a place in an approved postgraduate training programme.

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<sup>4</sup> Good medical practice, [http://www.gmc-uk.org/static/documents/content/GMP\\_.pdf](http://www.gmc-uk.org/static/documents/content/GMP_.pdf)

9. A doctor must sit such examinations as are required for the completion of training. These must be completed in accordance with the curriculum, including the timetable approved by the regulator (the GMC or GDC, as appropriate).

# SCHEDULE 02

## ARRANGEMENTS FOR PAY

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### Pay and other allowances

1. Doctors will be paid a basic salary at a nodal pay point linked to the grade and the level of responsibility required in the post to which they have been appointed, at the rates set out in Annex A, as reviewed from time to time.
2. The basic salary for a doctor employed full time is calculated on an average of 40 hours' work per week.
3. The value of basic pay for doctors training less than full time will be pro rata to the levels in Annex A, based on the proportion of full-time work that has been agreed.

### Additional hours

4. Additional hours of work set out in a doctor's work schedule will be remunerated at the basic pay rate, 1/40<sup>th</sup> of whole-time equivalent for each additional hour worked, subject to the provisions of paragraph 20 below.

### On-call availability allowance

5. A doctor on an on-call rota who is required by the employer to be available to return to work or to give advice by telephone, but who is not normally expected to be on site for the whole period, will be paid an on-call availability allowance.
6. This allowance will take the form of a cash sum set out in Annex A, as amended from time to time.
7. For doctors in the foundation grades employed on a full-time basis, the value of this allowance will be individual to those grades, linked to the nodal point on which the doctor's basic salary is paid.
8. For doctors employed on a full-time basis in grades other than the foundation grades, the value of this allowance will be common across all three of the higher nodal points.
9. The values of the allowances described in paragraphs 7 and 8 will vary depending on the frequency of the on-call rota commitment, and are set out in table 1 below.

**Table 1: On-call availability allowances**

On-call availability allowance frequency	Percentage of basic pay
More frequent than or equal to 1 in 4	10 per cent
Less frequent than 1 in 4	5 per cent

10. The frequency of the on-call rota will be set out in the doctor's work schedule.
11. For doctors employed on a less-than-full-time basis, in any grade, the value of the relevant allowance will be paid pro rata, based on the proportion of full-time commitment to the rota that has been agreed in the doctor's work schedule. For example, a doctor making a 50 per cent contribution to the rota would be paid 50 per cent of the value of the allowance paid to a doctor making a full contribution the rota.
12. This allowance will not be payable where a doctor's working pattern does not include periods that meet the description in paragraph 5 above.

## **Payment for work undertaken whilst on-call**

13. Doctors will be paid for their average hours of work undertaken while on call, either in the workplace or remotely, at the rates of pay described in this Schedule. The hours paid will be calculated prospectively across the rota cycle and the estimated average hours at each rate of pay will be set out in the work schedule. For the purposes of pay, these total estimates will be converted into equal weekly amounts by dividing the total number of prospective hours at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure and the doctor will be paid 1/12<sup>th</sup> of the annual figure for each complete month, or a proportion thereof for any partial months worked.

## **Hours that attract a pay enhancement**

14. An enhancement of 50 per cent of the hourly basic pay rate will be paid on any hours worked between 21.00 and 07.00, on any day of the week.
15. An enhancement of 30 per cent of the hourly basic pay rate will be paid on any hours worked between 17.00 and 21.00 on a Saturday, and between 07.00 and 21.00 on a Sunday.
16. Where a doctor is rostered to work a shift of any length starting on a Saturday, at a frequency of 1 in 4 or more frequently over the period of the rota cycle, an enhancement of 30 per cent of the hourly basic pay rate will be paid on any hours rostered to be worked by that doctor between 07.00 and 17.00 on a Saturday, as set out in the doctor's work schedule.
17. Where a doctor is rostered for an on-call duty of any length starting on a Saturday, at a frequency of 1 in 4 or more frequently over the period of the rota cycle, an enhancement of 30 per cent of the hourly basic pay rate will be paid for the prospective average hours of actual work between 07.00 and 17.00 on a Saturday, as set out in the doctor's work schedule. Where a doctor's working pattern includes both shifts and on-call duties on different Saturdays, both types of work will be counted for the purposes of determining whether the frequency meets the 1:4 threshold for the 30 per cent enhancement described in paragraph 15 above.

18. Doctors working on a less-than-full-time basis will be entitled to the enhancements described in paragraphs 16 and 17 above if their individual work schedule meets the criteria described in these paragraphs.
19. The number of hours in the rota for which an enhancement is paid will be assessed across the length of the rota cycle (as set out in the work schedule), as described in paragraph 11 of Schedule 4 of these TCS and converted into equal weekly amounts by dividing the total number of hours to be paid at each rate by the number of weeks in the rota cycle. The weekly amount will then be turned into an annual figure and the doctor will be paid 1/12<sup>th</sup> of the annual figure for each complete month, or a proportion thereof for any partial months worked.

## **Counting of hours**

20. Average total hours, and average hours that attract an enhancement, will be assessed in quarter hours, rounded up to the nearest quarter hour.

## **Flexible pay premia**

21. Flexible pay premia, as set out in Annex A, may be payable under the circumstances described in paragraphs 22 to 49.
22. A doctor must have a national training number to be eligible for flexible pay premia.
23. A doctor can receive more than one flexible pay premium where the eligibility criteria for more than one premium have been met. A doctor cannot be eligible for the same flexible pay premium twice.
24. Flexible pay premia will be fixed at the rate applicable at the point in time at which the doctor becomes eligible, as described in paragraphs 28 to 49 below, and will continue to be paid at that same rate for the remaining period in which the doctor is working in a post as part of the training programme that attracts the premium.
25. Flexible pay premia are additional to basic pay, and are not included for the purpose of calculating any other allowances or enhancements.
26. Where flexible pay premia are payable, these will be paid to less-than-full-time trainees pro rata to their agreed proportion of full-time work.
27. The values and application of flexible pay premia will be reviewed from time to time and details will be updated in Annex A.

### **a) General practice**

28. A flexible pay premium will be paid to doctors employed on general practice training programmes.

29. The value of such a premium for each doctor will be fixed at the rate applicable to the general practice training programme at the point in time when that doctor first entered that programme.
30. Such a premium is only payable to a doctor on such a programme whilst the doctor is working in a general practice placement. It is not payable when the doctor is working in a hospital or any other setting.
31. Such a premium will not be payable to doctors on a different training programme (for example, on a Foundation training programme) when they are working in a general practice placement.

## **b) Hard-to-fill training programmes**

32. Flexible pay premia may be payable for doctors working and training on defined hard-to-fill training programmes. Where this is the case, the identity of the defined programmes, the grades on those programmes for which the premium is payable and the value of the premia applying each programme will be set out in Annex A.
33. The value of each such premium will be fixed for each doctor at the rate set out in Annex A as applying to that programme at the point in time when that doctor first entered that programme.
34. Payment of such a premium to that doctor will continue at that same fixed rate while the doctor remains employed under these TCS, until such time as the doctor exits that training programme.

## **c) Clinical academics**

### **i) Integrated clinical academic pathway**

35. A flexible pay premium will be payable to a doctor on an integrated clinical academic pathway (e.g. an NIHR pathway), at the point at which the doctor has both successfully completed the higher degree specified by the academic pathway and taken up the next training placement on the same training programme.
36. The value of such a premium will be fixed for each doctor at the rate set out in Annex A for this purpose at the point in time when that doctor, having completed the higher degree, takes up the next training placement on the same training programme.
37. Payment of such a premium to that doctor will continue at that same fixed rate while the doctor remains employed under these TCS, until such time as the doctor exits that training programme.

### **ii) Other academic career pathways**

38. A flexible pay premium will be payable to a doctor who:

- a. has been appointed to and has taken up employment on a run-through or higher training programme; and
- b. has subsequently undertaken research toward a higher degree as part of an approved out of programme research experience (OOPR); and
- c. has returned to employment in a post on the same training programme having successfully completed a higher degree during that OOPR.

39. The value of such a premium will be fixed for each doctor at the rate set out in Annex A for this purpose, at the point in time when that doctor returns to employment in a post on the same training programme.

40. Payment of such a premium to that doctor will continue at that same fixed rate while the doctor remains employed under these TCS, until such time as the doctor exits the training programme.

#### **d) Leadership**

41. A flexible pay premium will be payable to a doctor who:
- a. currently holds a National Training Number (NTN); and
  - b. has taken time out of training since obtaining the NTN; and
  - c. has undertaken and successfully completed an HEE-approved leadership programme, which requires a full-time commitment of 12 months or more (or the part-time equivalent thereof); and
  - d. has returned to employment in a post on the same training programme.

42. The value of such a premium will be fixed for each doctor at the rate set out in Annex A at the point in time when that doctor, having completed the leadership programme, returns to employment in a post on the same training programme.

43. Payment of such a premium to that doctor will continue at that same fixed rate while the doctor remains employed under these TCS, until such time as the doctor exits that training programme.

#### **e) Oral and maxillo-facial surgery (OMFS)**

44. A flexible pay premium will be payable to doctors undertaking higher training in OMFS to recognise the requirement for such doctors to complete undergraduate degrees in both medicine and dentistry. The premium will be payable at the point in time when the doctor commences employment in a post on a higher training programme in OMFS.

45. The value of such a premium will be fixed for each doctor at the rate applicable to the OMFS higher training programme, as set out in Annex A, at the point in time when that doctor first entered that programme.

46. Payment of such a premium to that doctor will continue at that same rate while the doctor remains employed under these TCS, until such time as the doctor exits that training programme.

## f) **Exceptional flexible pay premia**

47. There will be occasions when doctors take time out of training to undertake recognised activities that are deemed to be of benefit to the wider NHS. These include but are not limited to public health emergencies. Where such occasions occur, these are set out in Annex A. A doctor who has undertaken such an activity may be eligible to receive a flexible pay premium upon return to training. Eligibility criteria for such a premium is set out in Annex A.
48. The value of any such premium will be fixed for each doctor at the time that the recognised activity takes place, as set out in Annex A, at the point in time when the doctor first undertook the activity.
49. Payment of such a premium to that doctor will begin at the point where the doctor returns to training in the same training programme on which the doctor was training prior to undertaking the recognised activity and will continue at that same rate while the doctor remains employed under these TCS, until such time as the doctor exits that training programme.

## **Pay protection on re-entering training**

50. Where a doctor chooses to switch directly from one training programme (other than a Foundation programme) into an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose) and the doctor's basic pay (as defined in paragraphs 1 to 3 above) in the new appointment is lower than that paid in the immediately previous appointment on the previous training programme, the doctor may be eligible for pay protection. To be eligible for protection, the doctor must have completed at least 13 months' continuous service at the level of basic pay paid in the immediately previous appointment on the previous training programme and must take up the first appointment on the new training programme no later than six months after leaving the original training programme.
51. The amount of any pay protection due to a doctor described in paragraph 50 above will be calculated by adding together the basic salary (as defined in paragraphs 1-3 above) for the post on the new training programme and the value of the flexible pay premium applied to that programme, and comparing this with the basic salary (as defined in paragraphs 1-3 above) paid to the doctor whilst employed on the previous training programme. Any flexible pay premium paid on the previous programme will not be taken into consideration for this purpose. Where total value of the new basic salary plus the new flexible premium is lower than the value of the old basic salary, then the doctor will be eligible to have his / her basic salary protected on a mark-time basis. The pay protection will take the form of an additional pensionable amount at the value of the difference between the old basic salary and the combined total of the new basic salary and the new flexible pay premium. This sum will not be taken into consideration when calculating pay for additional hours, hours at enhanced rates or any other amounts, which will be calculated using the actual basic



salary nodal value for the post in which the doctor is employed.

52. Where a doctor, for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010<sup>5</sup>), switches directly from one training programme (other than a Foundation programme) into another training programme, whether or not that programme is an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose), and the doctor's basic pay is reduced as a result of the switch, then the provisions of paragraphs 50 and 51 will also apply to that doctor.
53. Where a doctor already employed in the NHS in a nationally recognised career grade (defined for the purposes of this schedule as being an NHS medical practitioner appointed on national terms and conditions of service other than those for doctors and dentists in training), chooses to return to training in an agreed hard-to-fill training programme and as a result of the decision to return to training, the doctor's basic pay (as defined in paragraphs 1-3 above) would be lower than that received in the previous career-grade job (exclusive of any pay for additional hours / sessions, excellence awards or similar payments, on-call or other allowances, pay premia or any other supplementary payments paid or received) the doctor will be eligible for pay protection.
54. To be eligible for this pay protection the doctor must:
- a. have at least 13 months' continuous service in the same nationally recognised career grade at the point immediately prior to re-entering training, and
  - b. move immediately from their nationally recognised career grade to the hard to fill training programme.
55. The amount of any pay protection due to a doctor described in paragraph 53-54 above will be calculated by comparing the basic salary paid to the doctor whilst employed in the previous career grade (as described in paragraph 53 above), with the sum total of the following:
- a. the nodal point applicable to the doctor's entry level into the hard-to-fill training programme, plus
  - b. any additional payments due in that post, including:
    - i. pay for additional rostered hours
    - ii. any enhanced rates paid for hours worked that attract such enhancements
    - iii. any on-call availability allowance
    - iv. any appropriate flexible pay premium.

Where the basic salary paid to the doctor whilst employed in the previous career grade exceeds the sum total described above, the doctor will be eligible to have his / her basic salary protected on a mark-time basis and so will receive an additional amount sufficient to increase the total salary so that it equals the higher level of basic salary previously paid. This sum will not be taken into consideration when calculating pay for additional hours, hours at enhanced

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<sup>5</sup> Equality Act 2010, <http://www.legislation.gov.uk/ukpga/2010/15/contents>

rates or any other amounts, which will be based on the actual basic salary for the post in which the doctor is employed.

56. Where a doctor already employed in the NHS in a nationally recognised career grade (as defined in paragraph 53 above) re-enters training for reasons directly or indirectly linked to a disability (for the purposes of the Equality Act 2010<sup>6</sup>), in any training programme, whether or not that programme is an agreed hard-to-fill training programme (identified in Annex A as being one where a flexible pay premium applies for this purpose), and the doctor's basic pay is reduced as a result of the switch, then the provisions of paragraphs 53-55 will also apply to that doctor.

## Maternity pay

57. The provisions governing maternity pay are set out in Schedule 13.
58. Additionally to the above provisions, if a doctor returns from an approved period of time out of programme and:
- a. the continuity of service provisions mean the doctor is eligible for maternity leave and pay, but
  - b. the reference period for calculating maternity pay means that the value of the occupational maternity pay would otherwise be nil,
- then the maternity pay reference period is defined as being the doctor's last period of paid employment in the previous training placement immediately prior to commencing the period of time spent out of programme.

## London weighting

59. London weighting for doctors will be paid as set out in Annex A.
60. London weighting is a fixed sum, paid pro rata to doctors working less than full time, and is not taken into account in the calculation of any other allowances or enhancements.

## Pension arrangements

61. Doctors will be eligible for membership of the NHS Pension Scheme, the provisions of which are set out in the NHS Pension Scheme Regulations 2015<sup>7</sup> (as amended).
62. The following will be pensionable in the NHS Pension Scheme:
- a. All hours worked up to 40 hours per week on average and paid at the basic pay rate.
  - b. London weighting.
  - c. Flexible pay premia other than that for general practice described in paragraphs 28-31.

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<sup>6</sup> Equality Act 2010, <http://www.legislation.gov.uk/ukpga/2010/15/contents>

<sup>7</sup> The National Health Service Pension Scheme Regulations 2015, [http://www.legislation.gov.uk/uksi/2015/94/pdfs/uksi\\_20150094\\_en.pdf](http://www.legislation.gov.uk/uksi/2015/94/pdfs/uksi_20150094_en.pdf)

- d. Pay protection amounts as described in paragraphs 50-54.
63. The following will not be pensionable in the NHS Pension Scheme:
- a. Payments for additional rostered hours above 40 per week.
  - b. Enhancements paid for working unsocial hours.
  - c. On-call availability allowances.
  - d. Flexible pay premia for general practice training programmes described in paragraphs 28-31.
  - e. Travelling, subsistence and other expenses paid as a consequence of the doctor's work for the employing organisation or the wider NHS.

## **Changes to the work schedule affecting pay**

64. Where pay is increased as a result of changes to the work schedule, pay will be altered from the date that the change is implemented. Other than in exceptional circumstances, such changes to pay will usually be prospective.
65. Where changes to the work schedule are required by the employer and total pay would be decreased as a result, the doctor's total pay will be protected and so remain unchanged until the end of the particular placement covered by that work schedule. This protection will not extend to any subsequent placement, including a placement where the doctor returns at a later date to the same post.
66. Where changes to the work schedule are requested by the doctor and agreed by the employer, and total pay would be decreased as a result, the doctor's total pay will be reduced in line with the change in the work schedule, from the date that the change is implemented.

## **Pay in exceptional circumstances to secure patient safety**

67. Exceptionally, because of unplanned circumstances, a doctor may consider that there is a professional duty to work beyond the hours described in the work schedule, in order to secure patient safety. In such exceptional circumstances, employers will appropriately compensate the individual doctor for such hours, if the work:
- a. has been undertaken for the needs of the service, and
  - b. is authorised by an appropriate person (typically, this authorisation would be given before or during the period of extended working).
68. Such compensation may be by additional payment (at the basic pay rate as described in paragraph 4 above, uplifted by any enhancement that may apply at the time that the unscheduled work takes place, as described in paragraphs 14 to 19 above) or by time off in lieu, or by a combination of the two. Where safe working hours are threatened by such an extension of working hours, time off in lieu will be the preferred, and in some cases the only, option. Where such instances occur, the employer and the doctor should refer to the provisions in Schedules 5 and 6 as appropriate.
69. Where a payment is made to the doctor for additional work under the provisions of paragraphs 65-66 above, this is normally payable at the rate of pay applicable to the hours worked. This includes any enhanced rates as described

in paragraphs 15-19 above.

70. Where such additional hours are in breach of the Working Time Regulations' limit of a 48-hour average working week or of the absolute contractual maximum of 72 hours worked across any consecutive seven-day period set out in paragraph 7 of Schedule 3, or where the minimum rest requirement of 11 hours described in paragraph 18 of Schedule 3 has been reduced to fewer than eight hours, any hours above these 48- and 72-hour limits and/or which reduced the 11-hour rest period will attract a penalty rate, as set out in Table 2 below.

**Table 2: Penalty rates of pay**

<b>Normal rate paid</b>	<b>Penalty rate</b>
Plain time	Time plus 50%
Time plus 30%	Time plus 95%
Time plus 50%	Time plus 125%

## **Locum pay**

71. Where a doctor carries out additional work for the employer through a locum bank, as described in Schedule 3, paragraphs 40-41 of these TCS, such work will be paid at the rates set out for this purpose in Annex A.

# SCHEDULE 03

## WORKING HOURS

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### Principles

1. Contractual limits on working hours and protected rest periods, as set out in this schedule, are necessary to ensure both patient safety and the safety of the doctor.
2. The employer and the doctor must comply with the regulatory limits set out in the Working Time Regulations 1998<sup>8</sup> (the Regulations), as amended, or any successor legislation. The employer and the doctor should pay particular attention to the safeguards on hours and rest, including those related to night workers, as set out in the Regulations<sup>1</sup>.
3. The employer has a contractual and regulatory responsibility for ensuring the doctor is not contracted, or otherwise required, to work outside the limits covered in paragraph 1 and 2.
4. Individual doctors have a professional responsibility for ensuring that their total hours of work, including any work undertaken for any other employer, comply with the contractual and regulatory limits set out in paragraphs 1 and 2.
5. To provide assurance to both the employer and the doctor on safe working hours as described in paragraphs 1 to 4 above, a guardian of safe working hours will be appointed by the employer/host organisation. This role is described in Schedule 6.

### Limits on hours

6. No doctor should be rostered for more than an average of 48 hours of actual work per week, as calculated over the reference period defined in the Regulations.
7. No more than 72 hours' actual work should be rostered for or undertaken by any doctor, working on any working pattern, in any period of seven consecutive calendar days.
8. No shift (other than an on-call duty period as defined in the 'definitions' section of this document) should be rostered to exceed 13 hours in duration.

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<sup>8</sup> The Working Time Regulations 1998, <http://www.legislation.gov.uk/ukxi/1998/1833/contents/made>

9. No more than five long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be rostered or worked on consecutive days. Where five long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fifth long shift.
10. Where long shifts (as defined in paragraph 9 above) finish after 23.00, no more than four such shifts can be rostered or worked on consecutive days. Where four such shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fourth such shift.
11. No more than four night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where at least three hours of actual work falls into the period between 23.00 and 06.00.
12. Where three night shifts are rostered or worked consecutively, a doctor may be rostered to work a fourth consecutive night shift. However, if the doctor is not rostered for a fourth consecutive night shift, then there must be a minimum 48-hour rest period rostered immediately following the conclusion of the third night shift.
13. Where four night shifts are rostered or worked consecutively, there must be a minimum 48-hour rest period rostered immediately after the conclusion of the fourth and final night shift.
14. Where four long shifts (exceeding ten hours) which finish after 23.00 are rostered or worked consecutively, there must be a minimum 48-hour rest period rostered immediately thereafter.
15. A maximum of eight shifts of any length can be rostered or worked on eight consecutive days.
16. Where eight days are worked consecutively, there must be a minimum 48-hours' rest rostered immediately following the conclusion of the eighth and final shift.
17. No doctor should be rostered for work at the weekend (defined as shifts or on-call duty periods starting at any time between 00.01 on a Saturday and 23.59 on a Sunday) on consecutive weekends without written agreement. Regardless of any agreement, no doctor should be rostered to work at the weekend at a frequency of greater than 1 weekend in 2.
18. Other than as set out in paragraphs 6-17 above where longer minimum rest periods may apply, under the Regulations there should normally be at least 11 hours' continuous rest between rostered shifts, other than on-call duty periods.

19. Breaches of 11 hours' rest in a 24-hour period will be subject to compensatory rest, which must be given in a realistic time frame. In exceptional circumstances where, due to service need as required by the employer, the rest period is reduced to fewer than eight hours, the doctor will be paid for the additional hours worked that resulted in the shortening of the rest period, at the appropriate rate. 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.

## **Breaks**

20. A doctor must receive:

- a. at least one 30-minute paid break for a shift rostered to last more than five hours, and
- b. a second 30-minute paid break for a shift rostered to last more than nine hours.

21. The breaks described in paragraph 20 above can be taken flexibly during the shift, or combined into one longer break, but cannot be taken within an hour of the shift commencing or held over to be taken at the end of the shift.

## **On-call periods**

22. For the purposes of this Schedule, an on-call period is as defined in the definitions section of these TCS.

23. A doctor carrying an on-call bleep whilst already present at their place of work as part of the doctor's rostered duties does not meet the definition of on call.

24. The maximum length of an individual on-call duty period is 24 hours.

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

26. Unless agreed locally as described in paragraph 25 above, there must be no more than three on-call duty periods in any period of seven consecutive days.

27. The day following an on-call duty period (or following the last on-call period, where more than one 24-hour period is rostered consecutively) must not be rostered to last longer than 10 hours.
28. Whilst on call, a doctor should expect to get eight hours rest per 24-hour period, of which at least five should be continuous rest between 22:00 and 07:00. Where this is not expected to be possible, then the provisions of paragraph 29 apply.
29. Where it is expected that the rest requirements set out in paragraph 28 may not be met, rostered duty on the day following the on-call period must not exceed five hours.
30. Where during an on-call duty period, a doctor's expected overnight rest is significantly disrupted, causing a breach in the expected rest requirements, the doctor must inform their employer immediately, or as soon as reasonably practicable, and arrangements must be made for the doctor to take appropriate rest.
31. If, as a result of actual hours worked during the on-call period, a doctor's rest has been significantly disrupted and the doctor considers it unsafe to undertake work because of tiredness, the doctor must inform the employer that the doctor will not be attending work as rostered. No detriment to pay will result from the doctor making such a declaration. Arrangements for dealing with this issue must be agreed locally.
32. The work schedule of a doctor rostered to be on call will contain an average amount of time, calculated prospectively, for anticipated work during the on-call period. This is defined as working time for the purposes of these TCS. Any time during the on-call period when the doctor is not anticipated to be either working in the workplace or providing advice to the workplace, is defined as non-working time for the purposes of these TCS.
33. Where the doctor is required by the employer to be resident in the workplace, the entire period of residence will be counted as working time for the purposes of the Regulations. Only time anticipated and set out in the work schedule as working time will count towards the hours' limits, or for the purposes of pay, as set out in these TCS.
34. Where a doctor is required to work a night shift or a shift on a weekend as part of a rota for a department or service, the employer will not in addition roster a second doctor working that same rota to be available non-resident on call for the same night or weekend, unless there is a clearly identified clinical reason agreed by the clinical director and the work pattern is agreed by both the guardian of safe working hours as being safe and the DME as being educationally appropriate. A trainee asked to work such a rota who feels that



this is inappropriate will have the right to request a work schedule review, as set out in Schedule 5.

## **Opting out of the Regulations**

35. A doctor may voluntarily choose to opt out of the Regulations' average weekly limit of 48 hours, subject to prior agreement in writing with the employer. A decision to exercise this option is individual, voluntary and no pressure may be placed on the doctor to take this option.
36. Under these TCS, where a doctor has opted out of the Regulations' average weekly working hours, overall hours are restricted to a maximum average of 56 hours per week, across all or any organisations with whom the doctor is contracted to work or otherwise chooses to work. This must be calculated over the reference period defined in the Regulations. Additionally, the maximum of 72 hours worked in any period of seven consecutive days applies, as described in paragraph 7 above.
37. Under these TCS, a doctor opting out of the Regulations' weekly hours limit is still bound by all of the other limits set out in the Regulations and in these TCS.
38. A doctor's agreement to opt out may apply either to a specified period or indefinitely. To end any such agreement, a doctor must give written notice to the employer. The notice period will be seven days, or a period up to a maximum of three months specified in the agreement, whichever is the longer.
39. Records of such agreements must be kept and be made available to relevant recognised unions and appropriate regulators on request.

## **Locum work**

40. Where a doctor intends to undertake hours of paid work as a locum, additional to the hours set out in the work schedule, the doctor must first offer such additional hours of work to the employer / host organisation. The employer / host organisation can, but is not obliged to, offer the doctor the opportunity to carry out additional activity over and above the standard commitment set out in the doctor's work schedule up to a maximum average of 48 hours per week (or up to 56 hours per week if the doctor has opted out of the Regulations). Rates of payment for such work are set out in Annex A.
41. The employer will set out local processes and timescales:
  - a. for the doctor to indicate availability for such work, and

b. for the employer to decide whether or not to accept the offer of additional hours.

42. Only after the employer / host organisation has declined the doctor's offer to work additional hours as a locum should the doctor enter into any agreement to carry out any additional work for any other employer / host organisation, whether directly or indirectly (for example through an agency or limited company).

# SCHEDULE 04

## WORK SCHEDULING

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### Principles

1. These terms and conditions of service provide a framework for the safety of doctors in the training and service delivery domains of the working experience.
2. The employer or host organisation designs schedules of work that are safe for patients and safe for doctors, and ensures that work schedules are adhered to in the delivery of services.
3. Work scheduling for doctors allows employers to plan and deliver clinical services while delivering appropriate training.
4. Educational planning and clinical work scheduling are interlinked, reflecting the interdependence of training and service commitments of doctors. Where the doctor is on an integrated academic pathway, the academic components of the placement also need to be reflected in the work schedule, in accordance with Follett principles<sup>9</sup>.
5. The employer / host organisation will be responsible for ensuring that a generic work schedule is prepared for the post, which takes into account:
  - a. the expected service commitments, and
  - b. the parts of the relevant training curriculum that can be achieved in the post. This latter element must be consistent with the post's Application for Approval of a Training Post, which have been agreed with the Postgraduate Dean.
6. The generic work schedule will form the basis for a personalised work schedule.
7. A work schedule will normally apply for the duration of a training placement, and will identify the number and distribution of hours for which the doctor is contracted.
8. A work schedule may be subject to review from time to time.

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<sup>9</sup> A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties,  
<http://webarchive.nationalarchives.gov.uk/20060715145349/dfes.gov.uk/follettreview/>

## Generic work schedule

9. The generic work schedule must be provided to a doctor prior to starting a placement to ensure that the doctor is informed of the work and range of duties that are expected to be undertaken during the placement.
10. The generic work schedule will list and identify the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.
11. A standard full-time generic work schedule will be for a minimum of 40 hours and a maximum of 48 hours per week, averaged over a reference period defined as being the length of the rota cycle, the length of the placement or 26 weeks, whichever is the shorter. A part-time generic work schedule will not exceed 40 hours, averaged over this same reference period. When calculating the average total hours, the number of days' leave that would be taken by a doctor, on average, across the length of the rota cycle will be deducted from the rota and the remaining hours will be divided by the remaining weeks (including part-weeks) in the cycle. For example, in an eight-week cycle with six days' leave deducted, the total remaining hours would be divided by 6.8 weeks.
12. The generic work schedule will include a description of the hours to be worked, any shift working or on-call arrangements, including any service commitment to unscheduled urgent or emergency care, and will set out in general terms when and where the doctor's duties and responsibilities will be delivered.
13. The duties and responsibilities set out in the generic work schedule will include, as appropriate:
  - a. clinical care and service duties
  - b. specific training
  - c. work in or for other organisations (if required by the employer / host organisation).
14. Where the doctor is required to participate in a service commitment to unscheduled, urgent or emergency care, the work schedule will set out the expected requirements to contribute to a duty roster and/or on-call rota for the safe provision of service. The work schedule may include duties throughout the 24-hour day and the seven-day week, including work on statutory and public holidays.
15. The work schedule for a doctor on a general practice training programme working in a general practice setting should reflect the 2012 COGPED

guidance<sup>10</sup> or any successor document on the session split during the average 40-hour week that comprise a minimum full-time contract. Any additional hours of work above 40 must be included in the doctor's work schedule and linked through to the curriculum, as per those for doctors in hospital settings.

## Personalised work schedule

16. The generic work schedule will form the basis for a personalised work schedule which will be agreed between the educational supervisor and the doctor, in accordance with the *Gold Guide*<sup>11</sup> and/or other relevant documents, as amended from time to time. This will be agreed before or as soon as possible after the commencement of the placement.
17. The doctor and the educational supervisor are jointly responsible for personalising the work schedule, according to the doctor's learning needs and the opportunities within the post.
18. The educational review (with the educational supervisor, or approved clinical supervisor in a general practice programme) will include a discussion of the work schedule to ensure that their workplace experience delivers the anticipated learning opportunities.
19. The employer may need to make changes to a work schedule during the placement if there are significant changes in the facilities, resources or services. Every effort should be made to anticipate such changes in the work schedule and reach agreement on such changes.

## Work schedule objectives

20. The generic work schedule will describe the training opportunities and the service commitments required to achieve the objectives of the placement.
21. The personalised work schedule should add to the generic schedule the doctor's personal objectives in:
  - a. training (consistent with the education/training contract between the Deanery function and the doctor, and
  - b. service delivery, both to align the doctor's service commitments to the employer's objectives and to recognise not only that competencies can be achieved through service delivery but that some can only be achieved in this way.

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<sup>10</sup> Guide to a session for GP trainees and trainers, July 2012, <http://www.wessexdeanery.nhs.uk/pdf/BMAsessions.pdf>

<sup>11</sup> A Reference Guide for Postgraduate Specialty Training in the UK, The Gold Guide, Sixth Edition, <http://specialtytraining.hee.nhs.uk/files/2013/10/Gold-Guide-6th-Edition-February-2016.pdf>

22. The training objectives will set out a mutual understanding of the training needs of the doctor over the period of the work schedule, and of how, in working to achieve these objectives, the doctor will contribute to the objectives of the employer.

23. A doctor's individual objectives will depend in part on the specialty and the level of competencies achieved, and may on occasion differ from the objectives set out in the generic work schedule.

## **Setting and maintaining the work schedule**

24. The work schedule brings together activities to achieve service and learning objectives.

25. As a minimum, there should be an educational review and work schedule discussion at the start and finish of the placement for which the work schedule applies.

26. The personalised work schedule will be discussed and agreed at the first formal meeting between the educational supervisor for the placement and the doctor.

27. The doctor and educational supervisor will regularly consider progress against agreed learning objectives determined by the curriculum, and the doctor's service objectives.

28. Work schedule discussions should establish whether any changes in support or resources, or in planned service duties, are needed to enable the doctor to achieve the objectives within rostered working hours.

29. Discussions should take place if either the employer or the doctor consider that the training opportunities, duties, responsibilities, accountability arrangements or objectives have changed significantly, or need to change significantly, or that the agreed objectives may not be achieved for reasons outside the doctor's control.

## **Resolving disagreements over the work schedule**

30. The educational supervisor will make every effort to agree with the doctor appropriate changes to the work schedule, and to implement the changes within a reasonable time, taking into account the remaining duration of the post/ placement. If it is not possible to reach agreement or achieve the agreed outcome the doctor may invoke the provisions of Schedule 5.

# **SCHEDULE 05**

## **EXCEPTION REPORTING AND WORK SCHEDULE REVIEWS**

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### **Purpose**

1. The purpose of exception reports is to ensure prompt resolution and / or remedial action to ensure that safe working hours are maintained. The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose, in circumstances where earlier discussions have failed to resolve concerns.

### **Exception reporting**

2. Exception reporting is the mechanism used by doctors to inform the employer when their day-to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be:
  - a. differences in the total hours of work (including opportunities for rest breaks)
  - b. differences in the pattern of hours worked
  - c. differences in the educational opportunities and support available to the doctor, and/or
  - d. differences in the support available to the doctor during service commitments.
3. Exception reports allow the employer the opportunity to address issues as they arise, and to make timely adjustments to work schedules.
4. Exception reports should include:
  - a. the name, specialty and grade of the doctor involved
  - b. the identity of the educational supervisor
  - c. the dates and times of exceptions
  - d. the nature of the variance from the work schedule, and
  - e. an outline of the steps the doctor has taken to resolve matters before escalation (if any).
5. The doctor will send exception reports electronically to the educational supervisor.
6. The doctor will copy the exception report to the director of medical education (DME) in relation to training issues, and to the guardian of safe working hours in relation to safe working practices. In some cases, the doctor may copy the report to both.

7. Upon receipt of an exception report, the educational supervisor will discuss with the doctor what action is necessary to address the reported variation or concern. The supervisor will set out the agreed outcome of the exception report, including any agreed actions, in an electronic response to the doctor, copying the response to the DME or guardian of safe working hours as appropriately identified in paragraph 6 above.
8. The DME will review the outcome of the exception report to identify whether further improvements to the doctor's training experience are required.
9. The guardian of safe working hours will review the outcome of the exception report to identify whether further improvements to the doctor's working hours are required to ensure that the limits on working hours outlined in these TCS are being met.

## **Breaches incurring a financial penalty**

10. The guardian of safe working hours will review all exception reports copied to them by doctors to identify whether the doctor believes that the exception indicates a breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule) or of the maximum 72-hour limit in any seven days, or that the minimum 11 hours' rest requirement between shifts has been reduced to fewer than eight hours. Where a doctor highlights such concerns, the guardian will seek verification that this is the case. Where the concerns have been validated and shown to be correct, then the doctor will be paid for the additional hours at the penalty rates set out in paragraph 70 of Schedule 2 of these TCS. The guardian will additionally levy a fine on the department employing the doctor for those additional hours worked, at the rates set out in table 1 below:

**Table 1: Schedule of Fines**

<b>Normal rate paid</b>	<b>Penalty rate</b>	<b>Fine</b>
Plain time	Time plus 50%	Time plus 150%
Time plus 30%	Time plus 95%	Time plus 225%
Time plus 50%	Time plus 125%	Time plus 275%

## **Immediate safety concerns**

11. Where an exception report indicates concern that there is an immediate and substantive risk to the safety of patients or of the doctor making the report, this should be raised immediately (verbally) by the doctor with the consultant responsible for the service in which the risk is thought to be present (typically, this would be the head of service or the consultant on-call). The doctor must confirm such reports electronically to the educational supervisor (via an exception



report) within 24 hours.

12. The employer has a duty to respond as follows:
  - a. Where the consultant receiving the report considers that there are serious concerns and agrees that there is an immediate risk to patient and/or doctor safety, the consultant on call will, where appropriate, grant the doctor immediate time off from their agreed work schedule and/or (depending on the nature of the reported variation) ensure the immediate provision of support to the doctor. The consultant will notify the educational supervisor and the guardian of safe working hours within 24 hours. The educational supervisor will undertake an immediate work schedule review, and will ensure appropriate (and where necessary, ongoing) remedial action is taken.
  - b. Where the consultant receiving the report considers that there are serious but not immediate concerns, the consultant will ask the doctor to submit an exception report to the educational supervisor, describing the concern raised and requesting a work schedule review.
  - c. Where the consultant receiving the report considers that the single concern raised is significant but not serious, or understands that there are persistent or regular similar concerns being raised, the consultant will ask the doctor to raise an exception report to the educational supervisor within 48 hours.

## **Work schedule review process**

13. Where a doctor, an educational supervisor, a manager, or the guardian of safe working hours has requested a work schedule review, the process set out in paragraphs 14-28 below will apply.
14. The educational supervisor will meet or correspond with the doctor as soon as is practicable, ideally no later than seven working days after receipt of a written request for a review. Where this is in response to a serious concern that there was an immediate risk to patient and/or doctor safety as described in paragraphs 11-12 above, this must be followed up within seven working days.
15. The conversation between the doctor and the educational supervisor will lead to one of the following outcomes:
  - a. No change to the work schedule is required.
  - b. Prospective documented changes are made to the work schedule.
  - c. Compensation of time off in lieu is required.
  - d. Organisational changes, such as a review of the timing of ward rounds, handovers and clinics, are needed.

16. Organisational changes may take a reasonable time to be enacted. Where this is the case, temporary alternative arrangements, including amendments to pay, may be necessary.
17. The outcome of the conversation will be communicated in writing.
18. If dissatisfied with the outcome, the doctor may formally request a level 2 work review within 14 days of notification of the decision. The request must set out the areas of disagreement about the work schedule, and the outcome that the doctor is seeking.
19. A level 2 review discussion will take place no more than 21 working days after receipt of the doctor's formal written request. A level 2 review requires a meeting between the educational supervisor, the doctor, a service representative and a nominee either of the director of postgraduate medical education (where the request pertains to training concerns) or of the guardian of safe working hours (where the request pertains to safe working concerns). Where the doctor is on an integrated academic training pathway, the academic supervisor should also be involved.
20. The discussion will first consider the outcome of the level 1 conversation and will result in one of the following outcomes:
  - a. The level 1 outcome is upheld.
  - b. Compensation of time off in lieu is required.
  - c. No change to the work schedule is required.
  - d. Prospective documented changes are made to the work schedule.
  - e. Organisational changes, such as a review of the timing of ward rounds, handovers and clinics, are needed.
21. The outcome will be communicated in writing.
22. If dissatisfied with the outcome, the doctor may request a final stage work review within 14 days of notification of the decision. The request must set out the areas of disagreement about the work schedule, and the outcome that the doctor is seeking.
23. The final stage for a work schedule review is a formal hearing under the final stage of the employer's local grievance procedure, with the proviso that the DME or nominated deputy must be present as a member of the panel.
24. The hearing will take place within the timeframe specified in the local grievance procedure.
25. Where the doctor is appealing a decision previously taken by the guardian of safe working hours, a doctor in training working for the employing or host

organisation will be nominated by the employer's agreed junior doctor representatives to attend the panel in an advisory capacity.

26. The panel hearing will result in one of the following outcomes:
  - a. The level 2 outcome is upheld.
  - b. Compensation of time off in lieu is required.
  - c. No change to the work schedule is required.
  - d. Prospective documented changes are made to the work schedule.
  - e. Organisational changes, such as a review of the timing of ward rounds, handovers and clinics, are needed.
27. The outcome will be communicated in writing and a copy provided to the guardian of safe working hours.
28. The decision of the panel will be final.
29. Where at any point in the process of a work schedule review, either the doctor or the reviewer identifies issues or concerns that may affect more than one doctor working on a particular rota, it may be appropriate to review other schedules forming part of that rota. In this case, such reviews should be carried out jointly with all affected doctors and, where appropriate, changes may be agreed to the working pattern for all affected doctors working on that rota, following the same processes as described in paragraphs 13-28 above.

## **Reporting**

30. The guardian of safe working hours will report annually to the Board on all work schedule reviews relating to safe working hours.
31. The DME will report annually to the Board on all work schedule reviews relating to education and training.
32. A copy of these annual reports will be made available to the Care Quality Commission and to HEE.
33. Employers must retain copies of all reviews for a period of two years from the date that an outcome is reached. Where remuneration is approved as part of this process, records will be retained in line with the organisation's Standing Financial Instructions.

# **SCHEDULE 06**

## **GUARDIAN OF SAFE WORKING HOURS**

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1. The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around doctors' working hours in these terms and conditions are designed to ensure that this risk is effectively mitigated and that this mitigation is assured.
2. There are three functions which oversee the safety of doctors in the training and service delivery domains of their working experience:
  - a. The employer or host organisation designs schedules of work that are safe for patients and safe for doctors, and ensures that work schedules are adhered to in the delivery of services.
  - b. The director of medical education (DME) oversees the quality of the educational experience.
  - c. The guardian of safe working hours (hereafter referred to as the guardian) provides assurance to the employer, and host organisation if appropriate, on compliance with safe working hours by the employer and the doctor.
3. Doctors are also responsible for ensuring that both their pattern of work and their total hours of work, including any and all work undertaken for any employer, whether directly or indirectly (for example through an agency or limited company), comply with the limits set out in schedule 3, and that they remain safe to carry out clinical duties.

### **The role of the guardian of safe working hours**

4. The guardian is a senior appointment and the appointee will not hold any other role within the management structure of the employer / host organisation. The guardian will ensure that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate. The guardian will provide assurance to the Board that doctors' working hours are safe. (This assurance is in addition to the provisions and safeguards as set out in schedules 3, 4 and 5).

### **Appointment of the role of guardian of safe working hours**

5. The employer (and/or host organisation, if appropriate) must appoint a guardian of safe working hours to assure the safety of doctors. Appointment would normally be for a minimum of three years, subject to annual performance review.

6. The following principles should be taken into account in appointing to the role:

- a) It is the employer's responsibility to appoint the guardian.
- b) The appointment panel for the guardian should include the medical director or a nominated deputy, the director of HR/workforce or a nominated deputy, and two doctors in training, nominated by the local negotiating committee (LNC) or equivalent. At least one and if at all possible both of the doctors in training must be based in the appointing employer (or host organisation, if appropriate).
- c) The panel should reach consensus on the appointment.
- d) The recruitment process for the appointment of the guardian should otherwise follow local recruitment processes.
- e) The employer (and/or host organisation, if appropriate) will have discretion to set the guardian's time commitment, taking into consideration the number of rotas and the number of doctors in training for whom the guardian will have responsibility.
- f) Employers / host organisations can choose to act collaboratively to make and share the appointment across a number of employers.

## **Responsibilities of guardian of safe working hours**

7. The guardian will:

- a. act as the champion of safe working hours for doctors in approved training programmes
- b. provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of these terms and conditions of service
- c. receive copies of all exception reports in respect of safe working hours. This will allow the guardian to record and monitor compliance with the terms and conditions of service
- d. escalate issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level
- e. require intervention to mitigate any identified risk to doctor or patient safety in a timescale commensurate with the severity of the risk
- f. require a work schedule review to be undertaken, where there are regular or persistent breaches in safe working hours, which have not been addressed
- g. have the authority to intervene in any instance where the guardian considers the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily; and
- h. distribute monies received as a consequence of financial penalties to improve the training and service experience of doctors.

## Reporting

8. The guardian reports to the Board of the employer (and host organisation, if appropriate), directly or through a committee of the Board, as follows:
  - a. The Board must receive a *Guardian of Safe Working Report* no less than annually. This report will also be provided to the LNC, or equivalent.
  - b. Where the guardian has escalated a serious issue in line with paragraph 7(d) above and the issue remains unresolved, the guardian must submit an exceptional report to the next meeting of the Board.
  - c. The Board is responsible for providing annual reports to external bodies as defined in these terms and conditions, including Health Education England (Local office), Care Quality Commission, General Medical Council and General Dental Council.
9. There may be circumstances where the guardian identifies that certain posts have issues that cannot be remedied locally, and require a system-wide solution. Where such issues are identified, the guardian will inform the Board. The Board will raise the system-wide issue with partner organisations (e.g. Health Education England, NHS England, NHS Improvement) to find a solution.

## Accountability

10. The guardian is accountable to the Board.
11. The line management arrangements for the guardian are for local determination but this reporting line should be to the appropriate executive director or equivalent, who will be responsible for carrying out the annual appraisal of the guardian.
12. Appraisal of the guardian role should include appropriate and relevant 360-degree feedback, which will include feedback from doctors in training.

# SCHEDULE 07

## PRIVATE PROFESSIONAL AND FEE PAYING WORK

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### Principles

1. The doctor is responsible for ensuring that the employer is advised of any regular commitments the doctor has in relation to the provision of any private professional work.
2. The doctor is responsible for ensuring any private professional work undertaken by the doctor does not result in any detriment to NHS patients or services.
3. The doctor should be aware of the relationship between the hours of work undertaken under this schedule and the principles underlying the restrictions on total hours that the doctor can work under these terms and conditions of service as set out in Schedule 3.
4. A doctor must not be paid twice for the same period of time.
5. When undertaking private professional or fee-paying work, doctors in training must make clear their trainee status on each occasion.
6. Doctors are solely responsible for the payment and management of the tax and insurance liabilities and any related costs in respect of any private professional or fee-paying work that the doctor undertakes, and for ensuring that they have adequate and appropriate insurance and indemnity for such work, as per GMC guidance. This applies whether or not the work is undertaken on the employer's premises, or elsewhere. The doctor agrees to indemnify the employer for any costs or demands that the employer incurs in relation to such liabilities.

### Disclosure of information about private commitments

7. The doctor must keep the educational supervisor informed of any regular commitments in respect of private professional work. This information must be disclosed as part of the initial work schedule discussion and include details of the work involved and when it occurs. The doctor must also provide information in advance about any significant changes to this information.

### Scheduling of work

8. NHS or other contractual commitments must take precedence over the provision of private professional work, except where a doctor is asked at short notice to undertake NHS work beyond their agreed work schedule and this would prevent them from meeting pre-existing and previously disclosed private

professional commitments which cannot reasonably be rescheduled.

## Use of NHS facilities

9. The doctor must obtain the employing organisation's prior agreement to use NHS facilities, staff and/or resources for the provision of private professional or fee-paying work.
10. The employing organisation has discretion to allow the use of its facilities, staff and/or resources. The employer will make it clear which facilities, if any, a doctor is permitted to use for private purposes, and to what extent, and whether any charge will be levied for the use of these facilities, staff and/or resources.
11. If a doctor with the employing organisation's permission, undertakes private professional work in any of the employing organisation's facilities, the doctor must observe the principles and relevant provisions in the *Code of conduct for private practice*<sup>12</sup>.
12. Doctors must also make themselves aware of and comply with their employing and/or host organisation's policies and procedures for private practice.

## Patient enquiries about private treatment

13. Where, in the course of the doctor's duties, a doctor is approached by a patient and asked about the provision of private professional work, the doctor must refer the patient, without advice or comment, to the consultant responsible for the patient's care.

## Fee-paying services

14. Fee-paying work should normally be carried out in time for which the doctor is not being paid by the employer (i.e. in the doctor's own time). The employer may, but is not obliged to, agree with the doctor that fee-paying work can be undertaken in the circumstances set out in paragraphs 15 and 16 below.
15. If a fee is paid directly to the doctor for such work done during the time for which the doctor is paid by the employer, the doctor must remit the whole fee to the employing organisation.

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<sup>12</sup> A Code of Conduct for Private Practice, January 2004,  
[http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/DH\\_085195.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/DH_085195.pdf)



16. The employer can, but is not obliged to, agree that a doctor may retain the fee for such work carried out during time the doctor is being paid by the employer, provided that the doctor either:
  - a. authorises the employer to reclaim the salary for the time during which the fee-paying service was delivered, or
  - b. agrees with the employer to make up the time at a later date by carrying out additional NHS work for the requisite time during a period of time outside of the doctor's work schedule.

# SCHEDULE 08

## OTHER CONDITIONS OF EMPLOYMENT

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### Outside employment and financial interests

1. A doctor must declare:
  - a. any outside financial interest or any financial relationship with an external organisation they may have which may conflict or could be perceived to conflict with the policies, business activity and decisions of the employing organisation; and/or
  - b. any financial or pecuniary advantage they may gain whether directly or indirectly as a result of a privileged position within the employing organisation.
  
2. It is the responsibility of the doctor to ensure they comply with their corporate responsibilities as set out in the organisation's standing financial instructions.

### Research

3. All research must be managed in accordance with the requirements of the Department of Health research governance framework. Doctors must comply with all reporting requirements, systems and duties of action put in place by the employing organisation to deliver research governance. Doctors must also comply with the GMC guidance *Good practice in research*<sup>13</sup> as from time to time amended.

### Confidentiality

4. A doctor has an overriding professional obligation to maintain patient confidentiality as described by guidance from the regulatory bodies, and employer policies from time to time in force, subject to relevant legal exceptions.
  
5. A doctor must not disclose, without permission, any information of a confidential nature concerning other employees or contracted workers.
  
6. A doctor must not disclose, without permission, any information of a confidential nature concerning the business of the employer or of contractors of the

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<sup>13</sup> Good practice in research, [http://www.gmc-uk.org/guidance/ethical\\_guidance/5992.asp](http://www.gmc-uk.org/guidance/ethical_guidance/5992.asp)

employer, save where there is an overriding public interest or legal obligation to do so.

## Raising concerns

7. Should a doctor have cause for genuine concern about an issue (including one that would normally be subject to the requirements regarding information of a confidential nature set out in paragraph 4 above) the doctor has a professional obligation to raise that concern. A doctor should raise concerns, in accordance with local policy, and will not be subject to any detriment for raising such concerns.
8. If a doctor believes that a disclosure about malpractice, patient safety, financial impropriety or any other serious risk (including one that would normally be subject to paragraph 4) would be in the public interest, they have a right and a duty to speak out and be afforded statutory protection as required under the Public Interest Disclosure Act 1998<sup>14</sup> (PIDA) as amended from time to time. As far as practicable, local procedures for disclosure of information in the public interest should be followed.

## Publications

9. A doctor shall be free, without prior consent of the employing organisation, to publish material and to deliver lectures or speak at an event, whether on matters arising out of NHS service or not. This freedom is subject to the requirements regarding information of a confidential nature set out in paragraph 4 above, and the requirements regarding research set out in paragraph 3 above. Such communications, whether or not these activities take place in the doctor's own time, must be in good faith and without malice, and are subject to the employing organisation's protocols and practices (including those on social media usage and the press). The doctor must also follow guidance from the relevant regulatory bodies.
10. The doctor should be aware of the employing organisation's local policy regarding intellectual property. Where payment is received, the doctor should comply with the requirements of Schedule 7 - private professional work.

## Intellectual Property

11. The doctor must comply with the employing organisations policies and procedures for intellectual property. These will reflect *The NHS as an*

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<sup>14</sup> Public Interest Disclosure Act 1998, <http://www.legislation.gov.uk/ukpga/1998/23/contents>

*innovative organisation: a framework and guidance on the management of intellectual property in the NHS<sup>15</sup>, as amended from time to time.*

## **Transfer of information**

12. Where the doctor is required to rotate between employing organisations and/or host organisations, there will be a requirement on the employer/host organisations to transfer such personal and confidential information regarding the doctor's employment and training as is deemed necessary by the organisations for the completion of pre-employment checks and for the continuation of the doctor's training. It is a condition of employment that the transfer of such information occurs.
  
13. The employer / host organisation is required under the terms of the Learning and Development Agreement between the employer / host organisation and Health Education England (or successor document) to send and receive information about doctors to and from Health Education England in order to facilitate the management of training programmes. The employer will make every reasonable effort to comply with the time frames set out in the Learning and Development Agreement wherever and whenever it is possible to do so. Doctors and employers have a mutual obligation to facilitate such data transfers so as to enable appropriate notification of deployment by employers to future appointees, as set out in the Learning and Development Agreement. It is a condition of employment that the transfer of such information occurs.

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<sup>15</sup> A Framework and Guidance on the Management of Intellectual Property in the NHS, [http://www.homerton.nhs.uk/media/89852/doh\\_framework\\_\\_\\_guidance\\_on\\_managment\\_of\\_intellectual\\_property\\_in\\_the\\_nhs.pdf](http://www.homerton.nhs.uk/media/89852/doh_framework___guidance_on_managment_of_intellectual_property_in_the_nhs.pdf)

# SCHEDULE 09

## LEAVE

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### Principles

1. It is in the interest of doctors' health and wellbeing and the continued safety of patients in their care, that they take their full annual leave entitlement.
2. Leave required by the Working Time Regulations must be taken in each leave year, subject to paragraph 42 of this Schedule.
3. The employer and the doctor must make every effort to work together to ensure that the doctor is able to take the full annual leave entitlement.
4. Study or professional leave must be used for the purpose for which it is granted.
5. Safeguards on hours and rest as set out in Schedule 3 continue to apply during any period of leave.
6. In the case of a doctor contracted by a lead employer, decisions to approve leave requests rest with the host organisation, unless expressly stated otherwise.

### Annual leave

7. The annual leave year runs from the start date of the doctor's appointment.
8. The annual leave entitlement for a full-time doctor is as follows, based on a standard working week of five days:
  - a. On first appointment to the NHS: 27 days
  - b. After five years' completed NHS service: 32 days.

These leave entitlements include the two extra-statutory days previously available in England under the 2002 Terms and Conditions of Service.

9. As leave is deducted from the rota before average hours are calculated for pay purposes, as set out in paragraph 11 of Schedule 4, leave must be taken on days where the doctor is not rostered for a long shift, a night shift, a long, late shift, a weekend shift or an on-call duty, as defined in Schedule 3 of these TCS, or during shifts attracting an enhanced rate of pay, as set out in Schedule 2 of these TCS. 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.

10. Where the doctor's contract or placement is for less than 12 months, the leave entitlement is pro rata to the length of the contract or placement.
11. Leave arrangements for a doctor working non-standard weeks should be calculated in hours.
12. A doctor working less than full time will be allocated leave on a pro rata basis.
13. A doctor shall normally provide a minimum six weeks' notice of annual leave to be approved in accordance with local policies and procedures.
14. The employer should, where possible, respond positively to all leave requests, and should normally agree reasonable requests.
15. Employers must allow annual leave to be taken for life-changing events, for example a doctor's wedding day, provided that the doctor has given notice to the employer in accordance with paragraph 13 of this Schedule.
16. If, due to circumstances beyond the doctor's control, a reasonable request is made for leave outside the minimum six weeks' notice period, then the employer will fairly consider this while paying due regard to service requirements.
17. The doctor and the employer will work together to ensure that leave is appropriately planned and taken across the year. This is to ensure both access to training and the maintenance of service delivery, and to protect the safety of both doctors and patients.
18. In exceptional circumstances where agreement on planning leave is not possible despite the best reasonable efforts of the doctor and the employer, some leave may need to be allocated to ensure that all doctors are able to take their full leave entitlement while maintaining safe coverage of services. However, leave should not be fixed into a working pattern for this or any other reason without agreement.
19. In cases where exceptional circumstances or service demands have prevented a doctor from taking the full leave allowance, up to five days of leave per annum (pro rata for contracts or placements of less than 12 months' duration or for doctors who work less than full time), may be carried forward to the next post or placement with the same employer. This is not an entitlement and must be with the agreement of the relevant department, in line with the employer's local policy. With the agreement of the employer and in line with local policy, payment in lieu can be made for up to five days' annual leave (pro rata as appropriate) which could not be taken before a move to a new

employer.

## **Payment for annual leave**

20. Pay is calculated on the basis of what the doctor would have received had the doctor been at work, based on the doctor's work schedule and on any reference period that may be applied locally.
21. Where the employer offers a local scheme for the purchase of additional annual leave, a doctor will be permitted to seek participation in such a scheme, subject to any training requirements. The impact of any additional leave must be considered by HEE (local office) and agreed on behalf of the postgraduate dean. Any such agreed additional annual leave can only apply to the placement with that specific employer.

## **Public holidays**

22. Public holiday entitlement, as recognised by the NHS and set out in the definitions at the front of these TCS, is additional to annual leave entitlement.
23. A doctor working less than full time is entitled to paid public holidays at a rate no less than pro rata to the number of public holidays for a full-time doctor, rounded up to the nearest half day.
24. Public holiday entitlement for a doctor working less than full time shall be added to annual leave entitlement, and any public holidays shall be taken from the combined allowance for annual leave and public holidays.
25. A doctor who in the course of their duty is required to be present in the hospital (or other place of work) at any time (from 00.01 to 23.59) on a public holiday, or who is rostered to be on call on a public holiday, will be entitled to a standard working day off in lieu.
26. Where a doctor's working pattern includes scheduled rest days (sometimes known as zero hours' days) and such a day falls on a public holiday, then the doctor will be given a day off in lieu of the public holiday.
27. Where a public holiday, including Christmas Day (25 December), Boxing Day (26 December) or New Year's Day (1 January), falls on a Saturday or a Sunday, the public holiday will be designated instead as falling on the first working weekday thereafter. In such circumstances, no day in lieu then arises for the work undertaken on Christmas Day (25 December), Boxing Day (26 December) or New Year's Day (1 January).

## Study and professional leave

28. Study leave includes but is not restricted to participation in:
- study (linked to a course or programme)
  - research
  - teaching
  - taking examinations
  - attending conferences for educational benefit
  - rostered training events.
29. Attendance at statutory and mandatory training (including any local departmental training) is not counted as study leave.
30. Professional leave is leave in relation to professional work, as described in the definitions section of these TCS.
31. All requests for study leave will be properly considered by the employer. Any grant of study leave will be subject to the need to maintain NHS services (and, where the doctor is on an integrated academic pathway, academic responsibilities) and must be authorised by the employer.
32. A doctor is obliged to use study or professional leave for the purpose for which it has been granted. Safeguards on hours and rest as set out in Schedule 3 will continue to apply.
33. Study leave up to the limits described in table 1 below will normally be granted flexibly and tailored to individual needs, in accordance with the requirements of the curriculum. Requests for study leave in excess of these limits should be considered fairly where circumstances indicate such requests to be reasonable, and may be granted by the employer provided that the needs of service delivery can be safely met.

**Table 1: Study leave allowances**

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

34. Study leave for Foundation Year 1 doctors will take the form of a regular scheduled teaching/training session (or similar arrangement) as agreed locally.
35. Study leave for doctors at Foundation Year 2 and above will include periods of regular scheduled teaching/training sessions, and may also, with approval from the educational supervisor and service manager, include:
- undertaking an approved external course



- b. periods of sitting (or preparing for) an examination for a higher qualification where it is a requirement of the curriculum.

Requests for such leave will be viewed positively in most circumstances, but with a view to ensuring that the needs of service delivery can be safely met.

- 36. A doctor on a contract of employment of less than 12 months' duration is entitled to study leave on a pro rata basis.
- 36. Where a doctor working less than full time is required to undertake a specific training course required by the curriculum, which exceeds the pro rata entitlement to study and /or professional leave, the employer will make arrangements for additional study leave to be taken, provided that this can be done while ensuring safe delivery of services.

## Sickness absence

- 37. A doctor who is incapable of doing his or her normal work because of illness shall immediately notify his or her employer in accordance with the employer's procedures. A self-certificate will cover days one to seven of the period of sickness (including any non-working days). The doctor must obtain a medical certificate for subsequent days.
- 38. A doctor who becomes ill whilst on annual leave, shall immediately notify their employer in accordance with the employer's procedures on the first day of sickness. Further annual leave will be suspended from the date of notification subject to provision of a medical certificate.
- 39. Doctors are required to notify their employer as soon as possible of any illness, disease or condition that prevents them from undertaking their duties.
- 40. Where the employer considers at any time that a doctor is unable to perform some or all of their duties as a consequence of illness, the employer can require the doctor to attend an examination by the organisation's occupational health services, in accordance with local procedures.
- 41. A doctor absent from duty owing to illness (including injury or other disability) shall, subject to the provisions of paragraphs 51 to 55, be entitled to receive an allowance in accordance with the following table:

**Table 2: Scale of allowances**

During the first year of service	One month's full pay and two months' half pay
During the second year of service	Two months' full pay and two months' half pay
During the third year of service	Four months' full pay and four months' half pay
During the fourth and fifth years of service	Five months' full pay and five months' half pay
After completing five years of service	Six months' full pay and six months' half pay

42. The allowances set out in table 2 above are in line with those for all staff in the NHS, as set out in the *NHS Terms and Conditions of Service Handbook*<sup>16</sup>, and will be amended where any such amendment is agreed by the NHS Staff Council.
43. Employers will have discretion to extend the period of sick pay on full or half pay beyond the scale set out in table 2 above in exceptional circumstances and in line with local employer policies:
- a. where there is the expectation of return to work in the short term and an extension would materially support a return and/or assist recovery, particular consideration should be given to those staff without full sick pay entitlements
  - b. in any other circumstance that the employer deems reasonable.
44. During the rehabilitation period, employers should make the appropriate adjustments to allow the doctor to return to work. This may include working reduced hours, undertaking training or administrative activities without loss of pay. Any such arrangements need to be consistent with statutory sick pay rules.
45. Doctors who are unable to take their statutory annual leave (i.e. the leave to which they are entitled under the Working Time Regulations) in any leave year due to sickness absence will be permitted to carry over that leave to a subsequent leave year where employment is continuous. Any carried-over leave must be taken within 18 months of the end of the leave year in which it accrues. Where the doctor changes employer before taking this entitlement, the outstanding balance will be compensated through pay. The content of this paragraph does not apply to any leave granted under these TCS which exceeds the doctor's statutory entitlement under the Regulations, which will lapse if it is not taken in the leave year in which it accrues.
46. The period during which sick pay should be paid and the rate of sick pay for any period of absence is calculated by deducting from the doctors entitlement on the first day of sickness the aggregate periods of paid sickness absence during the 12 months immediately preceding that day. In aggregating periods of absence due to illness no account will be taken of:
- a. unpaid sick absence
  - b. injuries, diseases, or other health conditions sustained or contracted in the discharge of the doctors duties of employment, as defined in Section 22 of the *NHS Terms and Conditions of Service Handbook*<sup>17</sup>
  - c. injury resulting from a crime of violence, not sustained on duty but connected with or arising from the doctor's employment, where the injury has been the subject of payment by the Criminal Injuries Compensation Authority (England, Wales and Scotland) and/or the Compensation Agency (Northern Ireland)

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<sup>16</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

<sup>17</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

- d. as above, but an injury which has not attracted payment of an award as it has not met the loss of earnings criteria or was not one for which compensation above the minimum would arise.
47. The employer may, at its discretion, take no account of the whole or any part of the period of absence due to injury (not on duty) resulting from a crime of violence, not arising from or connected with the doctor's employment or profession.
48. For the purpose of calculating the appropriate allowance of paid sickness absence under paragraph 39, previous qualifying service shall be determined in accordance with the doctor's statutory rights and all periods of service, (without any break of 12 months or more, subject to paragraph 46 below), with a National Health Service employer shall be aggregated. Previous service with a non-NHS employer where placement is required should be included when calculating the allowance.
49. Where a doctor has broken their regular service for one of the following reasons:
- a. in order to go overseas in a rotational appointment forming part of a doctors recognised training programme; or
  - b. for an approved period of time out of programme for clinical training (OOPT), clinical experience (OOPE) or research (OOPR); then
- the doctor's previous NHS or approved service, as set out in paragraph 45 above, shall be taken fully into account in assessing entitlement to sickness absence allowance, provided that the employer considers that there has been no unreasonable delay between the training or OOP ending and the commencement of the subsequent NHS post.
50. For the purpose of sickness absence allowances, a doctor's previous contracted NHS locum service shall be recognised, subject to a minimum of three months' continuous NHS locum service.

## **Limitation of allowance when insurance or other benefits are payable**

51. The sickness absence allowance paid to a doctor when added to any statutory sick pay, injuries or compensation benefits, including any allowances for adult or child dependants, must not exceed the pay the doctor would have received had they been at work.

## **Recovering of damages from third party**

52. A doctor who is absent as a result of an accident is not entitled to sick pay if damages are received from a third party. Employers will advance to the doctor a sum not exceeding the amount of sick pay payable under this scheme, providing the doctor repays the full amount of sickness allowance to the employer, when damages are received. Once received the absence

shall not be taken into account for the purposes of the scale set out in table 2 in this Schedule.

## **Accident due to sport or negligence**

53. An allowance shall not normally be paid in a case of accident due to active participation in sport as a profession, or where contributory negligence is proved.

## **Injury sustained on duty**

54. An absence due to injury sustained by a doctor in the actual discharge of their duty, for which the doctor was not liable, shall not be recorded for the purposes of aggregation against future sickness absence.
55. The injury allowance provisions will apply as set out in Section 22 of the *NHS Terms and Conditions of Service Handbook*<sup>18</sup>, and should be read alongside the accompanying guidance issued by NHS Employers.

## **Termination of employment**

56. The sickness absence provisions of these TCS shall cease to apply to a doctor on the termination of employment by reasons of permanent ill health or infirmity of mind or body, of resignation, of age, or any other reason, provided that, where a doctor is in receipt of sickness absence allowance at the time of expiry of a contract, that allowance shall be paid during the doctor's illness, subject as a maximum to the doctor's entitlement to allowances under the provisions of table 2 in this Schedule.

## **Forfeiture of rights**

57. If it is reported to the employer that a doctor has failed to observe the conditions of Schedule 9, or has been guilty of conduct prejudicial to the doctor's recovery, and the employer is satisfied that there is substance in the report, the payment of the allowance shall be suspended until the employer has made a decision regarding the continued payment of the allowance. Before making a decision, the employer must give the doctor an opportunity of responding to the report. If the employer decides that the doctor has failed without reasonable excuse to observe the conditions of this Schedule, or has been guilty of conduct prejudicial to the doctor's recovery, then the doctor shall forfeit the right to any further payment of allowance in respect of that sickness or period of absence.

## **Special leave with or without pay**

58. Special leave may be granted in exceptional circumstances, on a short-term basis at the discretion of the employer. All requests for special leave will be

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<sup>18</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

considered by the employer in line with statutory requirements and local policy.

## **Maternity leave**

59. General provisions can be found in Schedule 13 – Sections of the *NHS Terms and Conditions of Service Handbook* applicable to doctors and dentists in training.

# SCHEDULE 10

## TERMINATION OF EMPLOYMENT

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1. A doctor employed under these terms and conditions of service is employed on a fixed-term basis and the contract will terminate at the end of the fixed term without the need for further notice from either party.
2. The contract of employment can be brought to an end prior to the expiry of the fixed-term arrangements. In such circumstances, either the doctor or the employer must give notice in writing, except where the provisions of paragraph 15 apply.

### Statutory notice periods

3. The employer shall give, as the minimum period of notice to terminate the employment of a doctor who has been continuously employed for at least four weeks (unless the period specified in paragraph 6 is longer):
  - a. one week's notice if the period of continuous employment is less than two years; or
  - b. one week's notice for each year of continuous employment if the period of continuous employment is at least two but less than 12 years; or
  - c. 12 weeks' notice if the period of continuous employment is 12 years or more.
4. The minimum period of notice to be given to the employer by a doctor who has been continuously employed for at least four weeks, shall be one week (unless the period specified in paragraph 6 is longer). The period of continuous employment shall be computed in accordance with the Employment Rights Act 1996, as amended from time to time.

### Contractual notice periods

5. The agreed minimum period of notice by both sides for doctors employed under these terms and conditions of service, unless the statutory minimum periods of notice as set out above, are longer, shall be as follows:

F1 F2 StR (Core Training) (CT) StR (Fixed Term Specialty Training Appointment) Dental Foundation Trainee (LDFT or DFT) Dental Core Trainee (DCT)	One month
StR (Run-through) StR (Higher Specialty Training) GP Specialty Trainee SpR	Three months

## **Application of notice**

6. Shorter or longer notice periods can apply where agreed between both parties in writing and signed by both.

## **Doctors rotating from one NHS employer to join another**

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

## **Termination of employment**

8. Whilst it is accepted that the majority of doctors employed within the NHS do their best to achieve high standards of behaviour and practice, on occasion a doctor may fail to meet the standards required, and in some circumstances this may lead to termination of employment.
9. The process for dealing with matters of conduct, competence, capability or performance will be detailed in the relevant policies of the employing organisation.

## **Grounds for termination of employment**

10. A doctor's employment may be terminated for the following reasons:
  - a. Conduct.
  - b. Capability.
  - c. Redundancy.
  - d. In order to comply with a statute or other statutory regulation.
  - e. Failure to hold or maintain a requisite qualification, registration, place on a General Medical Council approved training programme and/or license to practice.
  - f. Where there is some other substantial reason to do so in a particular case.
11. Should the application of any of the above procedures result in the decision to terminate a doctor's contract of employment, the doctor will be entitled to invoke a locally recognised appeals process, as set out in the relevant policies of the employing organisation.
12. In cases where employment is terminated, a doctor may be required to work the notice period, or if the employer considers it more appropriate, the doctor may be paid in lieu of notice, or paid through the notice period but not be required to attend work. Such arrangements are at the sole discretion of the employer.

13. Employment can be terminated without notice in cases of gross misconduct, gross negligence, where a doctor's professional registration and/or license to practice has been removed or has lapsed (without good reason) or a doctor's removal from a GMC-approved training programme. The postgraduate dean will be informed immediately by the employer when this circumstance arises.



# SCHEDULE 11

## EXPENSES

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### General

1. Expenses relating to travel, subsistence and other business expenses shall be paid to meet actual disbursements of doctors in the performance of their duties, and shall not be regarded as a source of pay or reckoned as such for the purposes of pension.
2. Claims for expenses shall normally be submitted within one month and as soon as possible after the end of the period to which the claim relates, subject to local procedures.
3. The following terms are used throughout these provisions:
  - a. 'Principal place of work' means the place of work from which the doctor conducts their main duties. Where a doctor has a joint contract with more than one employer, the term 'principal place of work' means the place from which the doctor conducts their main duties within that joint contract, irrespective of employer.
  - b. 'Official journey' means a journey in the performance of a doctor's duties.

### Business travel expenses

4. Costs incurred by doctors shall be reimbursed when, with the agreement of their employer, they use their own vehicles or pedal cycles to make official journeys.
5. When doctors use their vehicles for official journeys they must possess a valid driving licence, Ministry of Transport (MOT) test certificate and motor insurance that covers business travel. It is the doctor's responsibility to cover the costs of such licences, certificates and insurance. Doctors must be fit to drive, drive safely and obey the relevant laws e.g. speed limits. The doctor must inform the employer if there is a change in status.
6. When authorising the use of a vehicle, the employer must ensure that the driver has a valid driving licence and MOT certificate and has motor insurance that covers business travel.
7. The employer and doctor will agree the most suitable means of transport for the routine journeys that the doctor has to make in the performance of their duties. If a particular journey is unusual, in terms of distance or purpose, the mode of travel and expenses payable will be agreed between the employer and doctor before it starts.
8. Where the use of a vehicle is essential to the job, the employer may wish to assist by providing a lease or pool vehicle. In exceptional circumstances the employer may provide an advance of basic pay. Principles underpinning lease vehicle policies are provided by local employers

9. The reimbursement of excess travel costs when doctors are required to change their principal place of work as a result of organisational change will be for local policy to determine.

## Rates of reimbursement

10. For doctors who use their own vehicles or pedal cycles to make official journeys, their travel costs will be reimbursed at the appropriate rates.
11. The rates of reimbursement can be found in Section 17 of the *NHS Terms and Conditions of Service Handbook*<sup>19</sup> at table 7, which is updated from time to time as agreed with the NHS Staff Council. These rates are obtained by referring to costs for the average private vehicle user included in the AA guides to motoring costs. A summary of motoring costs which are taken into account is contained in the *NHS Terms and Conditions of Service Handbook* at Annex L.
12. The rate of reimbursement for motorcyclists can be found in Section 17 of the *NHS Terms and Conditions of Service Handbook* in column 4 of table 7, and the reserve rate in column 4 will move in line with the rate for car users in column 2 (see Annex L of the *NHS Terms and Conditions of Service Handbook*).

## Review

13. The standard rate of reimbursement in Section 17 of the *NHS Terms and Conditions of Service Handbook* at Column 2 in Table 7 will be reviewed each year, soon after the new AA guides to motoring costs are published, normally in April or May. Any changes to the standard rate of reimbursement, the reserve rate and the rate for motorcycle users in table 7, resulting from this review, will apply to all miles travelled from the following 1 July.
14. A second review will be conducted in November each year to ensure the rate in column 2 in table 7 (the standard rate) continues to reimburse doctors in line with motoring costs. Any changes to the standard rate of reimbursement, the reserve rate and the rate for motorcycle users in table 7, resulting from this review, will apply to all miles travelled from the following 1 January.

## Eligible mileage

15. Doctors shall be reimbursed for official journeys that are in excess of their return journey from home to principal place of work. Normally, the miles eligible for reimbursement are those travelled from the principal place of work to place visited and back. However, when the journey being reimbursed starts at a different location, for example home, the mileage eligible for reimbursement will be as set out in the example in table 8, contained in Section 17 of the *NHS Terms and Conditions of Service Handbook*.

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<sup>19</sup> NHS Terms and Conditions of Service Handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

## Passenger rate

16. With the exception of lease, pool or hire vehicle users, where other doctors or members of an NHS organisation are conveyed in the same vehicle on NHS business and their fares would otherwise be payable by the employer, the passenger allowance in table 7 of Section 17 of the *NHS Terms and Conditions of Service Handbook* will be payable to the vehicle driver.

## Reserve rate of reimbursement

17. A reserve rate of reimbursement, as in table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*, will apply to doctors using their own vehicles for business purposes in the following situations:
  - a. If the doctor unreasonably declines the employer's offer of a lease vehicle:
    - i. in determining reasonableness the employer and doctor should seek to reach a joint agreement as to whether a lease vehicle is appropriate and the timeframe by which the new arrangements will apply. All the relevant circumstances of the doctor and employer will be considered including the doctor's personal need for a particular type of car and the employers' need to provide a cost effective option for business travel
    - ii. if the doctor's circumstances subsequently change the original decision will be reviewed. The agreed principles underlying local lease vehicle policies are contained in the *NHS Terms and Conditions of Service Handbook* at Annex M;
  - b. When a doctor is required to return to work on any day (e.g. when called out in an emergency), and thereby incurs additional travel to work expenses.
  - c. If the doctor uses his or her own vehicle when suitable public transport is available and appropriate in the circumstances, subject to a maximum of the public transport cost which would have been incurred and the rules on eligible miles in paragraph 15 of this Schedule and table 8 in section 17 of the *NHS Terms and Conditions of Service Handbook*.

## Attendance on training courses

18. Additional travel costs incurred when attending courses, conferences or events at the employer's instigation will be reimbursed at the standard rates in table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook* when the employer agrees that travel costs should be reimbursed.
19. Subject to the prior agreement of the employer, travel costs incurred when doctors attend training courses or conferences and events, in circumstances when the attendance is not required by the employer, or who are on professional or study leave, will be reimbursed at the reserve rate in table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*, in line with the rules on eligible mileage in paragraph 15 of this Schedule and table 8 in section 17 of the *NHS Terms and Conditions of Service Handbook*.

## Study leave expenses

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

## Other allowances

21. Doctors who necessarily incur charges in the performance of their duties, in relation to parking, garage costs, tolls and ferries, shall be refunded these expenses on production of receipts, whenever these are available. However, charges for overnight garaging or parking shall not be reimbursed unless the doctor is entitled to night subsistence. This does not include reimbursement of parking charges incurred as a result of attendance at the doctor's principal place of work.

## Transporting equipment

22. Doctors who use their vehicles in the performance of their duties may be required to take equipment with them. Employers have a duty of care under the Health and Safety at Work Act 1974 and related legislation, to ensure that this does not cause a risk to the health and safety of the doctor. Doctors should not be allowed to carry equipment that is heavy or bulky, unless a risk assessment has been carried out beforehand. When, after the necessary assessment has demonstrated it is safe to carry equipment, an allowance (see table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*) shall be paid for all eligible miles (see paragraph 15 of this Schedule and table 8 in section 17 of the *NHS Terms and Conditions of Service Handbook*) for which the equipment is carried, provided that either:
  - a) the equipment exceeds a weight that could reasonably be carried by hand
  - b) the equipment cannot be carried in the boot of the vehicle and is so bulky as to reduce the seating capacity of the vehicle.

## Public transport

23. If doctors use public transport for business purposes the cost of bus fares and standard rail fares should be reimbursed.

## Relocation expenses

24. Assistance with relocation expenses, including removal or excess mileage, shall be provided to doctors who:
  - a. need to move their home or incur extra daily travel expenses as a result of being required by their employer to transfer principal place of work.
  - b. Are required to change their employer or who otherwise have to move home or incur extra daily travel expenses in order to satisfy the requirements of their professional training i.e. change of principal place of work on a rotational training programme.

25. Assistance may also be granted, at the employer's discretion, to doctors who as a result of taking up employment either need to move their home or incur extra daily travel expenses i.e. on first appointment to principal place of work. In exercising their discretion, employers shall take into consideration the Equality and diversity statement (see Schedule 13 – Sections of the *NHS Terms and Conditions of Service Handbook* applicable to doctors and dentists in training).
26. If the doctor has a home convenient to the principal place of work in which the second or subsequent post in the rotational appointment is to be held they may decide to travel the extra distance to where the previous post or posts are held and in such cases the doctor may be paid excess travel expenses when travelling to the previous post or posts.
27. Except where another body has responsibility for providing the assistance, the employer and the doctor can agree either:
  - a. assistance with removal expenses
  - b. assistance with temporary accommodation and/or excess travel expenses where the doctor travels daily the greater distance between their home and second or subsequent principal hospitals.

## **Removal expenses**

28. Except where another body provides the assistance, the scope and level of financial assistance to be provided should be determined by the employer, in agreement with the prospective doctor, prior to the post being accepted. In agreeing the assistance to be provided, the employer shall have regard to all the individual doctor's circumstances, including the need to re-house dependants and the comparability of new and previous accommodation.
29. The employer shall clearly indicate to the doctor the level of assistance that will be provided, the aspects of removal costs that will be reimbursed and, where applicable, the upper limit of payment in all usual circumstances. In providing assistance, authorities should ensure equity, while balancing their own interests with the needs of prospective employees.
30. The employer shall stipulate in the agreement reached with the doctor the procedure to be followed and the costs that will be reimbursed in circumstances where an authority has entered into an agreement with solicitors or others to provide house purchase/conveyancing services, private structural surveys, estate agency services and/or a removal service at preferential cost.

## **Excess travel expenses**

31. As outlined in paragraph 26, excess mileage may be paid instead of relocation expenses where appropriate and this should be agreed by the employer and the doctor prior to the doctor starting in post.
32. Excess mileage is deemed to be the difference, for each single journey, between the distance from the doctor's home to their principal place of work (the first place of work in the doctor's current training programme except under the circumstances described in paragraph 26) and the distance from their home to any second or subsequent principal place of work. Excess mileage may be

payable at the first appointment to a principal place of work under the circumstances described in paragraph 26.

33. The appropriate mileage rate will be paid in accordance with table 7 of section 17 of the *NHS Terms and Conditions of Service Handbook*.

## Subsistence allowances

34. The purpose of travel and subsistence allowances is to reimburse the necessary extra costs of meals, accommodation and travel and any other business expenses that arise as a result of official duties away from home (or principal hospital).
35. Where, locally, staff and employer representatives agree arrangements that are more appropriate to local operational circumstances, or which provide benefits to staff beyond those provided by these provisions, or are agreed as operationally preferable, those local arrangements will apply.

## Night subsistence

36. When doctors stay overnight in commercial accommodation with the agreement of the employer, the actual receipted cost up to the level set out in Annex N of the *NHS Terms and Conditions of Service Handbook*<sup>20</sup> shall be paid.
37. Where the maximum limit is exceeded for genuine business reasons (e.g. the choice of hotel was not within the employee's control or cheaper hotels were fully booked), additional assistance may be granted at the discretion of the employer.
38. Regardless of accommodation type, doctors staying overnight with the agreement of their employer will be reimbursed for the cost of meals, excluding alcoholic drinks, up to the level set out in Annex N of the *NHS Terms and Conditions of Service Handbook*<sup>21</sup>, subject to the production of receipts. If meals are provided free of charge, the cost of meals cannot be reimbursed. Additional assistance may be granted at the discretion of the employer.
39. Where doctors stay for short overnight periods with friends or relatives a flat rate at the level set out in Annex N of the *NHS Terms and Conditions of Service Handbook*<sup>22</sup> is payable. This includes an allowance for meals. No receipts are required.
40. Where accommodation and meals are provided without charge to doctors e.g. on a residential training course, an incidental expenses allowance at the level set out in Annex N of the *NHS Terms and Conditions of Service Handbook*<sup>23</sup> will

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<sup>20</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

<sup>21</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

<sup>22</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

<sup>23</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

be payable. All payments of this allowance are subject to the deduction of appropriate tax and national insurance contributions via the payroll system.

41. Travel costs between the hotel and any temporary place of work will be separately reimbursed on an actual costs basis.

### **Travelling overnight in a sleeping berth (rail or boat)**

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

### **Other business subsistence**

43. Any expenditure necessarily incurred by doctors on postage or telephone calls in the service of their employer shall be reimbursed subject to evidence of expenditure.

# SCHEDULE 12

## FACILITIES

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### Principles

1. The principles enshrined in this contract have been developed to ensure both patient safety and the safety of the doctor.
2. The employer / host organisation will make every effort to provide educational workplace facilities for doctors in line with those set out as minimum standards in the Learning Development Agreement between the employer / host organisation and HEE.
3. This schedule outlines the type of facilities that should be made available for doctors who are required to work during the overnight period.

### Access to food and drink

4. Where doctors are required to work during the overnight period, they should be able to access both hot and cold food and drink. It is not anticipated that restaurant facilities will be available overnight.
5. Outside of the period when restaurant facilities are open, there should be a range of foods available for purchase from vending machines or via other means, as applicable locally. Employers should make reasonable efforts to cater for various dietary requirements.
6. Where catering facilities are limited, organisations should identify alternative local establishments that can provide food during the night, or they may instead wish to consider providing facilities for the storage and preparation of food and drink brought in by the doctor.

### Access to rest facilities

7. Doctors who are rostered to work a night shift should have access to a space in which to take a meal and other rest breaks. This should ideally be provided in an area away from patients, where possible.
8. Employers are not required to provide a bedroom for doctors who are rostered to work a night shift.



9. Where a doctor advises the employer that the doctor feels unable to travel home following a night shift or a long, late shift due to tiredness, the employer should consider the provision of an appropriate rest facility where the doctor can sleep. The hours when the doctor is resting in the hospital under these circumstances will not count as work or working time. Where the provision of an appropriate rest facility is not possible, the employer should consider supporting alternative arrangements for the doctor's safe travel home.
10. Where a doctor is rostered to work on a non-resident on-call working pattern and is required to return to work during the night period, and the doctor considers it unsafe to undertake the return journey home due to concerns over tiredness, the employer should consider the provision of an appropriate rest facility where the doctor can rest. The hours when the doctor is resting in the hospital under these circumstances will not count as work or working time. Where the provision of an appropriate rest facility is not possible, the employer should consider supporting alternative arrangements for the doctor's safe travel home.
11. Where a doctor is rostered to work on a non-resident on-call working pattern and the doctor elects voluntarily, subject to the availability of accommodation, to be resident during the on-call duty period, a charge for any such accommodation shall be made and, provided that consent has been given, deducted from the doctor's salary.
12. Where a doctor is required to work overnight on a resident on-call working pattern, the doctor will be provided with overnight accommodation for the resident on-call duty period without charge.

# SCHEDULE 13

## SECTIONS OF THE *NHS TERMS AND CONDITIONS OF SERVICE HANDBOOK* APPLICABLE TO DOCTORS AND DENTISTS IN TRAINING

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1. The following sections of the *NHS Terms and Conditions of Service Handbook*<sup>24</sup> apply to doctors employed under these TCS
  - Section 15 Maternity leave and pay
  - Section 16 Redundancy pay
  - Section 22 Injury allowance
  - Section 25 Time off and facilities for trade union representatives
  - Section 26 Joint consultation machinery
  - Section 30 General equality and diversity statement
  - Section 32 Dignity at work
  - Section 33 Caring for children and adults
  - Section 34 Flexible working arrangements
  - Section 35 Balancing work and personal life
  - Section 36 Employment break scheme
  - Annex Z Managing sickness absences – developing local policies and procedures

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<sup>24</sup> NHS terms and conditions of service handbook, <http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook>

# **SCHEDULE 14**

## **TRANSITIONAL ARRANGEMENTS (TEMPORARY SCHEDULE)**

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1. The new contractual arrangements will have an initial period of pay protection for some existing doctors. This Schedule describes how these transitional pay protection arrangements will work for doctors in NHS employment on 2 August 2016 as part of approved postgraduate training programmes and under the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002 who were employed in a post forming part of such a training programme on or before 31 October 2015 and who either (a) move through another post or series of posts on such a training programme under those 2002 TCS and thence into appointment to a post on such a training programme under these terms and conditions, on or after 3 August 2016, or (b) move directly from such an appointment to an appointment to a post on such a training programme, on or after 3 August 2016.
  
2. The provisions of this Schedule 14 will expire at 23.59 on 5 December 2022.

### **SECTION ONE: TRAINEES IN THE FOUNDATION GRADES, CORE TRAINING GRADES AND EARLY STAGES OF RUN-THROUGH TRAINING**

3. The following doctors will be granted transitional pay protection under the arrangements described in this Schedule 14 at paragraphs 4 to 20 with effect from 3 August 2016:
  - a. All doctors remaining on F1 or remaining on F2 as at 3 August 2016.
  - b. All doctors entering F2 directly from F1 or from other training programmes on 3 August 2016.
  - c. All new entrants to core or run-through speciality training (CT1 / ST1) from F2 or from other training programmes on 3 August 2016.
  - d. All doctors moving into CT2, ST2 or CT3 grades from the grade immediately below or from other training programmes on 3 August 2016.
  - e. All doctors remaining in the CT1, ST1, CT2, ST2 or CT3 grades as at 3 August 2016.
  - f. All doctors progressing directly from core training or from other training programmes to higher training at ST3 point (or for doctors entering higher training in psychiatry or emergency medicine at the ST4 point) from on 3 August 2016.
  
4. Transitional arrangements will also apply to doctors who complete a training programme on 2 August 2016, having already accepted the offer of their next training programme but who, as either a direct result of the differing start

dates of different training programmes, or as a result of an agreed deferral of their start date, do not commence on 3 August 2016. In such cases, these arrangements will apply at the point at which the doctor re-enters training.

5. The transitional pay protection arrangements will be based on the pay that the doctor was earning on 31 October 2015. These arrangements will apply to all doctors in NHS employment on 2 August 2016 as part of approved postgraduate training programmes and under the Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002<sup>25</sup> whose status is described in paragraph 3, and who remain employed whilst training on such programmes on 3 August 2016, either in the same post or following a rotation into a different post/placement.

## Determination of pay protection

6. A doctor's protected level of pay will be calculated and will be used as a baseline or 'consistent cash floor' for each year until either the doctor exits training, or until three years of continuous employment have elapsed from the point that the doctor is first employed on these TCS, or until 5 December 2022, whichever is the sooner.
7. Doctors described in paragraphs 3 and 4 above who are subsequently absent from work on maternity leave, adoption leave, shared parental leave or long-term (more than three consecutive months) sick leave will have the period of time during which they are absent from work, up to a maximum of two years, discounted for the purposes of calculating the three-year period described in paragraph 6 above, which may therefore be extended by a maximum of two years, in direct proportion to the amount of time in which the doctor was absent from work for the reasons given above. In such circumstances, the doctor's protected level of pay will be used as a baseline or consistent cash floor for each year until either the doctor exits training, or until the extended period of continuous employment from the point that the doctor is first employed on these TCS described above has elapsed, or until 5 December 2022, whichever is the sooner.
8. Doctors described in paragraphs 3 and 4 training on a less-than-full-time basis will have the three-year period described in paragraph 6 above extended in direct proportion to the proportion of full time that they are employed. For example, a doctor employed on a 60 per cent basis will have the three-year period extended to a five year period. Where the hours worked by a doctor (up to a maximum of an average of 40 hours per week) are increased or decreased between or during appointments, such that the proportion of full time that the doctor is training is formally adjusted, both the

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<sup>25</sup> Terms and Conditions of Service NHS Medical and Dental Staff (England) 2002, [http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Terms\\_and\\_Conditions\\_of\\_Service\\_NHS\\_Medical\\_and\\_Dental\\_Staff\\_300813\\_bt.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Pay%20and%20reward/Terms_and_Conditions_of_Service_NHS_Medical_and_Dental_Staff_300813_bt.pdf)

actual cash value of the level of protected pay but also the length of the period to which it applied will be adjusted accordingly. In such circumstances, the doctor's protected level of pay will be used as a baseline or consistent cash floor for each year until either the doctor exits training, or until the extended period of continuous employment from the point that the doctor is first employed on these TCS described above has elapsed, or until 5 December 2022, whichever is the sooner.

9. The protected level of pay for an individual doctor will only be calculated once, and will be the sum of:
  - a. the incremental pay point for the doctor as at 31 October 2015; plus
  - b. any cost of living increase that may be awarded in April 2016; plus
  - c. the value of the banding supplement under the 2002 TCS as at 31 October 2015 for the rota on which the doctor was working on 31 October 2015, up to a maximum banding supplement of 50 per cent (Band 1A) or, for those doctors who have opted out of the Working Time Regulations 1998 (WTR<sup>26</sup>), to a maximum of Band 2A (80 per cent).

Where the doctor, on 31 October 2015, was a general practice trainee working in a general practice placement, the GP supplement payable at the time (45 per cent) will be used in place of any banding payment for this purpose. Where the doctor, on 31 October 2015:

    - i. was employed in a post on a training programme at ST1 level on 31 October 2015; and
    - ii. had service at ST3 level or above on a different programme before re-entering training on the current training programme; and
    - iii. was working on a programme where all ST1 level posts were unbanded as a result of the training programme curriculum and where all higher grade posts on that programme are paid a banding supplement,

then for the purposes of this paragraph, a banding supplement of 1B (40 per cent) will be used for the purposes of calculating the level of protected pay.
10. The doctor's actual total 'new contract' pay at appointment to the first post and subsequently at appointment to each new post under these TCS will be calculated as per the provisions of Schedule 2 of these TCS.
11. The protected level of pay will then be compared against the doctor's actual total new contract pay
12. Where actual total new contract pay is lower than the protected level of pay, the doctor will receive actual total new contract pay plus an additional amount in pay protection sufficient to return the doctor's total pay to the protected level of pay.

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<sup>26</sup> The Working Time Regulations 1998, <http://www.legislation.gov.uk/ukxi/1998/1833/contents/made>

13. Whether new contract pay or the protected level of pay has the higher value may change over the course of a doctors training programme. It is possible that the protected pay may be higher than new contract pay in some training placements, but not in others. Doctors listed in paragraph 3 will receive transitional pay protection as described in paragraph 12 for each placement / post in their training programme until the end of the transition period to which this Schedule applies or until the doctor exits training, whichever is the sooner.
14. Doctors absent from training on 31 October 2015 on maternity leave, paternity leave, adoption leave, shared parental leave or sick leave, or for approved out of programme (OOP) purposes who return to training between 1 November 2015 and 5 December 2022 in a post listed in paragraph 3, will have their protected level of pay calculated as the sum of:
  - a. the incremental pay point that the doctor might otherwise have reached at 31 October 2015; plus
  - b. any cost of living increase that may be awarded in April 2016; plus
  - c. the value of the banding supplement under the 2002 TCS as at 31 October 2015 for the rota on which the doctor would have been working on 31 October 2015, up to a maximum banding supplement of 50 per cent (Band 1A) or, for those doctors who have opted out of the WTR<sup>27</sup>, to a maximum of Band 2A (80 per cent).

## **Changes in hours during transition**

15. For those doctors described in paragraphs 3, 4 and 14 above, who are working less than full time on 31 October 2015, the cash floor will be calculated on a pro rata basis reflective of their actual hours of work. Those whose hours are subsequently increased or decreased (or who move from full time to less than full time) will have their cash floor value increased or decreased on a corresponding pro rata basis.
16. Where pay increases as a result of changes to the work schedule, the doctor shall be paid the new increased level of actual total pay. Where this remains lower than the cash floor, the doctor will continue to receive actual total pay plus a reduced amount of additional pay protection sufficient to return the doctor's total pay to the level of the cash floor.
17. Where changes to the work schedule of a doctor granted pay protection under these provisions are required by the employer, and total pay would be decreased as a result, the doctor shall continue to receive their previous pay, as specified in Schedule 2 paragraph 64.

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<sup>27</sup> The Working Time Regulations 1998, <http://www.legislation.gov.uk/uksi/1998/1833/contents/made>

18. Where a doctor requests and an employer agrees changes to the work schedule that result in hours being decreased, the value of the cash floor will be decreased in proportion to the decrease in hours.

## **Pay protection under previous arrangements**

19. Where, at the point of taking up an offer of appointment under these TCS, a doctor covered by the provisions of paragraphs 3 or 4 above has previously re-entered training from a nationally recognised career grade (defined for the purposes of this schedule as being an NHS medical practitioner appointed on national terms and conditions of service other than those for doctors and dentists in training) and is in receipt of pay protection on the basic salary (exclusive of any pay for additional hours / sessions, excellence awards or similar payments, on-call or other allowances, pay premia or any other supplementary payments paid or received) previously earned in that grade, this protected salary should be taken into account in the calculation of the cash floor.
20. Once this has been taken into account in the calculation of the cash floor, any previously agreed pay protection arrangements will be discontinued.

## **SECTION TWO: TRAINEES IN THE HIGHER TRAINING GRADES AND LATTER STAGES OF RUN-THROUGH TRAINING**

21. The doctors identified below will be granted transitional pay protection under the arrangements described in this Schedule at paragraphs 22-54 with effect from 3 August 2016:
- a. Doctors already at ST3 or above on a run-through training programme on 2 August 2016.
  - b. Doctors already in higher specialty training programmes on 2 August 2016.
  - c. Specialist registrars (SpRs) on a pre-2007 training programme.
22. Doctors outlined in paragraph 21 above will continue to be paid a basic salary on the pay scale (MN37) on which they were previously paid under the 2002 TCS, and will continue to receive annual increments on the anniversary of their previously agreed incremental date until they exit training or until three years of continuous employment have elapsed from the point that the doctor is first employed on these TCS, or until 5 December 2022, whichever is the sooner.
23. Doctors described in paragraph 21 above who are subsequently absent from work on maternity leave, adoption leave, shared parental leave or

long-term (more than three consecutive months) sick leave will have the period of time during which they are absent from work, up to a maximum of two years, discounted for the purposes of calculating the three-year period described in paragraph 22 above, which may therefore be extended by a maximum of two years, in direct proportion to the amount of time in which the doctor was absent from work for the reasons given above. In such circumstances, the doctor will continue to be paid in accordance with paragraph 22 above until either the doctor exits training, or until the extended period of continuous employment from the point that the doctor is first employed on these TCS described above has elapsed, or until 5 December 2022, whichever is the sooner.

24. Doctors described in paragraph 21 above, training on a less-than-full-time basis, will have the three-year period described in paragraph 6 above extended in direct proportion to the proportion of full time that they are employed. For example, a doctor employed on a 60 per cent basis will have the three-year period extended to a five year period. Where the hours worked by a doctor (up to a maximum of an average of 40 hours per week) are increased or decreased between or during appointments, such that the proportion of full time that the doctor is training is formally adjusted, both the actual cash value of the level of protected pay but also the length of the period to which it applied will be adjusted accordingly. In such circumstances, the doctor will continue to be paid in accordance with paragraph 22 above until either the doctor exits training, or until the extended period of continuous employment from the point that the doctor is first employed on these TCS described above has elapsed, or until 5 December 2022, whichever is the sooner.
25. Doctors described in paragraph 21 will, during the time that their basic salary is protected as described in paragraphs 22 to 24 above, continue to be paid, where appropriate, and based on the rota on which they are actually working, a banding supplement, as calculated under paragraphs 26-53 below. However, where a doctor described in paragraph 21 subsequently elects to re-enter training in a different training programme, any protection arrangements arising as a result of paragraphs 22 to 25 will be discontinued and the doctor will instead be entitled the same level of pay protection as for a doctor described in paragraphs 3 and 4, until the end of the original period of pay protection applying at the point that the doctor first accepted an appointment under these TCS.

## **Working hours for the purposes of banding at transition**

26. For the purposes of calculating the banding supplement for this group of doctors only, plain time is considered to be hours between 07.00 and 19.00, Monday to Friday, and weekends are classified as any working hours between



19.00 Friday and 07.00 Monday. These classifications do not apply to any other aspect of these TCS.

## **Calculating hours and banding for doctors working full-time working patterns**

27. Average hours for the purposes of calculating the banding supplement will be the number of actual hours to be worked over the cycle of the rota, divided by the number of weeks in the cycle of the rota
28. These TCS do not recognise the designation of partial shifts, 24-hour partial shifts or hybrid shift patterns described in the 2002 TCS. Such rotas are instead described in Schedule 3 of these TCS as on-call working patterns. Doctors undertaking partial shifts, 24-hour partial shifts or hybrid shifts are therefore classified as working on-call rotas and the banding payment should be calculated on that basis.
29. On-call working patterns are defined in Schedule 3 of these TCS. Shift working patterns are those not defined as on-call working patterns.

### **a) Rotas with an average of 40 hours per week**

30. Rotas with an average of 40 hours' actual work per week with all hours falling into plain time will not attract a banding supplement.
31. Rotas with an average of 40 hours' actual work per week with some hours falling outside plain time will attract a banding supplement calculated under paragraphs 32-37, according to the type of working pattern.

### **b) Rotas with an average of more than 40 hours but no more than 48 hours per week**

#### **i) On-call working patterns**

32. Where a doctor works a weekly average of at least 40 hours of actual work but no more than 48 hours' actual work, with a rota frequency of 1:6 or more frequent, a banding supplement of Band 1A (50 per cent of basic salary) will apply.
33. Where a doctor works a weekly average of at least 40 hours' actual work but no more than 48 hours' actual work, and where the rota frequency is one in eight (or more frequent) or the rota frequency is one in four weekends (or more frequent) and there is a contractual requirement for the doctor to be resident for four hours for clinical reasons during part of the on-call period on more than 50 per cent of occasions, a banding supplement of Band 1A (50 per cent of basic salary) will apply.
34. Where a doctor works a weekly average of at least 40 hours' actual work, but no more than 48 hours' actual work, and where the rota frequency is one in

eight (or less frequent) and there is a contractual requirement for the doctor to be resident, a banding supplement of Band 1B (40 per cent of basic salary) will apply.

35. Where a doctor works a weekly average of at least 40 hours' actual work, but no more than 48 hours' actual work, and where the rota frequency is one in eight (or less frequent), and there is no contractual requirement for the doctor to be resident, a banding supplement of Band 1C (20 per cent of basic salary) will apply.

## **ii) Shift working patterns**

36. Where a doctor works a weekly average of at least 40 hours of actual work but no more than 48 hours' actual work and the rota includes weekend working (defined for these purposes as being between 19.00 Friday and 07.00 Monday) on a frequency of one in four weekends (or more frequently) and / or more than a third of the average weekly hours worked fall outside of the period between 07.00 to 19.00 Monday to Friday, a banding supplement of Band 1A (50 per cent of basic salary) will apply.
37. Where a doctor works a weekly average of at least 40 hours of actual work but no more than 48 hours' actual work and the rota does not match the description in paragraph 36 above, a banding supplement of Band 1B (40 per cent of basic salary) will apply.

## **c) Rotas with an average of more than 48 hours but no more than 56 hours per week**

### **i) On-call working patterns**

38. Where a doctor works a weekly average of at least 48 actual hours of work but no more than 56 hours of actual work and where the rota frequency is one in six (or more frequent) a banding supplement of Band 2A (80 per cent of basic salary) will apply.
39. Where a doctor works a weekly average of at least 48 actual hours of work but no more than 56 hours of actual work and where the rota frequency is less frequent than one in six, a banding supplement of Band 2B (50 per cent of basic salary) will apply.

### **ii) Shift working patterns**

40. Where a doctor works a weekly average of at least 48 actual hours of work but no more than 56 hours of actual work on a rota including weekend working (defined for these purposes as being between 19.00 Friday and 07.00 Monday) on a frequency of one in three weekends (or more frequently); and / or more than a third of the average weekly hours worked fall outside of the period between 07.00 to 19.00 Monday to Friday, a banding supplement of Band 2A (80 per cent of basic salary) will apply.

41. Where a doctor works a weekly average of at least 48 actual hours of work but no more than 56 hours of actual work on a rota not described in paragraph 40 above, a banding supplement of Band 2B (50 per cent of basic salary) will apply.

## **Banding and the Working Time Regulations 1998**

42. Doctors working on patterns described in paragraphs 38-41 above must have opted out of the WTR<sup>28</sup>, as set out in Schedule 3 of these TCS. Doctors not wishing to opt out can only be contracted on rotas of no more than an average of 48 hours' actual work per week.
43. Rotas with a weekly average greater than 56 hours of actual work are not permitted under the terms of this contract. Employers must not create such working patterns, nor should doctors request to work such patterns.

## **Hours calculations for doctors working less than full time**

44. For doctors described in paragraphs 21 and 24 only, the proportion of basic pay paid to part-time doctors will be determined based on the number of actual working hours per week as follows:
  - a. Doctors working 20 hours or more, but less than 24 hours, shall be paid 0.5 of full-time basic pay.
  - b. Doctors working 24 hours or more, but less than 28 hours, shall be paid 0.6 of full-time basic pay.
  - c. Doctors working 28 hours or more, but less than 32 hours, shall be paid 0.7 of full time basic pay.
  - d. Doctors working 32 hours or more but less than 36 hours shall be paid 0.8 of full-time basic pay, and
  - e. Doctors working 36 hours or more, but less than 40 hours, shall be paid 0.9 of full time basic pay.

## **Calculation of banding supplement for doctors working less than full time on an on-call working pattern**

45. Doctors who work all of their hours between 07.00 and 19.00 on Monday through to Friday will not be paid a banding supplement
46. Doctors who carry out a proportion of their work outside of the hours of 07.00 to 19.00 on Monday through to Friday will be paid a banding supplement in accordance with paragraphs 47-53 below.
47. Where the doctor is working an on-call working pattern, as described in Schedule 3 of these TCS, and the rota frequency is 1 in 10 (or more frequent), then a banding supplement of Band FA (50 per cent of the basic

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<sup>28</sup> The Working Time Regulations 1998, <http://www.legislation.gov.uk/ukxi/1998/1833/contents/made>

salary as calculated under paragraph 44) will apply.

48. Where the doctor is working an on-call working pattern, as described in Schedule 3 of these TCS, and:
  - a. the rota frequency is 1 in 13.5 (or more frequent); or
  - b. the doctor works one weekend (19.00 Friday to 07.00 Monday) in 6.5 (or more frequently)and in addition to either (a) or (b) above, the doctor is either required to be resident and carrying out work after 19.00 or non-resident and doing four or more hours work after 19.00 on 50 per cent or more occasions, then a banding supplement of Band FA (50 per cent of the basic salary as calculated under paragraph 44) will apply.
49. Where the doctor is working on-call working pattern, as described in Schedule 3 of these TCS, and the rota frequency is 1 in 13.5 (or more frequent), or where the doctor works one weekend (19.00 Friday to 07.00 Monday) in 6.5 (or more frequently), but where the additional requirements set out in paragraph 48 are not met, a banding supplement of band FB (40 per cent of the basic salary as calculated under paragraph 44) will apply
50. Where the doctor is working on-call working pattern, as described in Schedule 3 of these TCS, and the rota frequency is 1 in 13.5 (or less frequent), but where the doctor is required to be resident for clinical or contractual reasons, a banding supplement of Band FB (40 per cent of the basic salary as calculated under paragraph 44) will apply.
51. Where the doctor is working on-call working pattern, as described in Schedule 3 of these TCS, and the rota frequency is 1 in 13.5 (or less frequent), but where the doctor is not required to be resident for clinical or contractual reasons, a banding supplement of Band FC (20 per cent of the basic salary as calculated under paragraph 44) will apply.
52. Where the doctor is working a shift pattern that does not meet the definition of an on-call working pattern as described in Schedule 3 of these TCS and more than one-third of hours fall outside 07.00 to 19.00 Monday to Friday, or where the doctor is required to work one weekend (any time between 19.00 Friday to 07.00 Monday) at a frequency of 1 in 6.5 (or more frequently), a banding supplement of Band FA (50 per cent of the basic salary as calculated under paragraph 44) will apply.
53. Where the doctor is working a shift pattern that does not meet the definition of an on-call working pattern as described in Schedule 3 of these TCS and the working pattern does not meet the description in paragraph 52 above, a banding supplement of Band FB (40 per cent of the basic salary as calculated under paragraph 44) will apply.

## **Doctors out of programme during transition**

54. Doctors referred to in paragraph 21 of this Schedule who are on a recognised out-of-programme experience (OOP), on maternity leave, adoption leave, shared parental leave or long-term sick leave, will upon return to the training programme be paid a basic salary on the same payscale and at the same incremental point that they would have been paid had they returned to take up an appointment under the 2002 TCS. Such doctors may also be entitled to receive a banding supplement, subject to a maximum of Band 2A (80 per cent of basic salary), in accordance with paragraphs 22-53 above. Such doctors will continue to receive annual increments on the anniversary of their agreed incremental date, and to receive banding supplements where these are appropriate, until they exit the training programme, or until their protection period has expired as described in paragraphs 22 to 24 above, or until 5 December 2022, whichever is sooner.

## **Changes in hours during transition**

55. Doctors referred to paragraph 21 of this Schedule who are training less than full time on appointment to a post under these TCS and who subsequently request to increase their hours of actual work will have their pay and banding will be re-calculated as per paragraphs 44 to 53 above.
56. Doctors referred to paragraph 21 of this Schedule who are training less than full time on appointment to a post under these TCS and who subsequently return to full-time working will have their pay and banding re-calculated as per paragraphs 22-43 above.
57. Doctors referred to in paragraph 21 of this Schedule who decrease their hours on appointment to a post under these TCS will have their pay and banding recalculated in line with paragraphs 22-53 above as appropriate. This may result in their pay being reduced on a pro rata basis.

## **Pay protection under previous arrangements**

58. Where, at the point of taking up an offer of appointment under these TCS, a doctor covered by the provisions of paragraph 21 above has previously re-entered training from a nationally recognised career grade (defined for the purposes of this schedule as being an NHS medical practitioner appointed on national terms and conditions of service other than those for doctors and dentists in training) and is in receipt of pay protection on the basic salary (exclusive of any pay for additional hours / sessions, excellence awards or similar payments, on-call or other allowances, pay premia or any other supplementary payments paid or received) previously earned in that grade, this protected salary should continue to be taken into account in the

calculation of the doctor's earnings in line with the provisions of paragraph 22.

59. Once this has been taken into account for the provisions of paragraph 22, any previously agreed pay protection arrangements will be discontinued.

## **Other transitional arrangements**

60. During the period from 3 August 2016 to 6 August 2019, doctors working less than full time who are paid either under the provisions of Schedule 2 of these TCS, will be entitled to be paid the enhanced rate of pay for work on a Saturday between 07.00 and 17.00 as described in paragraphs 16 and 17 of Schedule 2, where they make a pro rata contribution to a rota on which doctors working full time are eligible for these enhancements. This transitional provision will be kept under review to take account of both the HEE review on access and barriers to less-than-full-time training, and the development of services across the seven-day week.

## **Limits on application**

61. In all aspects other than the pay arrangements described in this Schedule, doctors described in paragraphs 3 and 21 will fall within the scope of these TCS.
62. The arrangements in this schedule shall cease to apply at 23.59 on 5 December 2022.

## **Annex A**

Please see the latest pay circular which deals with pay and conditions of service of NHS doctors and dentists training. This is available on the [NHS Employers website](#).

