



Department
of Health

Equality Analysis on the new contract for doctors and dentists in training in the NHS

March 2016

Equality Analysis on the new contract for doctors and dentists in training in the NHS (“Doctors”)¹

Introduction

1. This paper analyses the draft final contract for Doctors in the National Health Service (“**the NHS**”) (“**the new contract**”) in order to assist the Secretary of State for Health (“**the SoS**”) in giving effect to his Public Sector Equality Duty (“**the PSED**”) under s149 of the Equality Act 2010 (“**EqA**”). This requires the SoS to have due regard to each of the statutory equality objectives (or strands) set out in s149 EqA (s149 is set out in full in Annex A).
2. The paper provides a forward-looking analysis of the expected equalities impact of the new contract informed by, amongst other things: (a) the likely/foreseeable impact of the terms and conditions in the new contract, (b) the available data on the makeup of the current cohort of Doctors by reference to protected characteristics (see Table X-Z in Annex B), and (c) extensive engagement and negotiation between the British Medical Association (“**the BMA**”) and NHS Employers (“**NHSE**”) regarding the development of the new contract (further details of this work is set out in Annexes C and D). The paper is intended to assist the SoS in considering whether the draft terms and conditions of the new contract should be approved and/or should be subject to amendment before introduction.
3. Further work on the equalities impact of the new contract will continue after it is introduced. In particular, the SoS intends to commission a review of the impact of the new contract once a reasonable period has elapsed following introduction. This further work will help to ensure on-going compliance with the PSED. Equalities impact work will also be conducted at employer level.
4. In EU and UK discrimination legislation, there is a fundamental distinction between direct discrimination, on the one hand, and indirect discrimination on the other.

¹ Those in approved postgraduate medical and dental training posts, including posts in general medical practice training but not general dental practice training.

5. Direct discrimination is where an individual receives less favourable treatment because of a protected characteristic. Indirect discrimination concerns a provision, +criterion or practice (“**PCP**”) that puts someone with a protected characteristic at a particular disadvantage, compared with people who do not share the protected characteristic. However, a PCP that causes a particular disadvantage is lawful if it is a proportionate means of achieving a legitimate aim. In relation to disability, it may also be appropriate in certain circumstances to take positive action to remedy a disadvantage that would otherwise arise.

6. In preparing this equality analysis, consideration has been given to all of the statutory objectives under s149 EqA.

Key objectives of the new contract

7. The key objectives for the new contract are derived from the Heads of Terms for negotiation in 2013, which were recognised by the joint Memorandum of Understanding between the Department of Health, NHSE and the BMA signed under the auspices of ACAS on 30 November 2015. These are:
 - a. to enable employers to roster Doctors when needed across seven days including evenings and weekends more affordably to support the delivery of a 7 Day NHS for patients in accordance with the clinical standards developed by the Seven Days a Week Forum;
 - b. to end time-served automatic annual pay progression (“**AAPP**”) and establish a pay model based on the level of responsibility of the role being performed;
 - c. to provide Doctors with greater certainty and predictability of earnings by: (i) increasing basic pay, and (ii) reducing the proportion of overall pay that is derived from (variable) additional payments;
 - d. to ensure that Doctors working the most unsocial hours/patterns are paid accordingly;
 - e. to provide incentives to encourage entry into hard-to-fill training programmes or clinical academic training programmes and/or undertaking beneficial research work;
 - f. to provide stronger measures to ensure adherence to safe working hours and patterns;

- g. to improve training/support for training; and.
- h. to achieve cost-neutrality – whilst not seeking to save money overall and not preventing the total pay bill for junior doctors from rising as trusts recruit more Doctors, the new contract seeks no increase or reduction in pay bill (excluding employer pension contributions and transitional pay protection costs) per whole-time equivalent (“**WTE**”)/no change in average earnings for the same average number of hours worked as now.

Who will be affected?

- 8. The introduction of the new contract will affect Doctors who: (a) commence work for the first time, and/or (b) take up a new contract of employment after the new contract is introduced.

How will this the new contract be introduced?

- 9. The new contract will be introduced with effect from 3 August 2016, subject to a phased implementation between August 2016 and the end of 2017 to allow the NHS to introduce the new arrangements in a safe and managed way.

Background on development of the new contract

- 10. The draft terms and conditions of the new contract have been developed pursuant to extended discussions and negotiations between the BMA and NHSE from January 2013 to February 2016. Agreement was reached on the need to implement a new contract as far back as 2008. As at February 2016, approximately 90% of the issues under negotiation between the BMA and NHSE were agreed. The significant outstanding areas of disagreement related to pay for unsocial hours: specifically the extension of plain time on weekday evenings from 7 pm to 9 pm, and on Saturdays from 7 am to 5 pm for those working less than one Saturday in four, plus the rate of pay for Saturday and Sunday day time unsocial hours. Further details of the relevant background are provided in Annex C.

New contract pay structure

Basic pay

11. Under the new contract, there will be a significant increase in average basic pay – by some 13.5%.

12. The new contract establishes a system where Doctors' basic pay will not increase by AAPP. Instead pay progression will be dependent upon Doctors progressing to the next level of responsibility within the hierarchy of training posts (having demonstrated the required competencies to do so).

13. There will be five nodal points – each point equating to a post at the next level of responsibility. Basic pay will increase each time a Doctor takes up a post at the next designated level of responsibility. Table 1 below shows: (a) the nodal points with the 2016/17 basic pay values (calculated based on the assumption that there are no further changes to elements of the pay structure that would require these values to be recalibrated), and (b) the changes to the structure and pay values as between the offer made in November 2016 and February 2016.

Table 1 Nodal point structure and pay values

November 2015 offer		February 2016	
Level of responsibility	Indicative basic pay value	Level of responsibility	2016/17 basic pay value
F1	£25,500	F1	£27,000
F2	£31,600	F2	£30,000
CT1 / ST1	£37,400	CT1 / ST1	£37,000
CT2 / ST2		CT2 / ST2	
CT3 / ST3	£42,500	CT3 / ST3	£48,000
ST4		ST4	
ST5	£48,400	ST5	
ST6		ST6	
ST7		ST7	
ST8	£55,000	ST8	£52,000

F=Foundation training; CT=Core training; ST=Specialty training

Potential impacts of the nodal structure

14. AAPP is unfair. It means that people taking longer to progress are paid more than those with the same or greater level of responsibility. It is based on time “served” rather than actual progression through training and demonstrating that a doctor has met the competencies of the job. Replacing AAPP will impact on those who take longer to progress through training and, therefore, longer to progress to posts with higher levels of responsibility and pay. This may simply be because a Doctor fails to gain a post at the higher level but could also affect groups such as: (a) people for whom the outcome of the Annual Review of Competence Progression (“**ARCP**”) process is that additional training is required, (b) people who take time out of training to undertake research or other work in the wider interest of the NHS, (c) people who follow a clinical academic training pathway, (d) people who choose to retrain in a different specialty (or need to do so for non-disability related health reasons), (e) people who take time out on the grounds of ill-health, (f) people with disabilities that: (i) mean they need to retrain for a different specialty, or (ii) adversely affect their ability to obtain and demonstrate the required competencies, (g) people who take shared parental leave, (h) women who take pregnancy/maternity leave, and (i) people who train part-time (a greater proportion of whom are women and/or those with caring responsibilities). Below we set out

the reasons why the nodal pay structure improves fairness and equity in relation to pay, and we also describe the transitional protections which will address affected groups where they may be affected such as transitional pay protection and flexible pay premia.

15. AAPP means that there are Doctors whose current pay is 'out of step' with their stage of training because AAPP is not based on stages of training only on time served. Those Doctors who take up a new contract at the relevant level of responsibility may be concerned that their overall pay in the new contract is reduced compared to the AAPP approach. This is more likely to be the case for those groups noted above (and the disparity will be greater for those who have been in training longer). The transitional protection, which is referred to in the justification below, in the main addresses such concerns. The analysis focuses on the potential impact, if any, on protected characteristics taking into account the transitional protections provided and the overall increase in basic pay of 13.5%.

Justification

16. AAPP is unfair because people taking longer to progress are paid more than those with the same or greater level of responsibility. Replacing AAPP with nodal pay progression is consistent with: (a) ensuring that there is fair pay that reflects the level of responsibility each Doctor assumes, (b) the independent Review Body on Doctors' and Dentists' Remuneration's ("**the DDRB**") recommendation to strengthen the link between pay and outcomes and move to a more professional contract, (c) the Government's policy of ending time-served AAPP across the public sector, and (d) the General Medical Council's ("**the GMC**") aim of making progression through training programmes competence-driven.

Mitigation

17. Consideration has been given to a number of measures to address the potential impact of the nodal pay structure under the new contract on the affected groups noted above.

(a) Restructure of nodal points and pay values

18. The Government initially proposed a basic pay model with six nodal points. Following extensive negotiation with the BMA, the new contract has been restructured to: (a) have five nodal pay points instead of six, and (b) 'frontload' pay increases, so that larger basic pay increases occur earlier in career progression, this means that the largest group of Doctors receive the same basic pay through the last five years of their training. This is illustrated in Table 1 above.

(b) Transitional pay protection

19. The new contract provides for periods of transitional pay protection. Doctors currently in training will either: (a) transfer to the new arrangements, including new pay terms, with 'cash floor' pay protection²; or (b) transfer to the new arrangements but remain on existing pay terms, continuing to receive increments (and banding payments up to the level of Band 2A – see below), - see, further, the section on pay protection below.

(c) Flexible pay premia

20. The new contract provides for flexible pay premia for Doctors: (a) following clinical academic pathways (where time spent in academic placements is part of the required training), (b) taking time out for research or other work in the wider interest of the NHS, and/or (c) returning to training/switching to training in hard-to-fill training programmes – see, further, the section on flexible pay premia below. Consequently this will ensure that staff who need to take time out from training posts for these vital reasons will not lose financially in respect of their pay as a Doctor as well as benefiting overall from the 13.5% pay increase.

(d) Measures relating to people absent from work

21. Consideration has been given to further measures in respect of Doctors who take time away from work for reasons including: (a) maternity, (b) caring responsibilities, (c) disability, and/or (d) ill-health. The specific measures considered were: (a) additional pay on return to work; and (b) arrangements to support accelerated progression to a higher nodal point following return to work.

² Modelling suggests that over three quarters of these Doctors will see their pay increase under the new contract.

22. Although such measures could be seen as promoting equality of opportunity for the Doctors affected, we do not currently consider arrangements of this sort to be fair or appropriate because: (a) a core principle of the new contract is the direct link between level of responsibility and work undertaken and pay. This would be undermined by the proposed measures, (b) the Academy of Medical Royal Colleges' publication "Return to Practice - April 2012" sets out how to plan a safe and effective return for Doctors who have taken time out and states "*Patient safety is the guiding principle of this report and must be put first, above all other considerations.*". The clinical context means that there is limited scope for any 'shortcuts' (whether actual or perceived), and (c) the approach under the new contract is consistent with Government policy that pay progression which merely recognises periods of time served rather than competence is not appropriate. Staff not receiving AAPP (most private sector staff and many public sector staff including most civil servants) expect to return to work on the same salary that they left on plus any cost of living increase.

23. However, we note that Health Education England ("**HEE**") and the Royal Colleges do, in certain circumstances, make arrangements for flexible training. The proposed new nodal pay structure is based on competency rather than time served. HEE has committed to work to: (a) identify and remove educational barriers to, and constraints upon, access to flexible training, liaising with others including the GMC, (b) overcome cultural barriers to flexible training, and (c) convene a group to take these issues forward, beginning its work and reporting on progress as quickly as possible.

24. While the new basic pay structure may operate in a manner that disadvantages those who attain greater levels of responsibility at a slower pace compared to the current arrangements we consider that it is clearly a proportionate means of meeting a legitimate aim, and therefore lawful.

Pay for additional hours worked and for on-call availability

25. Under the existing contract 'banding payments' (additions to basic pay, which are not pensionable) vary from 20-80% of basic pay depending on the working pattern

of each post. The banding payment model contains a number of elements that are unfair:

- a. Doctors may work anything between 41 and 48 hours, and yet receive the same pay;
- b. Doctors on rotas with no night shifts can be entitled to the same pay as Doctors on rotas with night shifts;
- c. Doctors on rotas with no Sunday working can be entitled to the same pay as Doctors on rotas with Sunday working; and
- d. a 100% banding payment applies where there is a breach of the current 'New Deal' requirements of 2000. A single breach, by one Doctor, of the shift length or rest requirements puts the entire rota (the group of Doctors on the same working pattern) in breach and triggers a 100% pay supplement to all Doctors working that rota. The pay supplement applies for the duration of that rota, including retrospectively (meaning the payment would apply to each Doctor until the end of the rotation).

26. The BMA and NHS Employers agreed in 2013 to formally negotiate changes to the new contract and, as long ago as 2008, the BMA agreed that the current contract needed to be reformed. The new contract replaces the banding payment system with a new model that seeks to more fairly reward Doctors for the amount of work actually done. Average total earnings will remain the same but the money currently used for banding payments will be distributed differently. The most significant features of the new model are:

- a. higher basic salary for a 'basic' working week (see the section on nodal points/basic pay above);
- b. proportionate payment for additional hours worked, up to a contractual maximum of 8 hours (or 16 hours if the Doctor has opted out of the Working Time Regulations ("**the WTR**"));
- c. on-call availability payments (varying according to the frequency of the on-call commitment);
- d. payment for work undertaken as a result of being on-call (this is included in (a) and (b) above);
- e. enhanced rates of pay for work done during unsocial hours ('premium-time' periods), including a Saturday 'Intensity' payment (SIP); and
- f. flexible pay premia.

Further detail on additional pay

(a) Additional hours payments

27. Additional hours will be paid at the relevant pay rate (1/40th of WTE) for each additional hour worked (the payment rate is based on the time at which the additional hours are worked so that unsocial hours attract a higher rate).

(b) On-call availability payments

28. On-call availability payments will be made to Doctors who are required to be available to return to work/provide telephone advice, but are not normally required to be on-site for all of the on-call period. Such a role is usually 'non-resident'. However, in a small number of cases, a Doctor may be required to be 'resident' whilst on-call (in these circumstances the periods on-call count as work for the purposes of the limits in the WTR but not for the purposes of the contract – only the hours actually worked count towards the hours limits in the contract). Such arrangements are exceptional, and are most common in remote hospitals where resident on-call Doctors are the only practical solution.

29. The Government initially proposed: (a) an on-call payment of 2, 4 or 6% of basic salary, dependent on the frequency of the on-call commitment, and (b) payment for hours actually worked. This was consistent with the terms applicable in the NHS to career grade doctors, associate specialists (together known as "SAS doctors") but slightly less than for consultants.

30. In negotiations, the BMA raised another, more generous proposal, specifically: (a) an on-call payment rate equating to up to 3.3 times that received by other NHS doctors. The rationale advanced by the BMA for this proposal was that childcare is more expensive at times Doctors are likely to be on-call and that the position under the new contract would adversely affect single parents (a disproportionate number of whom are women), and further (b) that a carers' allowance should be exclusively available to single parents. Following discussion with NHS Employers of the equality implications, the BMA subsequently withdrew proposal (b), accepting that

giving special treatment to single parents (alone) in relation to on call alone would not be fair or justifiable.

31. Following extensive negotiation with the BMA, the new contract has been restructured to: (a) increase the percentages used to calculate the on-call availability payments to 5% (if on-call less frequently than 1 in 4) and 10% (if on-call more frequently than 1 in 4), and (b) fix the salary against which the relevant percentage is applied for ST1-2 Doctors to the ST3-7 nodal point, thus increasing the cash value of the payments for those Doctors. The new contract now expresses the additional payment as a cash value based on the above principles, rather than a percentage. For Doctors in the Foundation stages, the on-call availability payments will be calculated by reference to the same percentages but will be based on the Foundation Doctors' own nodal point values. This is in most cases significantly more generous than the consultant or SAS doctor contracts.

(c) Changes to 'plain time' and unsocial working hours payments

32. 'Plain time' (or core hours) means the periods in which ordinary/basic rates of pay apply, with premium rates applying at other times (which are sometimes referred to as 'unsocial hours').

33. Under the existing contract, plain time is defined as 7am to 7pm, Monday to Friday, with a Doctor working 40 hours or fewer during those periods receiving basic pay only.

34. The new contract: (a) extends the definition of plain time to cover 7am to 9pm, Monday to Friday and 7am to 5pm, Saturday, and (b) provides for enhanced payment rates during premium time at: (i) time plus 50% for work undertaken on nights (9pm to 7am, every day), and (ii) time plus 30% for work undertaken on Saturdays between 5pm and 9pm and on Sunday between 7am and 9pm. The independent DDRB recommended that an extension of plain time in the evenings and on Saturdays would bring the arrangements for Doctors into line with the broader economy.

(d) Saturday Intensity payments

35. The new contract provides for Saturday 'Intensity' payments ("**SIPs**"). Doctors will be paid time plus 30% for all work undertaken between 7am to 5pm where they work shifts beginning on Saturday at a frequency of 1 in 4, or more frequently.

(e) Flexible pay premia

36. The new contract provides that flexible pay premia should be available for: (a) recruiting Doctors for hard-to-fill training programmes. Initially, this will apply to general practice, emergency medicine, psychiatry, and oral and maxillofacial surgery. Where a premium applies, it will apply for the duration of the training programme at the level that applied when the Doctor entered that programme, (b) people pursuing a clinical academic training path and/or undertaking work (such as research and leadership programmes) for the benefit of the wider NHS and continuing patient care (see Table 2 below for further details), (c) providing pay protection for retraining for hard-to-fill training programmes. This will apply to people changing specialty during training and those returning to training from the career grades (e.g. consultants), (d) people who change specialty because of disability or because of the need to care for a person with a disability (this will also apply to both changes during training and return from the career grades), and (e) exceptional payments where time out is taken for activities deemed of benefit to the wider NHS which will include, but not be limited to, public health emergencies.

37. Decisions on the application and level of the flexible pay premia in future years will be informed by the National Occupation Shortage List and advice from HEE and other stakeholders. In addition, the DDRB will be provided with evidence about hard-to-fill training programmes, to enable it to review the use of the premia and make recommendations to Government on appropriate application and value.

Table 2

November offer		Final contract	
Academia ¹	£3,125	Academia ¹	£4,000
Emergency medicine training programmes at ST4 and above	£1,500	Emergency medicine training programmes at ST4 and above	£1,500
General practice ²	£8,200	General practice ²	£8,200
		Oral and Maxillofacial Surgery	£1, 500
Psychiatry training programmes at ST1 and above	£1,500	Psychiatry training programmes at ST1 and above	£1,500

Notes:

- Academic premia will be paid to those on recognised academic programmes upon successful completion of a higher degree; or to those completing higher degrees whilst holding a training number and on an OOP approved by the postgraduate dean, upon successful completion of the higher degree and return to training. A similar premium will be paid to Doctors taking time out of programme to undertake work deemed to be of wider benefit to the NHS, as defined in the contract schedules.
 - The general practice premium will only be paid to Doctors undertaking general practice placements as part of a general practice training programme (replacing the GP supplement). It will not be paid to those Doctors whilst they are in hospital or other community placements, or to Doctors on other programmes (e.g. F2) undertaking placements in general practice.
38. For general practice, the premium serves as a recruitment and retention payment, replacing the existing mechanism, the “GP registrar supplement”, which has ensured broad parity between the average level of hospital banding supplement in payment and earnings in the general practice placement of GP training (where the hospital banding supplements do not apply, mainly because additional hours, on-call and unsocial hours have not been a feature of GP training in the practice setting). For oral and maxillo-facial surgery, the premium recognises the requirement for such Doctors to complete undergraduate degrees in both medicine and dentistry.

Potential Impacts of additional payment arrangements

- Replacing the existing banding system under the existing contract with an approach that links pay more directly to actual patterns of work means that three-quarters of Doctors will be better off based on modelling shared with the BMA and no one working legal contractual hours will see their salary decrease compared to the current contract amongst the current cohort of Doctors (if the position under the

new contract is compared with the pay of Doctors on 31 October 2015; the last pay day before the November contract offer was made).

40. Under the new contract, the pattern of pay distribution as between different individuals and specialties will depend on working patterns. Depending on working patterns, average earnings in some specialties under the new contract may increase, while average earnings in other specialties may reduce. If a particular specialty has a disproportionate percentage of people with a protected characteristic, this could give rise to equalities implications (e.g. if women's pay is reduced compared to men's), but if this were the case we consider that any impact would be justifiable legally as an indirect impact resulting from a legitimate aim, as set out in paragraph 7 above.
41. The components of the additional pay arrangements also raise some discrete issues.
42. **On-call availability payments:** the BMA has suggested that the decision not to provide for higher levels of on-call availability payment will disproportionately and/or unfairly affect single parents with childcare responsibilities (a disproportionate percentage of whom are women).
43. The BMA has also suggested that the changes to on-call availability payments will disproportionately impact on specialties with a high proportion of on-call work, citing the examples of psychiatry and public health.
44. **Changes to 'plain time' and unsocial hours payments:** the BMA has suggested that extending the periods constituting plain time and paying plain time rates for the extended period (between 7 to 9pm on weekdays, and on Saturdays) will disproportionately/unfairly disadvantage those who need to arrange childcare (a disproportionate percentage of whom are women).
45. The combined effect of the provisions of the new contract relating to unsocial hours and SIPs also means that people working in specialties with daytime hours from Monday to Friday and fewer than 1 in 4 weekends will not be entitled to enhanced unsocial hours payments. The BMA says that this is likely to affect some specialties

(such as paediatrics and obstetrics and gynaecology) where there is a disproportionate number of women Doctors.

46. Consideration has been given as to whether additional payment arrangements under the new contract, particularly pay for weekend working (including SIPs), might give rise to a particular disadvantage relating to religion or belief.

47. **Saturday Intensity payments:** Negotiations did not address whether any pro-rata arrangement should apply for part-time Doctors. Consideration has been given to this issue.

Analysis/Mitigation/Justification

48. This restructuring of additional pay is the corollary of the 13.5% average increase to basic pay under the new contract. The restructuring achieves a key BMA requirement, supported by the DDRB, to rebalance earnings by allocating a greater proportion of total remuneration to basic (pensionable) pay, with less reliance on variable pay. The additional pay model under the new contract seeks to achieve this whilst also ensuring that those working the most unsocial hours continue to receive premium pay for those hours.

49. Additional pay will vary based on working pattern (which will vary by specialty). Should there be any equalities impact, it is likely to be indirect. Doctors with the most intense working patterns will receive higher pay regardless of their gender, or any other protected characteristic. The relative redistribution of pay caused by these components of the new contract is a deliberate measure to tie remuneration more closely to work done.

50. Any disadvantage arising from redistribution of pay must also be considered in the context of the 13.5% average increase in basic pay under the new contract. Overall, total pay is expected to remain consistent – average earnings remain the same, although the total pay bill will rise as more Doctors are employed by the NHS. Increasing the amount of basic (fixed) pay and linking variable pay more closely to the amount of work and the extent to which hours are unsocial seeks to ensure that those Doctors working the most unsocial hours are the best rewarded,

whilst also ensuring that those working fewer unsocial hours are still rewarded well enough to ensure that there is no material detriment.

51. As described further below, the new contract includes guarantees on pay protection during a transitional (time-limited) period. The modelling shared with the BMA suggests that over three-quarters of those moving to be paid under the new contract during the period of protection will see their pay increase; the rest will be protected until the end of transition in August 2019. Doctors at ST3 and above will be paid according to the current contract until August 2019 (longer for those working part time or taking an approved break from training for reasons, for example, of maternity, caring for children, elderly relatives, vulnerable adults).

52. Consideration has been given to alternative options for redistributing pay, specifically the BMA's proposals, advanced in negotiations, for reducing basic pay, and increasing premium rates and the coverage of premium rates, to include all of Saturday, whilst staying within the cost envelope and/or retaining a revised version of the banding system that applies under the existing contract.

53. However, we do not consider that these proposals would be likely to achieve the intended outcomes and benefits of a new, more professional, contract. The provisions of the new contract are consistent with the Government's commitment to ensuring that patients receive the same high quality service across the seven day week. The DDRB recognised that: (a) Doctors already work across seven days, and (b) the existing contract definitions of plain time (see above) are out of line with the wider economy where unsocial hours enhancements are increasingly not payable for working on Saturdays. In addition, the BMA proposals did not meet the shared objective of giving a significant increase in base pay and were more generous than the payments made to other clinical staff under both the consultant contract and Agenda for Change.

54. **On-call availability payments:** consideration has been given as to whether payment of a higher premium is appropriate.

55. A 10% on-call availability allowance is higher than that which is payable under any other NHS medical contract and Doctors also, in addition, are paid for actual hours

worked during the on-call period. Account should also be taken of the average 13.5% increase in basic pay.

56. Taken together, the provisions in the new contract for: (a) increased basic pay, (b) on-call availability payments, and (c) payment for work actually undertaken whilst on-call, often at enhanced pay rates (because of the time at which the work is being done), provide significant remuneration for Doctors undertaking on-call work. We consider that the position under the new contract strikes a fair balance (and incorporates a significant compromise to address the BMA's representations).

57. Consideration has also been given to the position of part-time Doctors. We recommend that a cash sum equivalent to a 10% or 5% pay enhancement for part-time Doctors should be paid pro-rata based on the proportion of full time work for on-call that has been agreed in the work schedule.

58. **Changes to 'plain time' and unsocial hours payments:** as noted above, consideration has been given to potential alternative proposals but we do not consider that they would provide the same overall benefits. Specifically this is in relation to the objective of being able better to roster Doctors across seven days. In terms of cover over a seven day week, the contract should have the effect of making it more affordable to roster Doctors into the evenings and for part of Saturdays (subject to frequency) and will also better reward those Doctors working in those specialties which require intensive work at other (unsocial) times; particularly nights. Further: (a) any potential impact must be balanced with increased basic pay, and (b) whilst there is likely to be an increase in Doctors working at weekends, and into the evenings on weekdays, the greater impact for the medical workforce will be on consultants and it is anticipated that the impact on individual Doctors will be limited. Since May 2010, the Doctor workforce has increased by over 4,300 and by increasing plain time working, future increases in the Doctor workforce will be better able to support 7 Day Services. The BMA has frequently noted that Doctors already work during weekends. The provisions of the new contract in respect of SIPs, in particular, provide a mechanism to reward Doctors being scheduled to work 1 Saturday in 4 or more frequently. Overall, the changes will assist in meeting one of the key contract objectives of supporting the delivery of a Seven Day NHS for patients. We believe that it is likely to improve the

training offer at weekends, when aligned with changes to ensure a greater consultant presence on Saturdays and Sundays.

59. **Saturday working:** data on the breakdown of the Doctor workforce by religious belief is limited (see Annex B), but our current assessment is that the new contract is unlikely to have a detrimental impact on individuals according to their religion or beliefs, given that Doctors are already expected to be available across seven days and that pay will relate to the working pattern in the work schedule for the post, which will be tailored to the educational needs of the individual Doctor.
60. **Saturday Intensity payments:** it is recommended that Doctors working part-time should be entitled to SIPs on a pro-rated basis. This will be kept under review as the 7 Days Services are rolled out to ensure that any pro rata payment equates equally with treatment in respect of full time staff.
61. **Flexible pay premia:** Consideration has been given to the position of Doctors who need to change specialty due to: (a) difficulties connected to disability, for example having to change from surgery to a specialty that will require less fine physical motor skills, and/or (b) the need to care for a disabled relative. The new contract provides that if a Doctor needs to change specialty for these reasons pay protection will apply as if the Doctor was moving to a hard-to-fill training programme. This will cover both: (a) Doctors changing specialty during training, and (b) Doctors returning from the career grades.

Pay protection during transition

62. The new contract provides two types of transitional pay protection arrangements that seek to offer reasonable protection against disruption from the redistribution of pay under the new contract for those Doctors already in training.
63. Doctors who are in the early stages of training (Foundation and core/specialty training (CT/ST1 to CT/ST2 – in some cases CT3)) will move onto the new contract with the protection of a 'cash floor'.

64. Doctors in the last three to six years of their training (depending on the length of training for their specialty) (ST3 (or in some cases ST4) and above) will move onto the new contract when they change post as they progress through training. However, they will remain on pay terms similar to those applicable under the existing contract for the period in which transitional pay protection arrangements apply.
65. The move to better reward progress and responsibility in the new contract means that those in training who have taken longer to progress, benefit most from AAPP under the existing contract, and are likely to be most affected by the introduction of the new contract. This group will include part-time workers (disproportionately female) and those who have taken time out of training (including for reasons related to maternity or disability). Part-time working is more common in the registrar group, in particular at the higher stages of registrar training, so this approach to transition gives part-time workers more active protection of their pay than straightforward cash floor pay protection. Allowing them to continue on the existing pay system provides a measure of protection in respect of anticipated earnings for those whose career choices were made some time ago. It allows this group to receive the annual increments that they currently expect, whereas those in the 'cash protection' group will benefit over the same period by career progression through the nodal pay structure increases. The former group will remain on pay terms similar to those applicable under the existing contract for the period in which transitional pay protection arrangements apply. The highest level of protection that will apply is Band 2A (80% pay supplement). (Rotas with weekly average hours in excess of 56 hours of actual work are not permitted under the new contract.) The exclusion of band 3 (which is currently triggered for the entire rota when there is a breach of the current contract limits by one Doctor on a rota) affects a small number of Doctors (around 500), who will be protected on the basis of an 80% banding (if opted out) rather than the 100% banding that applies when such breaches occur, and we have no evidence to indicate that any protected group is more affected than others.
66. The period of transitional pay protection is three years (from phased introduction in 2016/2017). Where Doctors remain in training at the end of transition they will move onto the new contract pay terms. Doctors who are part-time or who take approved time out of programme will have three 'full' years of protection (e.g. a Doctor

working part-time on a 0.5 WTE basis would have six actual years of pay protection).

67. We have also considered the impact of the pay protection arrangements on protected groups. It was initially proposed that Doctors absent from work on 31 October 2015 (the date for determining the cash floor for pay protection) for maternity or other approved reasons (e.g. caring for children, an elderly relative, vulnerable adult or health related reasons), would have their cash floor calculated using the basic pay they would have earned had they not been absent, plus the cost of living award made in April 2016, plus the banding of the last post they were in prior to 31 October 2015. We have considered further and have now provided that such Doctors should have the cash floor calculated as if they were not absent – i.e. the banding used for the cash floor calculation will be the banding applying, on 31 October 2015, to the rota on which they would have been working had they not been absent. The employer will need to assess this reasonably having regard to the likely banding payment that the next placement would have attracted (usually the post that they are actually placed into on return). This means that they would be treated the same as Doctors who were working at the relevant date and therefore will not be disadvantaged financially.

Pension arrangements

68. The increase in basic pay under the new contract means an increase in pensionable pay. For those in the Career Average Revalued Earnings (CARE) scheme (the majority of Doctors), this means a greater contribution towards the value of final pension.

Locum work payment and private professional work/fees

69. The new contract provides that where a Doctor wishes to undertake locum work in addition to the duties in their work schedule/contract of employment, the NHS employer has first refusal on that time and can secure it at contract rates. This will apply equally to full-time and part-time Doctors. The requirement will not apply to: (a) voluntary work, and/or (b) acting as medical support for instance for sports teams.

70. There is no requirement for Doctors to do locum work. The hours Doctors work are set out in their individual work schedule, which is tailored to their educational needs, including those who train/work part-time.

71. The new contract includes provisions to prevent Doctors being paid twice for the same period of time. This is consistent with the position that applies to consultants.

72. We do not envisage that these provisions significantly impact adversely on any protected groups.

Hours of working

73. The new contract introduces limits on working hours which provide stronger protections for safe working, including capping average weekly hours at 56 hours where Doctors opt out of the WTR protections and limiting maximum weekly working hours to 72 (where the WTR allows for 91). The following limits will apply to working patterns under the new contract:

- a. A maximum of 48 weekly hours on average (extended, but still limited, to 56 hours a week on average for those Doctors who choose to opt-out of the WTR);
- b. new maximum of 72 hours in any consecutive seven day period (lower than the 91 hours possible within average weekly hours of 48);
- c. no rostered shift to exceed 13 hours (excluding overnight on-call duty periods);
- d. new limits on working patterns:
 - i. no more than five consecutive long shifts (i.e. longer than 10 hours);
 - ii. no more than four consecutive night shifts (i.e. where at least three hours fall between 11pm and 6am);
 - iii. a maximum of four consecutive long late evening (twilight into night) shifts; (exceeding 10 hours and finishing after 2300);
 - iv. a maximum of eight consecutive shifts; (irrespective of length);
 - v. a minimum of 48 hours rest after:
 1. three or four consecutive night shifts;
 2. five consecutive long shifts;
 3. four consecutive long late evening (twilight into night) shifts;

- 4. eight consecutive shifts;
- e. no consecutive weekends to be scheduled without the individual Doctor's agreement and an absolute limit of an average of 1:2 weekends in any rota;
- f. limits on on-call working:
 - i. no more than three rostered on-calls in seven days except by agreement;
 - ii. single on-call duty periods of 24 hours other than at the weekend when two consecutive duty periods are permitted; guaranteed rest arrangements where overnight rest is disturbed; and
- g. Paid rest-breaks:
 - i. 30 minutes if shift exceeds five hours;
 - ii. 2x30 minutes if shift exceeds nine hours, taken flexibly across the shift.

74. The new contract places a mutual obligation on employers and Doctors to comply with the protections. The employer has a contractual and regulatory responsibility for ensuring the Doctor is not contracted, or otherwise required, to breach the protections.

Work Scheduling and Safeguards: work reviews, exception reporting and the Guardian role

75. Under the new contract Doctors will have a work schedule for each post they take up. This will set out the service commitments and working pattern for the post, and will be tailored for the individual Doctor's educational needs.

76. To ensure that these safe working patterns are adhered to, there will be a system of safeguards, as follows:

- a. A Guardian of safe working hours for each organisation, appointed jointly with Doctors;
- b. appraisal of the Guardian by board level director based on multi-source feedback and agreed key performance indicators (“KPIs”);
- c. safe working hours enshrined as a KPI in the performance management framework for all managers;
- d. regular review of work schedules with the educational supervisor, which could lead to agreed changes;

- e. work schedule reviews on request and when required by the Guardian;
- f. best practice guidance on rostering;
- g. exception reports where hours, working pattern or educational opportunities vary significantly from the work schedule – leading to review, and changes where agreed;
- h. escalation process if issues not resolved: informal review; formal review; grievance/appeal. Involvement of trust director of postgraduate medical/dental education;
- i. financial penalty levied on employer for breaches of WTR 48-hour average working hours or contractual 72-hour weekly limit or where the minimum eleven hours rest requirement between shifts has been reduced to fewer than eight hours, with payment to the Doctor for excess hours at 1.5 times the hourly rate and a fine at 2.5 times the hourly rate to be paid to the Guardian (to be invested in educational resources and facilities for Doctors (over and above monies already allocated to those areas));
- j. annual reports on work schedule reviews and outcomes to the Care Quality Commission, HEE and the DDRB; and
- k. compensation where Doctors work beyond the work schedule in exceptional circumstances to secure patient safety.

Addressing the impact on equalities – by protected group

Sex and pregnancy/maternity

77. As shown in Table X in Annex B, the majority of Doctors are women. The revised pay structure under the new contract is fairer and will advance equality of opportunity between all Doctors (including between those who have protected characteristics and those who do not) and help to foster good relations between persons who share a relevant protected characteristic and those who do not. However, replacing a pay system based on time elapsed and broad banding with one that is based on equal pay for work of equal value, inevitably means that some will do better than others compared with the theoretical counterfactual of the current contract.

78. Disadvantages that may arise can be summarised as follows: (a) although they may benefit overall, certain features of the new contract will adversely impact on

those who work part-time, and Table Y in Annex B shows that a greater proportion of women than men work part-time, (b) women, but not men, take maternity leave and some aspects of the new contract have certain adverse impacts regarding maternity, (c) certain features of the new contract will potentially adversely impact on those who have responsibilities as carers; we consider (and assume for the purposes of this analysis) that this group will disproportionately comprise women, (d) we consider it possible (and assume for the purposes of this analysis) that in some specialties with a disproportionate number of women, Doctors will be advantaged less than other Doctors under the new pay structure because the level of additional payments for Saturday working which Doctors in that field are likely to receive will be less than those in specialties predominantly receiving SIPs , and (e) we consider that whilst it is possible that increased rostering of staff in evenings and weekends (as opposed to during day time in the week) may improve conditions for many Doctors working part-time because they may be able to arrange cheaper and more informal childcare arrangements in the evenings and at weekends if they have family support; equally in some circumstances it may impact on those with childcare responsibilities who do not have such opportunities, given the higher cost of childcare at those times, and that they may be disproportionately women. Clearly, it would be artificial to analyse each of these areas in isolation. The cumulative effect of these matters – together with the other terms of the new contract – must be considered, in particular the 13.5% average increase in basic pay, and the extensive measures and underlying aim, as set out in paragraph 7 above, in the new contract to strengthen adherence to safe working hours, which will be advantageous for all Doctors and could, in some cases, advance equalities objectives. The advantages are important when considering the justification for any disproportionate impact which may be perceived – this is discussed in the paragraphs throughout this section.

79. As regards basic pay, the nodal pay model has been revised to mitigate the effect of the removal of AAPP (by both: (a) reducing and flattening the nodal points, and (b) ‘frontloading’ pay increases). Further, transitional pay protection will significantly mitigate any adverse effect on Doctors currently in training.

80. Insofar as the nodal pay model may disadvantage women working part-time (as compared with the hypothetical position under the existing contract) we consider

that this is consistent with the principle of pay based on level of responsibility that underpins the new contract. Any indirect adverse effect which may occur is a proportionate means of achieving a legitimate aim.

81. Table Z in Annex B shows gender split by specialty group. As described above, the redistribution of earnings under the new contract is intended to produce the result that Doctors working in specialties with the most intense and/or unsocial working patterns, including those who are actually required to work when on-call, will receive higher pay than Doctors in specialties with less intense/unsocial rotas (e.g. pathology). This redistribution of pay is a deliberate measure to tie remuneration more closely to the specific demands of each post.

82. Particular consideration has been given to whether special provisions should be made under the new contract for those taking maternity leave and those working part-time. Such provisions could be seen as promoting equality of opportunity for women. However, we have concluded that such measures would be inconsistent with the principle of pay based on level of responsibility that underpins the new contract, whose justification is set out in paragraph 16.

83. As explained above, detailed consideration has also been given to the various components of the additional payment structure under the new contract: (a) as to on-call availability payments, we consider that the payments proposed are fair and that any indirect adverse effect on women is a proportionate means of achieving a legitimate aim, and (b) as to the changes to plain time and SIPs, while these changes may, in isolation, disadvantage women (as compared with the hypothetical position under the existing contract and with those receiving SIPs under the new contract) we consider that this must be balanced with the 13.5% average increase in basic pay, the flatter nodal point structure meaning those most likely to be working part time will receive the same level of pay through the later years of their training whether full or part-time, and the principle of those working the most intense/unsocial hours receiving the most pay. Any indirect adverse effect on women is a proportionate means of achieving a legitimate aim. Whilst this may disadvantage lone parents (who are disproportionately female) due to the increased cost of paid childcare in the evenings and weekend, in some cases this may actually benefit other women, for example where individuals have partners, it may

be easier to make informal, unpaid childcare arrangements in the evenings and weekends than it is during the week due to the increased availability of partners and wider family networks at weekends and in the evenings.

84. As detailed above, we recommend that a number of steps are taken to amend the draft new contract to address the position of part-time Doctors (a disproportionate number of whom are women). We consider that these measures will help to advance equality of opportunity between men and women Doctors and help to foster good relations between them.
85. In summary, while there are features of the new contract that impact disproportionately on women, of which some we expect to be advantageous and others disadvantageous, we do not consider that this would amount to indirect discrimination as the impacts can be comfortably justified. The position under the new contract will be that Doctors: (a) will remain, objectively, very well paid, (b) will benefit from a 13.5% average increase in basic pay, (c) will benefit from additional pay arrangements which, both objectively and in comparison with other NHS staff, are generous, (d) will progress under a fairer pay model where pay is linked to responsibility and those who work the most intense/unsocial hours receive the highest pay. In addition, from a patient perspective, more affordable evening and weekend working is expected to improve patient care across seven days.
86. Data from HEE suggests that there are 2,500 Doctors with the training status of 'Maternity/Other': approximately 100 are in the Foundation stages of training; the rest are split approximately 50:50 between ST1-3 (broadly, core training) and ST4-8 (higher specialty training). In relation to the new contract, the treatment of those returning from maternity leave is consistent with what happens for other groups of staff in the NHS and the wider public sector, and in the private sector. As explained above, we recommend that special provision is made to improve the position in respect of transitional pay of women who are absent on maternity leave at the time of transition. We consider that these measures will help to advance equality of opportunity between men and women Doctors and help to foster good relations between them.

Disability

87. Table X in Annex B gives a breakdown of the Doctor workforce by disability status.

We consider (and assume for the purposes of this analysis) that a disproportionate number of Doctors with disability will work part-time. Insofar as issues arise in connection with part-time status, the analysis above in respect of 'sex' applies *mutatis mutandis*.

88. We recommend that the new contract should specifically provide that flexible pay premia will apply where a Doctor needs to change specialty because of a disability or the need to care for a person with a disability. We consider that these measures will help to advance equality of opportunity for Doctors with disabilities and (a) remove or minimise disadvantages suffered Doctors with disabilities that affect them in this way, and (b) help meet the needs of Doctors with a relevant disability. This reflects s149 of the EqA, which states "*The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities*" and "*Compliance with the duties in this section may involve treating some persons more favorably than others*".

Race

89. Table X gives a breakdown of the Doctor workforce by ethnic group. Pay under the new contract relates to level of responsibility and working patterns, and we do not currently envisage any significant equalities impact of introduction of the new contract in relation to race.

Age

90. Table X in Annex B shows that the age distribution of the Doctor workforce is relatively narrow and predominantly young with little scope for differential impact across age bands. In any case, payments under the new contract will be based upon level of responsibility and working patterns, as detailed above, which is considered a fair method of determining reward independent of age. The current time-served pay progression arrangement, irrespective of levels of responsibility, is likely to favour those who are marginally older. As such there could be said to be inherent age discrimination at the core of the current contract. Whilst age discrimination can of course be objectively justified it is a legitimate aim and a

proportionate means to make changes as the change to a nodal pay model will remedy any potential unfairness. The move to payment based on level of responsibility is likely to favour those who are marginally younger, but this is justified as a fairer method of determining reward. We do not currently envisage any other significant equalities impact of introduction of the new contract in relation to age.

Gender reassignment: including transgender

91. There is no data available on this category. We do not envisage any significant equality impacts on this basis.

Sexual orientation

92. Table X in annex B gives a breakdown of the Doctor workforce by sexual orientation. We do not envisage any significant equality impacts on this basis.

Religion or belief

93. Table X in Annex B gives a breakdown of the Doctor workforce by religious belief. The data is limited but our assessment is that the new contract will not differentially impact individuals according to their religious beliefs. We considered, in particular, whether changes related to the definition of plain time and SIPS might impact on those for whom Saturday is the holy day. Our assessment is that the new contract is unlikely to have a detrimental impact on individuals according to their religion or beliefs, given that Doctors are already expected to be available across seven days and that pay will relate to the working pattern in the work schedule for the post, which will be tailored to the educational needs of the individual Doctor. Sunday is obviously also a holy day for some religions. In the same way, we do not consider that the new contract raises any significant equality impacts as regards Sundays. To the extent that there is any limited impact in increasing the number of Saturdays and Sundays that Doctors are expected to work, this can be justified by the improvements in patient care from increasing the rostering of staff at the weekend.

Further work to assess equalities impact of the new contract

94. As set out above, this is a forward-looking analysis of the expected equalities impacts of the new contract. We will consider carefully any equalities issues and

any motivation and recruitment and retention risks that may be generated by the new contract. These risks will be monitored closely.

95. The new contract is fair and justified as good for both staff and patients. We consider that the new contract will advance equality of opportunity and further good relations between different groups. Insofar as the new contract has an indirect adverse effect on people with protected characteristics we consider that the new contract is a proportionate means of achieving a legitimate aim, or aims. We envisage that as Doctors' awareness of the reality of the content of the new contract increases, and as Doctors gain direct experience of its operation, its popularity will increase.

96. As discussed with the BMA, NHS Employers and NHS Improvement will conduct a review 18 months after introduction, with the BMA's involvement if they choose. NHSE will report back to the SoS on the equalities impact of the new contract in order to assist the SoS in continuing to give effect to his PSED. We will also consider and, where necessary/appropriate, commission NHSE to conduct further research or make further adjustments to the new contract. NHSE will publish the findings and any action plan on its website.

Next steps

97. NHSE will continue to work with the service to prepare for introduction of the new contract. NHSE will maintain the contract under the current collective bargaining arrangements with the BMA (if they choose to engage), making changes as needed. The DDRB will continue to make annual recommendations to government on pay levels for Doctors, taking account of evidence from all parties.

NHS Pay Team, DH

March 2016

Public sector equality duty in the Equality Act 2010

149 Public sector equality duty

- (1) A public authority must, in the exercise of its functions, have due regard to the need to —
 - (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
 - (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
 - (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
- (2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
- (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to —
 - (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
 - (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
 - (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
- (4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
- (5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to —
 - (a) tackle prejudice, and
 - (b) promote understanding.
- (6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

- (7) The relevant protected characteristics are —
- age;
 - disability;
 - gender reassignment;
 - pregnancy and maternity;
 - race;
 - religion or belief;
 - sex;
 - sexual orientation.
- (8) A reference to conduct that is prohibited by or under this Act includes a reference to —
- (a) a breach of an equality clause or rule;
 - (b) a breach of a non-discrimination rule.
- (9) Schedule 18 (exceptions) has effect.

Evidence

1. The main source of data on the characteristics of the Doctor workforce is the Electronic Staff Record System (ESR), the payroll and human resources system used by all but two NHS trusts. ESR informs workforce publications by the Health and Social Care Information Centre (HSCIC) and can also inform supplementary analyses beyond the scope of those publications.
2. Across their publications, HSCIC data is available on the distribution of the Doctor workforce across many of the protected characteristics. Table X below summarises the latest available information. This is supplemented by table Y, which sets out part-time working rates by gender, and table Z, which outlines the gender split by specialty.
3. Assessments of any potential differential impact of the new contract across equality dimensions are largely qualitative. Outcomes faced by individuals under the new contract depend on their personal circumstances in two key regards:
 - Their stage of training, as distinct from their current pay point, and how this reads across to the level of responsibility which will determine basic pay under the new contract; and
 - their specific working patterns *in future posts* (as distinct from their current banding supplement in their current posts), which will determine levels of additional pay under the new contract.
4. We have compared *sample* data on the stage of training with ESR data on current pay point; working patterns in future posts are unknowable. We have used the best indications from current data to inform our assessment of how many Doctors would see a fall in pay on moving onto the new contract and thus the arrangements for transitional (time-limited) pay protection; however, there are data limitations and the future may not follow the patterns of the past.
5. Data about *future* working patterns cannot yet be known, but will inform the full assessment of the actual impact of the contract, post-introduction.

Table X: Proportion of Doctor Workforce by Various Equality Dimensions, October 2014

	Proportion of:	
	Registrars	Other Doctors in Training
<u>DISABILITY</u>		
Disabled	0.7%	1.5%
Not Disabled	71%	73%
Not Disclosed	15%	14%
Unknown	14%	12%
<u>ETHNICITY</u>		
White	51%	57%
Black or Black British	4%	3%
Asian or Asian British	27%	20%
Mixed	3%	3%
Chinese	3%	3%
Any Other Ethnic Group	3%	3%
Unknown	9%	10%
<u>GENDER</u>		
Female	54%	57%
Male	46%	43%
<u>RELIGIOUS BELIEF</u>		
Atheism	11%	16%
Buddhism	1%	1%
Christianity	24%	22%
Hinduism	7%	5%
Islam	9%	7%
Jainism	0%	0%
Judaism	1%	1%
Sikhism	1%	1%
Other	3%	3%
Not Disclosed	30%	30%
Unknown	13%	14%
<u>SEXUAL ORIENTATION</u>		
Heterosexual	58%	60%
Gay	1%	1%
Lesbian	0%	0%
Bisexual	0%	0%
Not Disclosed	28%	25%
Unknown	13%	14%
<u>AGE BAND</u>		
Under 25	0%	30%
25 to 34	67%	64%
35 to 44	30%	4%
45 to 54	3%	1%
55 to 64	0%	0%
65 and Over	0%	0%

Source: Derived from Health & Social Care Equality & Diversity Publication, April 2015

Table Y: Doctor Part-time Working Rates by Gender, September 2014

	Other Doctors	
	Registrars	in Training
Proportion of Males that are:		
Full Time	98%	99%
Part Time	2%	1%
Proportion of Females that are:		
Full Time	82%	96%
Part Time	18%	4%

Source: Derived from Health & Social Care Annual Workforce Publication, March 2015

Table Z: Doctor Gender Split by Specialty Group, September 2014

	Registrars		Other Doctors in Training	
	Male	Female	Male	Female
All Specialties	46%	54%	43%	57%
Accident & emergency	50%	50%	44%	56%
Anaesthetics	50%	50%	45%	55%
Clinical oncology	39%	61%	32%	68%
Dental group	47%	53%	42%	58%
General medicine group	44%	56%	42%	58%
Obstetrics & gynaecology	25%	75%	27%	73%
Paediatric group	28%	72%	31%	69%
Pathology group	35%	65%	42%	58%
PHM & CHS group	29%	71%	37%	63%
Psychiatry group	38%	62%	44%	56%
Radiology group	57%	43%	43%	57%
Surgical group	69%	31%	48%	52%

Source: Derived from Health & Social Care Annual Workforce Publication, March 2015

Relevant background

1. The BMA and others identified the need for reforming the 'New Deal' Doctors' contract (introduced in 2000) as far back as 2008. A case for change and principles for a new national contract were set out in a Scoping Study report by NHSE published in 2012.
2. Following a stakeholder event in January 2013 – involving Doctors and their trade unions, employers, other NHS organisations, the Royal Colleges, postgraduate deaneries/educators, the GMC, devolved administrations – discussions began to discuss Heads of Terms for negotiations.
3. Negotiating teams representing NHSE (and counterparts from the devolved administrations) and the BMA 'junior doctors' committee ("**the JDC**") agreed draft Heads of Terms ("**the HoTs**") in July 2013. These were ratified by the four UK Health Departments and by the JDC as the mandate for UK-wide negotiations. The JDC also represented the British Dental Association ("**the BDA**") during HoTs discussions and in negotiations. The HoTs provided that the new contract must "*Be consistent with all aspects of UK law, including working time regulations and the Equalities Act.*"
4. Negotiations began in October 2013, scheduled to run to the end of October 2014. However, the BMA left negotiations in mid-October 2014. The UK Health Departments then asked the DDRB to make recommendations on a new contract (Scotland asked for observations only). NHSE, the UK Health Departments, the BMA and a number of other parties submitted evidence to the DDRB.
5. The DDRB made recommendations to the UK Health Departments in July 2015, broadly endorsing NHSE proposals as the basis for further negotiations. The SoS invited the BMA to return to negotiations, being clear that a negotiated agreement was preferred but that a new contract would be introduced if agreement could not be reached.

6. The BMA did not return to negotiations. The DDRB offered to explain to the BMA the rationale for its recommendations, but the BMA did not take up this offer. On 4 November 2015, NHSE published an offer that was ‘firm, not final’ – reflecting that further work and modelling remained to be done, and the continued hope that the BMA would agree to negotiate. The published offer document stated: “*The new pay system and contract will not break any equality laws and will be subject to a full equality impact assessment before implementation*”. On 5 November 2015, the BMA balloted its members for industrial action.

7. Following talks involving ACAS, the parties agreed to re-enter negotiations and a memorandum of understanding was signed by the BMA, NHSE and the Department of Health on 30 November 2015. This stated that “*Collaborative work on pay will include an ‘open-book’ approach to the November 2015 pay calculator and supporting data and models, including cost-neutrality and equality impact, helping ensure clear systems for pay progression and managing transition.*”

8. Further negotiations began in December 2015 and ended in February 2016. Whilst there was agreement on approximately 90% of the issues under negotiation between the parties, the key sticking point was the BMA’s refusal to negotiate on any change to the number of hours designated as plain time, the rate of pay for those hours and the days on which those hours would be worked, despite giving a written undertaking at ACAS that it would do so. This refusal was despite significant movement from the management side on the time designated as unsocial including a Saturday intensity payment for the 40% of Doctors working one in four Saturdays or more

9. The SoS was advised by NHS leaders that further progress by negotiation was unlikely. He therefore announced, on 11 February 2016, that a new contract would be introduced without further negotiation. On 12 February 2016, a summary of certain terms of the draft contract was published, showing the changes that had been made, as a result of negotiations with the BMA, since the November offer, and with a suggested timetable for a phased introduction from August 2016. NHSE have continued to work on the proposed terms and condition for the new contract and to prepare associated guidance, including a pay circular with 2016/17 pay rates, and model contract of employment.

Engagement and involvement

1. We have engaged stakeholders in gathering evidence or testing the evidence available:
 - a. NHSE' scoping study, conducted 2010-2011, took account of views from employers and the BMA and BDA;
 - b. NHSE held a stakeholder event, January 2013, involving employers of Doctors and other NHS organisations, Doctors/trades unions, Royal Colleges, postgraduate deaneries/educators, the GMC, devolved administrations;
 - c. representation of staff side (trade unions) and management side (NHS employing organisations) through negotiating teams. Development and discussion of proposals in discussion papers, presentations, and draft schedules of terms and conditions;
 - d. use of wider reference group of employers to inform negotiations, develop and test proposals;
 - e. the BMA used its own wider structures – full JDC and wider BMA, and consultation with members;
 - f. commissioning an independent review by the DDRB, with any party free to submit evidence to that review and with all evidence and the DDRB's report being published. This was an open and transparent process, with all parties (who responded to the DDRB's call for evidence) publishing their evidence and free to comment on evidence submitted by others; and
 - g. publication of letters between the BMA and DH/NHSE; publication of details of the various iterations of the proposed contract, sending these to all Doctors in England; and the leader of the NHS negotiating team meeting Doctors to discuss the issues during negotiations. See:
<https://www.gov.uk/government/collections/junior-Doctors-contract> ; and
<http://www.nhsemployers.org/your-workforce/need-to-know/junior-Doctors-contract>

2. We have engaged stakeholders in testing the policy or programme proposals through refinement of the “firm, not final, offer” (published by NHSE in November 2015) taking account of:

- a. negotiations with the BMA between December 2015 and February 2016, where there was agreement on 90% of the detail;
- b. wider stakeholder meetings during, and informing, negotiations;
- c. detailed modelling of revised proposals, subsequent to those negotiations; and
- d. written and verbal feedback from stakeholders, including individual Doctors and employers.

3. This engagement has involved the following groups:

- a. In negotiations: Doctors were represented by the BMA; employers were represented by NHSE and employer representatives from the devolved administrations; there was also a joint sub-group to consider specific issues relating to general practice Doctors;
- b. NHSE sent to all Doctors in England details of the offer made in November 2015 and of the offers made in negotiations with the BMA in January 2016, including the summary of the proposed final terms; and
- c. NHSE and DH have responded, and continue to respond, to many questions and suggestions from individual Doctors and employers, Royal Colleges and others (including patients and public), taking these into account in developing the contract and guidance, and publishing the answers to frequently asked questions.

4. The key outcome from these activities is that the views of Doctors, either directly or through their representative body and other organisations, and of the wider public, and the views of an independent pay review body, have informed the final contract, mainly through negotiations with the BMA.