Local equality analysis for the introduction of the junior doctors’ contract

Description of decision:

The Introduction of the national junior doctors’ contract.

Owners of the policy:

Royal Free London NHS Foundation Trust

Annexes:

- Annex A: National Equalities Analysis and Equalities Statement
  Dept of Health May 2016
- Annex B: National terms and conditions
- Annex C: 2016 EDS2 Grading and Equality Objective Report
- Annex D: Recent CQC reports
- Annex E: GMC Survey results 2016
- Annex F: NHS Improvement implementation timeline
- Annex G: Trust Demographics Tables
  - Will need copy from Yemisi as in process of harmonisation
- Annex I: Equality and Diversity Report 2014 / 2015 published January 2016 and includes the
  Equality and Diversity Inclusion Action Plan.
- Annex J: Local Equality Analysis Comparison Grid

What are the main aims, purpose and outcomes of the functions, strategy, project or policy and how does it fit in with the wider aims of the organisation?

1. To introduce the nationally junior doctors’ contract at Royal Free London NHS Foundation Trust.

2. Nationally, the aims of the contract 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 seven-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.

3. Specific local aims in introducing the 2016 contract are:

The main aim is the “elimination of any discrimination” as a consequence of the introduction of the new contract for doctors in training, via the present process of supervision and subsequent escalation.

How does the Trust look to achieve this?

The Trust Equality and Diversity Policy has the following statement of intent:

“The Royal Free Hampstead NHS Trust is committed to equal opportunities. It is the policy of the Trust to ensure that no service user, visitor, former, present or future employee or job applicant receives less favourable treatment on the grounds of their (actual or perceived) race, sex, disability, sexual orientation, religion or belief, marital status, age, creed, colour, nationality, national or ethnic origin or on the grounds of their association with someone belonging to or perceived as belonging to one of these groups, nor is disadvantaged by any provision, criterion or practice which cannot be shown to be justified”.

In addition the Trust mission statements, especially “B” and “D” are of crucial importance.
a. Excellent outcomes in clinical services, research and teaching

b. **Excellent experience for our patients and staff**

c. Excellent financial performance

d. **Continual development of a strong and highly capable organization**

In addition to the overall organisational objectives, the trust is committed to working with staff and patients to grade the trust performance against 18 separate domains within four Equality and Diversity goals which are:

1. – Better health outcomes  
2. – Improved patient access and experience  
3. – A representative and supported workforce  
4. – Inclusive leadership

See Annex J 2016 EDS2 Grading and Equality Objective Report for greater detail for the above.

4. The new contract will apply to all 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. The new contract sets out their terms of employment.

The Trust will need to identify where it is already taking action to eliminate discrimination but also where it needs to take further action to support this purpose.

For example:

Giving junior doctor’s the opportunity to complete the e-learning equality and diversity MaST module to help them gain a better of understanding of relevant equality legislation and its implications in the workplace.

The Trust could include a presentation at both Trust and local inductions and give time to the relevant Staff Network Groups such as those supporting:

a. LGBT staff forum  
b. BME Staff forum  
c. Staff with disabilities forum
Discussion of how to eliminate discrimination needs to be raised at the relevant forums for clinical staff such as:

a. New contract Local Implementation Group  
b. Junior Doctor Executive Forum  
c. Local Negotiating Committee  
d. Divisional Board Meetings  
e. Staff Experience Improvement Plan Group

5. The key stakeholders include:
   • the trust’s current and future junior doctors  
   • the trust’s other clinical and non-clinical staff  
   • patients

6. The new contract is planned to be introduced with effect from 3 August 2016, subject to a phased implementation from October 2016.

   The Trust Governance structure, via the Joint Patient and Staff Steering Committee will be responsible for overseeing that all possible actions are taken to ensure the elimination of discrimination, but ultimate responsibility will sit with the Trust Board.

   The Trust’s Equality and Diversity Action Plan January 2016 (see Annex I) provides significant detail on how the Trust will continue to address and improve its actions in this area.

   Information on all aspects of the Trust’s Equality and Diversity work can be located at both the Trusts’ intranet and external facing webpage:

   Link to Trust Intranet “Equality and Diversity Home Page” for staff

Link to Trust external facing FreeNet Equality and Diversity web page for members of the public:

http://freenet/freenetcms/default.aspx?&s=42&p=1011&m=1306

The Post Graduate Medical Education Centre will hold all email addresses for training grade doctors and will be able to email a copy of the Equality and Diversity monthly newsletter and identify those named individuals who can be contacted to discuss any issues or problems.

7. The local implementation program will follow the nationally published timeline from NHS Improvement, see Annex F

The Director of Workforce and Organisation Development will have overall responsibility for the introduction of the new terms and conditions to the Trust. Operationally, the responsibility will sit with the Interim Assistant Director of Workforce and process will require significant input and support from both the post graduate medical education, medical workforce projects team and medical recruitment teams plus engagement with educational supervisors, clinical managers, and service managers in addition to junior doctor representatives.

As lead employer for HENCEL and HENWEL GP trainees this will also require input from host organisations that participate in the scheme. The GP Contract meetings will be the forum for overseeing the new junior doctor contract implementation for those in practices and host organisations, with separate meetings organised external to that as and when appropriate.

How will progress be measured?

8. What will be the local mechanism for measuring equality and diversity issues during and following the new contract implementation?

In addition to the standard measures of recording complaints and incidents on Datix for example, less traditional avenues such as contacts with the Trust Chaplaincy will also be considered.
With respect to the actual contract implementation itself, progress will be measured in terms of the numbers of trainees due to transfer that are transferred to 2016 TCS in line with the implementation program, as reported in the regular submissions to NHS Improvement via the UNIFY2 report (currently weekly) and through the Local Implementation Group and eventually via the Guardian of Safe Working Hours quarterly board report. For GP trainees, progress will be reported and measured in discussion with HEE due to the contractual relationship.

What data is available to help inform the impact assessment?
Check available data research, studies, reports, audits, surveys, feedback etc. concerning each equality target group (race, religion/belief, disability, gender, sexual orientation and age) for this particular function or policy and list them below for each area.

9. The Equality and Diversity Report 2014 / 2015 published January 2016 has detailed information regarding both our staff (including protected characteristics) and patient population (demographics, ethnicity, religion, health, deprivation etc)

Where, if any, are the gaps in the information required? What are the reasons for any lack of information? List them below in each area of race, religion/belief, disability, gender, sexual orientation and age.

10. Gaps in the relevant data are:

The following protected characteristics are not currently recorded on ESR.

- Gender reassignment
- Pregnancy (Maternity is recorded)

Is additional information required? If yes, what is needed and how will this be carried out?

11. What further information is required? None
Analysis of the introduction of the new contract

12. Impact analysis detailed in the table below.

The Employee Relations Team have been contacted and asked if they are able to report on any identified trends within Equality and Diversity complaints and grievances raised by doctors in training. It may be useful to see if they are able to identify doctors in training as a separate group and if not it should be recommended to do so in the future. This level of recording in detail should be extended to distinguish doctors working in the Trust from countries outside the UK.

Any data from the Employee Relations Team will be used to populate the table below which needs to reference tangible evidence.

<table>
<thead>
<tr>
<th>Does or could the policy or function have any influence on any of the equality strands in relation to:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>• promoting equality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• eliminating discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• achieving equality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
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<tr>
<td>Sexual orientation</td>
<td></td>
<td></td>
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<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender reassignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity and pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assess the likely impact on equality

13. Potential impacts analysis detailed in the table below

See Annex J – Local Equality Analysis Comparison Grid
Could the function/strategy/project/policy in the way it is planned/delivered have a negative impact on any of the equality target groups (i.e. it could disadvantage them) or could it have a positive impact on any of the groups, contribute to promoting equality, equal opportunities or improve relations?

<table>
<thead>
<tr>
<th>Group affected</th>
<th>Positive impact(s)</th>
<th>Negative impact(s)</th>
<th>Reason(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic groups</td>
<td>No likely Impact</td>
<td>No likely Impact</td>
<td>See Annex J</td>
</tr>
<tr>
<td>Faith groups</td>
<td>No likely Impact</td>
<td>No likely Impact</td>
<td>See Annex J</td>
</tr>
<tr>
<td>Disability groups</td>
<td>Likely positive Impact</td>
<td>Likely Negative Impact has been mitigated</td>
<td>See Annex J</td>
</tr>
<tr>
<td>Gender groups</td>
<td>Likely positive Impact</td>
<td>Likely Negative Impact has been mitigated</td>
<td>See Annex J</td>
</tr>
<tr>
<td>Sexual orientation groups</td>
<td>No likely Impact</td>
<td>No likely Impact</td>
<td>See Annex J</td>
</tr>
<tr>
<td>Age groups</td>
<td>No likely Impact</td>
<td>No likely Impact</td>
<td>See Annex J</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>No likely Impact</td>
<td>No likely Impact</td>
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</tr>
<tr>
<td>Maternity and pregnancy</td>
<td>Likely positive Impact</td>
<td>Likely Negative Impact has been mitigated</td>
<td>See Annex J</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>Likely positive Impact</td>
<td>Likely Negative Impact has been mitigated</td>
<td>See Annex J</td>
</tr>
</tbody>
</table>

Where you have indicated there is a negative impact on any group, is that impact:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lawful? i.e. it is not discriminatory under anti-discriminatory legislation

Intended?

14. Any negative impact listed above is taken from the National Equalities Statement and the mitigating actions it lists to address any possible discrimination.
15. Changes can be made to the function or policy, for example:

   a. Giving junior doctors the opportunity to attend unconscious bias training
   b. Including an equality and diversity presentation within both corporate and local inductions
   c. Increasing the detail and volume of data collection
   d. Commence specific “junior doctor listening sessions”

16. [TBC locally]

   Not Applicable.

17. [TBC locally]

   What previous or planned engagement (both locally and nationally) on this function/topic/policy/area/project has taken place/will take place with groups/individuals from equality target groups?

<table>
<thead>
<tr>
<th>Equality target groups</th>
<th>Summary of engagement carried out or planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race: black and minority ethnic communities</td>
<td>Proposal to invite junior doctors to Staff Network Groups via PGMEC distribution lists</td>
</tr>
<tr>
<td>Faith groups</td>
<td>Trust’s multi-faith chapels are available across the main sites, and accessible to junior doctors.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Disability</td>
<td>Proposal to invite junior doctors to Staff Network Groups via PGMEC distribution lists</td>
</tr>
<tr>
<td>Gender</td>
<td>The Trust is in the process of setting up a women’s network which junior doctors are welcomed to join.</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Proposal to invite junior doctors to Staff Network Groups via PGMEC distribution lists</td>
</tr>
<tr>
<td>Age</td>
<td>Currently no engagement project planned.</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>Junior doctors will be invited to the LGBT staff forum event planned for later in the year.</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>Trust’s maternity guidance will apply.</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>Currently no engagement project planned.</td>
</tr>
</tbody>
</table>

18. [TBC locally]

**Have you involved your staff (who have or will have direct experience of implementing the strategy/policy/working on the project) in taking forward this impact assessment? If yes, how?**

Yes

19. [TBC locally]
Make a decision on the policy

20. Policy decision risks detailed in the table below.

Potential Risks

<table>
<thead>
<tr>
<th>What is the potential risk on equality? (indicate one)</th>
<th>Potential Risks on equality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly likely to have an adverse effect on equality <strong>High risk</strong></td>
<td>May possibly have an adverse effect <strong>Moderate risk</strong></td>
</tr>
<tr>
<td>Highly likely to promote equality of opportunity and good relations <strong>High potential</strong></td>
<td>May have the potential to promote equality and good relations <strong>Moderate potential</strong></td>
</tr>
</tbody>
</table>

If the potential for risk and benefit occurred, how substantial would these be in terms of the number of people affected and the severity of the problem?

<table>
<thead>
<tr>
<th>If the potential for risk and benefit occurred, how substantial would these be in terms of the number of people affected and the severity of the problem?</th>
<th>What is the potential risk on equality? (indicate one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lots of people from different groups may be affected to some extent</td>
<td>Highly likely to have an adverse effect on equality <strong>High risk</strong></td>
</tr>
<tr>
<td>A few people may be adversely affected to some extent</td>
<td>Highly likely to promote equality of opportunity and good relations <strong>High potential</strong></td>
</tr>
<tr>
<td>A few people may be affected but the effect on them will be highly adverse</td>
<td>May possibly have an adverse effect <strong>Moderate risk</strong></td>
</tr>
<tr>
<td>A lot of people may be severely affected</td>
<td>May have the potential to promote equality and good relations <strong>Moderate potential</strong></td>
</tr>
<tr>
<td></td>
<td>Probably will not have adverse effect <strong>Low risk</strong></td>
</tr>
<tr>
<td></td>
<td>Probably will not promote equality or good relations <strong>Low potential</strong></td>
</tr>
</tbody>
</table>

21. [TBC locally]

- **What practical actions are required to reduce or remove any adverse/negative impact?**
- Raising junior doctor’s awareness of equality during their induction process.

22. [TBC locally]

- **Give details of how the results of the impact assessment will be published.**
- This analysis will be published on the trust’s intranet and publically in the annual report of the board.

- A copy of Local Impact Analysis will also be sent to Debbie Sanders who is the Chair of the Equality Steering Group.
24. Locally

Give details of the monitoring arrangement

This will be monitored against the trust’s EDS rating and also for impact on the current Measures of Trust performance:

- quality of clinics and treatments
- medical research
- teaching and training new medical staff
- patient satisfaction and experience
- value for money
Annex A – National Equalities Analysis and Equalities Statement
Dept of Health May 2016

Annex A – National Equalities Analysis and Equalities Statement
Dept of Health May 2016

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

a. Doctors may work anything between 40 and 52 hours, and all receive the same pay.
b. Doctors on call with no night shifts can be entitled to the same pay as Doctors on call with night shifts.
c. Doctors on call with no on-call duties can be entitled to the same pay as Doctors on day release with on-call duties.
d. In 70% banding payments are given where there is a breach of the normal
   35-hour week requirements, giving the ratio the group of doctors on
   the same working patterns in breach and 35% pay supplement to
   doctors working full time. The pay supplement applies for the duration
   of that rule, including retrospectively (meaning the payment would apply to
   each doctor with the end of the rule).

26. The Work and Health Committee’s report in 2010 on junior doctors’ salaries
    and, as long ago 2008, the BMA agreed that the current model
    should not be enforced. The new model includes the banding payment
    system with an agreement that works for over forty hours for doctors
    for the amount of work actually done. Average full-time earnings will remain
    the same but the money currently used for banding payments will be
    distributed differently. The most significant

a. Higher basic salary for a ‘base’ working week (most in tabular on red

b. proportionate payment for additional hours worked, up to a contractual
   maximum (100% to 37 hours for the doctor has opted out of the working
   time regulations (‘Base Wt’).

5. all hourly payments (including the frequency of the

6. duty payments paid as a result of being on-call (this is included in
   hours as above).

7. enhanced rates paid for work done during unsociable hours (‘unsociable’
   periods, including a ‘substitute’ ‘unsociable’ payments (‘USP’), and

8. Reveal pay premia.
Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

Version 1

6 July 2016
Annex D: Recent CQC reports

http://www.cqc.org.uk/sites/default/files/old_reports/RAL01_The_Royal_Free_Hospital_INS1-1171776311_Scheduled_27-03-2014.pdf

Please note that this is the most recent CQC report March 2014. The report from inspection in February 2016 is not yet available.

Annex E: 2016 GMC Survey Results

Click to enlarge
## Implementation timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016</td>
<td>Assessing guidelines on safe working hours</td>
</tr>
<tr>
<td>26 July 2016</td>
<td>Orientation of safe working hours conference, London</td>
</tr>
<tr>
<td>3 August 2016</td>
<td>Consultation</td>
</tr>
<tr>
<td>October 2016</td>
<td>Transition to the new terms and conditions of service (TCS) for:</td>
</tr>
<tr>
<td></td>
<td>- Clinicians E and above</td>
</tr>
<tr>
<td>November - December 2016</td>
<td>Transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>- 31 doctors taking up new appointments</td>
</tr>
<tr>
<td></td>
<td>- 31 doctors taking up new appointment and sharing cases with FY1 doctors</td>
</tr>
<tr>
<td>February - April 2017</td>
<td>Transition to the new TCS for:</td>
</tr>
<tr>
<td></td>
<td>- Psychiatry trainees taking up new appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- Paediatric trainees taking up new appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- Surgical trainees taking up new appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>- FY1 doctors and FY1 trainees ISTIC1 taking current appointments and</td>
</tr>
<tr>
<td></td>
<td>sharing cases with any of the above</td>
</tr>
<tr>
<td>August - October 2017</td>
<td>All remaining trainees taking up new appointments (all grades)</td>
</tr>
<tr>
<td></td>
<td>All new doctors (all grades)</td>
</tr>
</tbody>
</table>

### Notes:

1. The above dates are for trainee doctors employed on long-term contracts, in lead employer arrangements, and for those with junior lead arrangements or a single placement contract in August 2016, or those whose contracts have a matrix allowing them to be entered in the TCS in this way, when trainees will remain on the 2013 TCS until they finish training and/or their current contracts expire.
2. There will be some parts of the country whereension dates do not coincide precisely with the above timetable. In such cases, trainees will move to the new terms at the rotation date following their placement in the TCS, and by October 2017 at the latest.
Annex H:

Royal Free London NHS Foundation Trust: Trust Equality Policy

I have attached links to both the Royal Free and BCF as these are in the process of being harmonized.

BCF Policy:

..\Guidance\Equality and Diversity Policy - BCF.pdf

RFH Policy:

..\Guidance\Equality and Diversity Policy - Royal Free.pdf


Annex J: Local Equality Analysis Comparison Grid

PSED - GRID.xlsx