BMA Cymru Wales

NHS Wales Employers
Cyflogwyr GIG Cymru

Framework agreement for reform to the terms and conditions of service for resident doctors and dentists in Wales

August 2025

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Foreword

This framework describes an agreement reached between representatives of NHS Wales Employers and the British Medical Association's Welsh resident doctor committee on reform to the terms and conditions of service for doctors and dentists in training in Wales.

This package of reform is judged by both parties to fulfil the mandate provided by the Cabinet Secretary for Health and Social Services for a costed, mutually agreed proposal that addresses the areas detailed in the ministerial mandate.

This agreement summarises the outcome of discussions held through social partnership and through negotiation. It sets out an agreement for contract reform from 2026/27, alongside preparatory work prior to these dates and review stages following implementation.

It sets out changes to the pay scale and terms and conditions of service for resident doctors and dentists in training (henceforth referred to as 'residents'') that employers, the British Medical Association (BMA) Cymru Wales, and the Welsh Government are agreeing to implement over the period of the agreement and going forward. It also sets out a series of other agreements to provisions and policies relevant to residents that lie outside of their terms and conditions of service.

The framework is adopted following the confirmation of relevant funding received from the Cabinet Secretary for Health and Social Services. The investment supports reforms to pay scales and terms and conditions of service over the course of the three-year implementation period.

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Definitions

Resident	Resident doctor or dentist who is undertaking a formal training programme
Flexible (Part time)	A resident employed on a part time/less than full time basis
Additional Hours	Work undertaken within the resident's personalised job plan beyond 40 hours and up to an average 48 hours per week
Overtime	Work undertaken that is not detailed within the resident's personalised job plan and is not additional, elective shifts (i.e. locum/extra contractual work)
Locum/extra contractual	Work undertaken by volition that is outside of the core contract of employment e.g. medical bank
Resident job plan	A work schedule containing clinical, training, academic and any other workplace commitments, as detailed in the TCS
F1 and F2	Residents at Foundation levels
Registrar	Residents who hold a Foundation Programme Certificate of Completion or equivalent
Enhanced progression	Pay progression subject to criteria being evidenced as detailed in the TCS
Standard progression	Progression based on annual incremental date
Locally employed doctor	A doctor employed directly by a health board or trust who is working on a resident doctor rota.

1 Introduction

1.1 Basis of agreement

Welsh Government, NHS Wales Employers and BMA Welsh resident doctors committee agreed to enter contract negotiations in 2024, building on the basis of previous negotiations conducted between 2020 and 2022. These talks commenced in early 2025 based on a mandate provided by the Cabinet Secretary for Health and Social Care.

The agreed aims of the negotiations were:

- To improve the recruitment, retention, motivation, and engagement of resident doctors and dentists in order to make Wales the preferred destination for medical and dental training.
- To ensure high-quality care by enabling employers and staff to meet shared responsibilities to patients, while maintaining competitiveness with other UK and international training programmes.
- To develop an equitable and progressive pay structure aligned with skills, experience, and Welsh Government longer term commitments to pay restoration.
- To provide clear entitlements to protected study time, modernise terms and conditions to support well-being and patient safety, and ensure affordability and return on investment in line with *A Healthier Wales* and the Workforce Strategy.

The initial phase of talks considered the current contractual landscape in the UK, the availability of necessary information for further contract reform discussions, and lessons learned from past contract reform processes. From here, detailed discussion was held on all areas of the terms and conditions, with particular focus on the working week, balancing training and clinical duties, the pay structure and pay system.

With a deal now agreed, the intention is to put this to a referendum of BMA resident doctor members in Wales. Members will be asked to consider whether they accept the new contract. If members vote to accept the new contract it will come into force in August 2026. The existing contract will be closed to new entrants employed on or after 1 August 2026 and existing employees will be transferred to the new terms and conditions at appropriate stages in training and in accordance with a transition and implementation timetable, an outline of which is set out in section 9. It is anticipated that there will be specific circumstances whereby some residents who expect to complete their training soon or have extenuating circumstances may not have to transfer to the new contract. Likewise, depending on the stage of training, a pragmatic approach will also be adopted with regards to residents who defer their training during the transitional phase.

If BMA members accept the new contract, and the Cabinet Secretary for Health and Social Services subsequently approves its introduction, the implementation process will begin. This will be staged to ensure the continuity and smooth running of the health service and the best experience for residents upon transfer. More information is provided in the relevant section of this document.

1.2 Scope and status

This framework document represents the outcomes of negotiations and a summary of the new terms and conditions of service ("the new contract"). NHS Wales Employers has agreed these changes on behalf of HEIW, health boards and trusts in Wales. BMA Welsh resident doctors committee will now consult their membership on the proposals.

This agreement covers both resident doctors and dentists. For ease, this document uses the term "resident" to refer all in scope.

It is recognised that the 2002 TCS are widely mirrored in other employment contexts; the reforms set out in this framework agreement will be extended to those affected. For example:

- Academic trainees who hold a National Training Number/Deanery Number and are substantively employed by universities.
- Public health registrars.
- Locally employed doctors who work on rotas alongside resident doctors.

Both parties are committed to partnership working to ensure the new contract supports the delivery of strategic health objectives in Wales through the recruitment and retention of residents.

This agreement covers all NHS employers in Wales that employ or host residents and equivalent local roles as appropriate. It will be adopted subject to the confirmation of relevant funding received from the Cabinet Secretary for Health and Social Services and the approval of all negotiating parties.

This agreement does not summarise every detail of the new TCS, which will be issued separately if the contract deal is agreed. The final TCS will need to undergo a legal review by the relevant parties.

Guidance will be issued as required to express and clarify the shared intention behind contractual provisions and the intended use and implementation of the new contract.

Welsh Ministers have an equality duty under s.149 of the Equality Act 2010 to consider the impact of any changes in relation to the protected characteristics. The parties have developed this agreement and have been guided by a working Equality Impact Assessment throughout. However, a comprehensive equalities impact assessment on the new contract will be undertaken during the implementation stage and prior to implementation.

1.3 Investment

If BMA Cymru Wales and NHS Wales Employers agree the new contract via their respective consultative processes, the Cabinet Secretary for Health and Social Services will make available funding to invest in the cost of the proposed reforms. This equates to an investment of up to 4% of the value of the current resident doctor workforce costs as of 2025/26.

The contractual reforms contained in this agreement have been robustly costed as best possible using available data. Funding provided by Welsh Government for the cost of the proposed reform will be based on the modelled costs. This includes an agreed proportion for implementation and transition. Should any further costs arising from the implementation of the

contract be experienced by employers, these will be outside of the envelope provided and managed by employers.

As investment provided for transitional arrangements (for example, transitional pay protection) tapers off, it is agreed that this will be reviewed in partnership and any funding unlocked by the tapering off of these arrangements will be considered for further investment in the new contract.

1.4 Areas for further development and agreement

The contract reform proposed in this document is very wide-ranging and will require support of a range of non-contractual changes to working practices, partnership arrangements and resourcing. It is recognised that it was not feasible to discuss all changes required for full implementation of the new contract in the context of negotiation.

Therefore, all parties have committed to a programme of work, some as part of implementation plans, to take forward to priorities established in the new contract and ensure they are put into practice as best as possible. The following areas for further development. for implementation and future work are agreed by all parties:

- The *Code of Practice: Provision of Information for Postgraduate Medical Training* will be reviewed in partnership and an equivalent document agreed for Wales to reflect its new contractual status.
- A single lead employer (SLE) implementation working group will examine the relationship between contract implementation and the SLE arrangements for residents in Wales to ensure clear, mutually agreed division of contractual responsibilities between the lead and host employers.
- A Digital Systems Working Group will be established to support the practical implementation of the new contract. This group will collaborate closely with workforce teams, the SLE, and payroll departments to ensure digital systems and processes are aligned with the new requirements.
- Work in partnership will take place to identify ways in which production and provision of rotas/schedules/job plans can be streamlined to avoid delays.
- Work in partnership will continue to develop mechanisms for locally employed doctors to achieve greater security of employment as detailed later in this document.
- Work in partnership will continue to review, identify and address causes for and impact of “bottlenecks “in training as detailed later in this document.
- Work in partnership will be undertaken to agree appropriate rates for or a methodology for setting extra contractual work undertaken by residents in NHS Wales organisations. If the contract deal is approved by all parties for implementation, BMA Cymru Wales will cease to promote the BMA 2002 TCS rate card unless a dispute arises in the future or partnership talks to agree rates fail.
- Work in partnership will be undertaken to develop appropriate policy/guidance to support effective resident job planning.
- Work in partnership will be undertaken to develop criteria for identification of “mandatory” courses and to establish a process for automatic approval of attendance or participation of these courses as part of an overarching study leave improvement workstream as detailed later in this document.

This programme of activity is not exhaustive, and all parties will agree additional elements through the implementation period.

2 A new contract for Wales

2.1 The 2002 contract

The *National Health Service Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service (England and Wales) Terms and Conditions of Service*, also known in its application to doctors and dentists in training as the "2002 contract" or "New deal contract", was introduced over twenty years ago.

In the earlier discussions on contract reform in 2020–22, it was agreed that the contract was no longer functioning as intended and had lost the confidence of both doctors and employers. Rota monitoring exercise response rates were low, reflecting a lack of faith in the system, and it was agreed that the TCS required modernisation. All parties have maintained this view in the intervening years.

In initial discussions in 2025, an overarching principle of simplification of TCS was agreed, with all parties acknowledging the need to test proposals to ensure they could be implemented at a practical level.

2.2 Social partnership

The new contract has been developed in social partnership. Time has been taken to consider and learn from the previous negotiations and framework. Through building an understanding of each other's perspectives, establishing shared priorities and working on joint solutions, the parties have ensured that the new contract has the confidence of all parties, and all elements are mutually supported and considered sustainable, suitable and implementable.

3 Pay structure

3.1 Aims of the new pay structure

The aims of the pay structure are to:

- Create a simple to understand pay system.
- Move to an hours-based model of pay, where each hour of work has a clearly defined value and residents are more accurately and fairly remunerated for their work.
- Reduce the number of pay points and frontload pay within the reduced points to reduce the gender pay gap, support early career earnings and improve pension outlook.
- Redistribute some out of hours (OOH) pay, currently contained within banding supplements, into basic pay to reduce variations in pay across rotations and improve pension outlook.
- Ensure established flexible training pathways are supported and appropriately remunerated.
- Ensure the pay system does not discriminate against protected groups.

3.2 Pay scale

The pay scale for the new contract is made up of seven pay points. The pay point determines the basic pay level for a nominal 40-hour working week.

Pay Point	Year	2002 TCS		New contract	
		Spine	Value	Spine	Value
F1	1	Min	£35,390	1	£40,000
	2	1	£37,487		
	3	2	£39,587		
F2	1	Min	£43,466	1	£50,000
	2	1	£46,192		
	3	2	£48,915		
Registrar (post-foundation)	1	Min	£46,324	1	£55,000
	2	1	£49,046		
	3	2	£52,853	2	£62,000
	4	3	£55,157		
	5	4	£57,929	3	£68,000
	6	5	£60,706		
	7	6	£63,482	4	£74,000
	8	7	£66,259		
	9	8	£69,034	5	£78,000
	10	9	£71,814		

The value of pay for residents working flexibly (part-time) will be pro rata to the levels set out above and in the Medical and Dental Pay Circular according to the hours set out in their job plan.

The annual basic pay values included in this Framework Agreement have been set in respect of the 2025/26 pay scales. The pay scales published in this agreement will be considered in the usual manner by the Welsh Government for an uplift alongside all other medical pay scales following the publication of recommendations by the Review Body on Doctors' and Dentists' Renumeration (DDRB) in the 2026/27 pay year (i.e. prior to implementation) and in subsequent years.

The new pay structure frontloads pay earlier in the pay scale than the 2002 TCS pay scale. This means that all residents receive a higher level of basic pay than before, with more of it earlier in their career. It also means that pay progresses in larger, less frequent amounts after F2. It also redistributes the balance of pay further into basic pay, which enhances contributions to the NHS pension scheme and reduces the significant fluctuations in pay observed in banding. It increases the level of earnings that may be routinely considered by lenders, e.g. for mortgages. We expect the new pay scale to reduce the gender pay gap.

3.3 Pay progression

The new pay progression system has a single pay point each for Foundation 1 and Foundation 2. Pay progression for residents in foundation training will be based on the development of competency denoted by the progression from F1 to F2.

There is then a scale for registrar level (i.e. those who hold a FPCC or equivalent) with standard progression every two calendar years on the resident's incremental date.

Pay progression between spinal points 2 and 3 of the registrar scale will be known as 'enhanced pay progression'. It will require a resident to have 4 years total equivalent experience following completion of their Foundation Programme, of which 2 years must be in a formal training programme (including dental core training) or equivalent.

Residents in the career grades who return to training will have all years of equivalent experience post foundation counted for the purposes of the above calculation.

Pay Point	Year	New Pay Structure	
		Spine	Value
F1		1	£40,000
F2		1	£50,000
Registrar	1	1	£55,000
	2		
	3	2	£62,000
	4		
	5	3	£68,000
	6		
	7	4	£74,000
	8		
	9	5	£78,000
	10		

Residents with experience gained in local employment or from work abroad will be able to access enhanced progression based on being able to evidence the following criteria:

- Competencies completed as per equivalent training year and specialty requirement (this may be evidenced by an appropriate certificate of readiness)
- Regular meetings with an Educational Supervisor or equivalent
- Demonstrate their contributions to a wider role, for example, meaningful participation in or contribution to relevant:
    - Management or leadership
    - Service development and modernisation
    - Teaching and training (of others)
    - Committee work
    - Representative work
    - Innovation
    - Audit
- Continual Professional Development (including courses, training sessions and presentations)
- Evidence presented as would be expected from ARCP or appraisal process.

Where a resident is able to evidence the criteria described above, each year of service as a locally employed doctor (LED) or doctor abroad will be regarded as equivalent to a year in a training programme for the purposes of calculations towards enhanced pay progression. If the doctor is unable to provide this evidence, or where the equivalent experience took the form of locum work, then each calendar year in service will be counted as equivalent to half a year in a formal training programme for these purposes.

Residents who have undertaken an out of programme experience (OOP) or an academic qualification relevant to their training programme will have each year of these counted as equivalent to a training programme year for the above purposes.

4 Elements of pay

4.1 Principles

The principle of the new pay system is that residents will be paid for the actual hours that they work. Instead of the 2002 contract's banding system, the new contract pays for individual hours of work that are contained in the resident's individual job plan, as well as overtime hours that are reported through the rostering system. There are enhanced rates for work undertaken outside of core hours/in unsocial hours.

Where a resident works for fractions of an hour, pay will be for each quarter hour, rounded to the nearest quarter hour.

4.2 Basic pay

Basic pay is awarded at the relevant point value for an average 40-hours of work per week. For flexible (part-time) residents, this is paid pro-rata for the proportion of full-time work that has been agreed.

4.3 Additional hours contained in the job plan

Additional hours of work that are contained in the resident's job plan (i.e. rostered hours) will be paid at 1/40th of full-time basic pay, i.e. at an hourly rate, up to a safe working maximum of an average 48 hours per week.

4.4 Overtime

In some circumstances, additional work may be undertaken that is not detailed in the job plan. This may include, but is not limited to:

- Staying beyond a scheduled shift end time due to service demands.
- Performing work (either remotely or on-site) during a non-resident on-call duty period.
- Undertaking work outside of scheduled hours to participate in a training opportunity required for progression within the training programme.

In these circumstances, the resident must report the additional hours worked outside of the job plan via the rostering system. They will receive payment at the appropriate hourly rate for the time and day the work was performed. All additional work undertaken outside the job plan must

be recorded within the same roster period in which it occurred. This replaces the current rota monitoring system that determines bandings on the 2002 contract.

Authorisation for additional pay will be in accordance with the organisation's pay and financial controls processes. Approved additional hours or overtime will be paid in the next payroll cycle following submission, subject to the organisation's standard payroll deadlines. It is expected that all submissions for additional pay/overtime are accurate and genuine and as such no separate clinical supervisor sign-off will be required. Where the payroll team identifies concerns regarding the validity of a roster, these concerns must be referred to the person authorising the roster and, where necessary, Guardian of Safe and Flexible Working for review/investigation.

The guardian will be expected to monitor overall patterns of reporting of additional hours of work (additional hours and/or overtime) in order to ensure resident job plans are accurate, reflective of service demands, and maintain safe design limits.

4.5 Core and unsocial hours

Core hours will be between 07:00 and 19:00, Monday to Friday, as is the case on the 2002 contract.

An enhancement of 50 per cent of the hourly basic rate will be paid on any hours worked between 19:00 and 07:00 Monday to Friday, and any hours worked on a Saturday, Sunday or Bank Holiday. This forms a supplement additional to the basic pay and additional hours detailed in 4.2 and 4.3.

4.6 On-call availability and work

Where a resident is required by their employer to be available to return to work or provide telephone advice for a duty period but are not expected to be on site for the whole period, they will be paid an availability rate of 50 per cent of their basic hourly rate for the hours they are available.

Residents will be paid for any actual hours worked while on-call – either on site or remotely – at the appropriate rate for the hours worked. Payment for these hours will be made retrospectively via the rostering system, in accordance with the on-call payment process. For pay purposes, the on-call availability allowance will count towards the pay for actual hours worked for each hour or part thereof applicable, i.e. payment for actual work performed will form a 'top up' of the hourly availability rate, or any part thereof, up to the relevant rate.

Where a resident is required to work for 75% or more of the on-call duty period, they shall be paid for the total on-call duty period at the full appropriate hourly rate and not the 50% availability rate.

4.7 Pay premia

In addition to the other pay elements, a new category of pay premia will be introduced in order to pay residents working in specific training pathways which are deemed in particular need of recognition.

4.7.1 General practice

A pay premium shall be paid to residents employed on general practice training programmes. The premium will be paid at a rate of 30% of point 1 of the registrar scale, as defined in the pay circular. It will be paid pro-rata for residents who work flexibly (part time). The purpose of this premium is to appropriately compensate work performed in general practice; it is not a recruitment premium, nor specific targeting of a hard-to-fill specialty.

The premium will only be paid to GP registrars when they are working in a general practice placement. It is not payable when the resident is working in a hospital or any other setting. It will not be payable to residents on a different training programme when they are working in a general practice placement (for example, on a foundation training programme).

4.7.2 Oral and maxillo-facial surgery (OMFS)

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

The premium will be paid at a rate of 8.6% of point 1 of the registrar scale, as defined in the pay circular. It will be paid pro-rata for residents who work flexibly (part time). The purpose of this is to compensate for the longer length of training and the impact of this on pay progression; it is not a recruitment premium, nor specific targeting of a hard-to-fill specialty.

4.7.3 Resident Recruitment and Retention Premia (RRP)

In order to ensure effective application of equal pay for equal value principles, employers will be required to submit applications for any temporary recruitment and retention premia. These applications and, where approved, review and withdrawal or extension of the premium will be overseen by Medical and Dental Business Group (MDBG).

5 Safe working hours

5.1 Limits on working hours

The new contract will introduce comprehensive and wide-ranging limits on working hours, designed to ensure that the rotas are safe for both patient and resident, sustainable and provide a higher quality of work–life balance than the old contract does. Employers must abide by these working limits as well as by the statutory working time regulations. Residents will have a professional responsibility to ensure that their total hours of work comply with these limits.

The limits will be as follows:

- No more than 48-hours worked in an average week, taken over a 26-week reference period or the rota length if this is shorter.
- No more than 72 hours' actual work in any 168-hour period.
- No shifts longer than 13 hours.
- No more than 4 consecutive long shifts (longer than 10 hours).
- 48 hours' rest after 4 consecutive long shifts (longer than 10 hours).
- No more than 7 consecutive shifts of any length.

- 48 hours' rest after 7 consecutive shifts of any length.
- All reasonable steps must be taken to avoid a weekend frequency higher than 1 in 3, with an absolute limit of 1 in 2.

5.2 Breaks

For shifts rostered to last more than 5 hours, a 30-minute break must be provided. For shifts longer than 9 hours, another 30-minute break must be provided. For night shifts (i.e. where part of the shift takes place between midnight and 7am inclusive) longer than 12 hours, a third 30-minute break must be provided. These breaks should be taken separately and spaced evenly. If they are combined, the break should take place towards the middle of the shift wherever possible. Breaks are counted as working time for pay purposes.

5.3 On-call periods

On-call duty periods, where a resident is expected to be available to attend at their workplace or provide telephone advice, may last no longer than 24 hours (and can be extended by between 15 minutes and 1 hour for handover). These duty periods cannot be worked consecutively except at weekends, when 2 are permitted, or more by local agreement subject to scrutiny and approval by the Guardian of Safe and Flexible Working. No more than 3 on-call duty periods can be rostered in 7 consecutive days. Residents are entitled to 8 hours' rest, and 5 continuous hours' rest, in a 24-hour period whilst on-call. The day following an on-call duty period cannot be rostered for more than 10 hours' work, or 5 hours' work if the rest entitlements during the preceding on-call duty period could not be met.

Where overnight rest is significantly impeded by work during an on-call duty period, arrangements must be made immediately for adequate rest and time off in lieu taken within 24 hours. Where rest has been significantly disrupted, the default assumption is that the resident maybe unsafe to undertake work due to tiredness and they must inform the employer that they will not be attending work as rostered, other than ensuring a safe handover of patients. No detriment in pay will be experienced by the resident.

Where an on-call duty period is defined as 'low intensity', typically being an expectation of less than 3 hours' actual work during the NROC period, a limit of 7 consecutive duty periods will apply. Subject to local agreement and oversight as above, this may be extended to 12 consecutive duty periods.

5.4 Facilities when too tired to drive home

Where a resident has worked a long shift or night shift, or has been rostered on-call and has been required to attend at their place of work, and subsequently judges that they are too tired to safely drive home, the host employer must provide them with an appropriate rest facility or, where this is not possible, cover reasonable expenses for their safe journey home by other means, as well as return to work for their next shift or to collect their vehicle. This will be managed via existing expensing arrangements.

5.5 Leave

Annual leave entitlement will be at 28 days upon first employment in the Welsh NHS, rising to 33 days after 5 years of employment. These entitlement values include the additional day of

annual leave granted by the Minister for Health and Social Services in December 2021 and previous statutory days. All annual leave entitlements will be calculated and recorded on an hours-based system within the Electronic Staff Record (ESR).

Residents may take one day of annual leave against a shift of any length provided the shift takes place wholly on one day and no part of the shift attracts an enhanced hourly rate of pay. Other shifts must be swapped according to existing arrangements. Whilst it is the resident's responsibility to arrange swaps, the employer must facilitate this.

Employers must allow leave to be taken when requested for a life-changing event, provided sufficient notice is given.

No other significant changes are made in the new contract, compared to the old contract, with regards to other types of leave except that, as part of the introduction of the common schedules of the *NHS Terms and Conditions of Service Handbook*, residents will have access to shared parental leave policies and child bereavement leave under sections 15 and 23 of the *Handbook*.

6 The working week

6.1 Principles of Resident Job Planning

Job planning will be introduced for residents to provide a clear picture of clinical duties and scheduled training and to allow employers to appropriately plan and deliver clinical services alongside training commitments.

These resident job plans will reflect the contractual safe working hours. They will detail all clinical commitments for which the individual resident is contracted alongside required training and other commitments agreed with their educational supervisor and the host employer (for example, rota coordination). They will indicate safe staffing levels for the medical team the placement is in and define educational development time (EDT) entitlements.

The clinical commitments of job plans should be based upon well designed rotas that are, where possible, co-produced with residents and adhere to appropriate Welsh guidance that will be developed in social partnership.

Resident job plans will typically apply for the length of the placement and should be discussed at a minimum at the start and finish of the placement. The resident job plan will also form the basis of discussions between the resident and their educational supervisor on their progress against training objectives.

Employers will be responsible for ensuring that a system is in place to allow residents to request annual leave prior to the commencement of a placement, to allow this to be factored into the resident job plan.

6.2 Provision of resident job plan

The new contract stipulates minimum periods prior to the commencement of a placement by which the resident must receive each piece of resident job plan documentation in line with the *Code of Practice: Provision of Information for Postgraduate Medical Training* (All-Wales version will be published during implementation).

These are summarised as follows:

Resident Job plan element	Deadline for providing to resident
Generic Resident Job Plan	8 weeks prior to commencement of placement
Duty roster (confirming rota slot)	6 weeks prior to commencement of placement
Personalised Resident Job Plan	Before or within 4 weeks of commencement of placement

Where a resident job plan or rota has not been provided within the contractual time limit, or access has not been provided to the additional work reporting system or exception reporting system within the contractual time limit, a financial penalty will be incurred as detailed below. Prior to implementation of the new contract, the parties will work together to improve processes to mitigate the likelihood of delays resulting in missed deadlines.

6.3 Generic resident job plan

The generic resident job plan will provide the resident with an understanding of the range of work, duties and training commitments involved in a placement prior to its commencement. It details broad intended educational outcomes, work duties, other workplace activities and the number and distribution of hours for which the resident is contracted. It will detail entitlements to EDT, minimum staffing levels within the team, and will be subject to regular reviews by the relevant training programme director (TPD).

The generic resident job plan must include time for local workplace inductions. Where a resident is beginning work in an unfamiliar setting, the induction must be included in the generic resident job plan prior to the commencement of clinical duties, which will not be undertaken until it is completed. Inductions must be delivered in line with the NHS Wales Fatigue and Facilities Charter.

6.4 Personalised resident job plan

The generic resident job plan should form the basis of the personalised job plan, which will be agreed between the resident and their educational supervisor. They will personalise the job plan according to the learning needs of the resident and the opportunities available in the post. It may also include other professional duties that are agreed with the educational supervisor, which may include, for example, rota coordination duties or participation in the resident doctor forum (RDF).

This conversation will be the opportunity for the resident to raise caring responsibilities that should be factored into the resident job plan where possible.

6.5 Part time resident job planning

Residents who train flexibly (part time) will have bespoke resident job plans which reflect their agreed training percentage and ensure they are working the correct pro-rata hours. The process of agreeing this job plan should begin as soon as possible after the resident has been notified of their placement.

6.6 Clinical academic resident job planning

Residents on an integrated academic training pathway will have their academic commitments reflected in their personalised resident job plan in accordance with Follett principles. Where employment arrangements place the resident under the new terms and conditions, the resident, academic employer and clinical employer will agree a job plan for the placement prior to its commencement to accurately reflect the resident's various commitments.

6.7 GP registrar resident job planning

GP registrars will receive job plans just like hospital-based residents. Their job plan must reflect COGPED guidance on the split of sessions for GP residents for their basic 40-hour working week. Additional hours of work above 40 must be linked to the curriculum and be agreed in the resident job plan.

7 Maintaining high training and working conditions

7.1 Guardian of Safe and Flexible Working

The contract contains a number of safeguards to ensure safe working conditions that mitigate against staff fatigue. The Guardian of Safe and Flexible Working (hereafter referred to as the Guardian), a new role introduced enshrined in the new contract, will provide assurance to the host employer and the lead employer that safe working hours are being complied to.

They will also promote and improve support for flexible (part time) and other models of flexible working/training. Recognising that increasing numbers of residents are electing to undertake their training on flexible basis, the role is intended to champion flexible training pathways and support residents and employers by providing guidance and being a point of contact on such issues.

The Guardian is a senior appointment that all health boards will be required to make. However, health boards with a smaller number of residents may appoint a single Guardian to work collaboratively across multiple employers. The lead employer will appoint a 'Lead Guardian' to provide strategic oversight on its behalf and ensure compliance with the safeguards within host organisations.

The Guardian will work with RDFs that will be set up in all host employers where they do not already exist. RDFs will function to represent the views of residents and to scrutinise the Guardian.

The Guardian is a new and vital role within NHS Wales, designed to support and advocate for trainees. To ensure the successful development, embedding, and long-term impact of this role, it is essential that the Guardian is properly funded and fully supported within organisations. This also includes the provision of dedicated administrative support to enable the Guardian to function effectively and deliver meaningful improvements in training experience and working conditions. It has been agreed that funding provision will be ringfenced as part of an Implementation and Transition fund.

The Guardian will:

- act as the champion of safe working hours and flexible training for residents.
- provide assurance to residents and employers that residents are safely rostered and enabled to work hours that are safe and in compliance with the TCS.
- receive copies of all exception reports in respect of safe working hours. This will allow the guardian to record and monitor compliance with the terms and conditions of service.
- escalate issues in relation to working hours that are raised in the review of additional hours reports to the relevant executive director, or equivalent, for decision and action, where persistent additional working beyond resident job plans has not been addressed at a departmental level.
- require intervention to mitigate any identified risk to resident or patient safety in a timescale commensurate with the severity of the risk.
- require a resident job plan review to be undertaken, where there are regular or persistent breaches in safe working hours, which have not been addressed.
- have the authority to intervene in any instance where the guardian considers the safety of patients and/or staff is compromised, or that issues are not being resolved satisfactorily; and
- distribute monies received as a consequence of financial penalties to improve the training and service experience of residents.

The Guardian will report twice a year to the organisation's board, which will include information on all rota gaps on all shifts. A consolidated annual report on rota gaps and the plan for improvement will be included in the organisation's quality account. These reports will also be shared with the local negotiating committee (LNC).

Where the Guardian has escalated a serious issue which remains unresolved, they will submit an exceptional report at the next meeting of the board. Where the Guardian identifies an issue with specific posts that cannot be solved locally, they will inform the board, who will raise the system-wide issue as appropriate.

7.2 Appointing a guardian

Organisations will be provided with guidance on the appointment and support of the Guardian role. Funding will be provided as part of contract reform for a minimum sessional requirement dependent upon the size of the organisation. This will be reviewed as the role is introduced to ensure that Guardians are properly resourced.

7.3 What is exception reporting?

The new contract will introduce a new system for reporting instances when the personalised job plan is not reflected in the actual working conditions, training entitlements, or safe working limits of the residents. This system is called 'exception reporting' – in other words, when an exception from your agreed pattern of work takes place, it must be reported. This system is not used to report overtime, except when it causes the resident to breach safe working limits.

Exception reporting ensures that residents are working within safe limits and experiencing a high-quality training and working environment. Where an exception report shows this has not occurred, it enables employers to take steps to address the issue and ensure a breach does not happen again. As a source of information on resident working patterns, it will enable employers

to make informed decisions about staffing in order to support clinical services and training opportunities.

Residents will be able to exception report a range of events including, but not limited to:

- Staffing levels below those defined in the job plan for a given shift.
- Being redeployed at short notice to another working area (e.g. a different ward)
- Being unable to attend or undertake scheduled training due to service demand.
- Performing additional work that causes the resident to breach their safe working hours limits as defined in schedule 3.
- Concerns regarding workload in non-resident on-call duty periods
- Being required to act in a different role to their normal one (e.g. acting up or acting down)
- Being unable to undertake professional activities that the resident is required to fulfil by their employer (e-portfolio, induction, e-learning, Quality Improvement and Quality Assurance projects, audits, mandatory training / courses) due to service demand.
- Being unable to undertake any activities that are agreed between the resident and their employer, such as quality improvement, attendance at the RDF, rota coordination/maintenance responsibilities, or patient safety tasks directly serving a department or wider employing organisation, due to service demand.

7.4 How will residents be able to exception report?

Exception reports will be administered by a consistent digital system across Wales that all residents must have access to from the first day their employment begins with NHS Wales under these TCS. Residents will be able to report the type of exception, when and where it occurred, other residents who were also affected, and what steps have already been taken to resolve the issue.

Exception reports do not preclude conversations within teams, for example to arrange time off in lieu, but should be used in parallel to ensure that an accurate record is kept of when exceptions have occurred. This enables employers to better understand work pressures and design rotas accordingly.

7.5 What happens to exception reports?

All exception reports will have a clear actioner who will determine the appropriate action in response to the exception. All exception reports will be copied to the resident's educational supervisor regardless of if they are the actioner. The resident will copy in the Director of Medical Education where the exception relates to training and the Guardian of Safe and Flexible Working where it relates to safe working practices, either of whom may be an actioner.

The appropriate course of action will depend upon the nature of the exception that occurred. It may include additional education and development time, or changes to the job plan. Where the report has flagged that other residents were affected, the actioner may follow up with the other affected residents and, if appropriate, register additional reports to reflect that multiple residents were affected. They may discuss an appropriate action in response to the exception with the affected individual(s) or decide upon the appropriate course of action where this is clear.

For reports of missed training opportunities that were contained in their personalised job plan, the resident will receive educational development time in lieu of their missed training. This will normally involve their release from their normal rostered duties for an equivalent training opportunity (not already contained in their individual job plan) in the near future, but where this is not possible it may also involve release from their normal rostered duties for individual study or other training activities. In exceptional circumstances, where options above are not available or not appropriate in the circumstances, the resident may receive additional pay in lieu of the lost training time to undertake training or individual study in otherwise un-rostered time.

Where an exception report has not received a response within 7 working days, the Guardian of Safe and Flexible Working will have the authority to independently action the report. The Guardian will routinely review the outcome of exception reports to identify whether further improvements to the job plans are required to ensure safe working hours are being maintained. They will also be able to investigate whether other residents were affected and if further action is required.

7.6 Breaches that incur a financial penalty

Some breaches of working hour limits will incur a financial penalty to the host employer. This will take place where the exception that is reported is determined to have caused the resident to have breached the safe working hours limits as follows:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the job plan); or
- A breach of the maximum 13-hour shift length; or
- A breach of maximum of 72 hours worked across any consecutive 168-hour period.
- where 11 hours rest in a 24-hour period has not been achieved (excluding on-call shifts); or
- where five hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
- where 8 hours of total rest per 24-hour non-resident on-call shift has not been achieved.

The resident will be paid for the hours that incurred the breach at a penalty rate of two times the relevant hourly rate, and the Guardian of Safe and Flexible Working will additionally levy a fine on the department for the additional hours at a penalty rate of two times the relevant hourly rate.

Where a concern is raised that breaks have been missed on at least 25% of occasions across a four-week reference period, and the concern is validated and shown to be correct, Guardian of Safe and Flexible Working will levy a fine at the rate of twice the relevant hourly rate for the time in which the break was not taken.

Where a breach that incurs a financial penalty can be demonstrated to affect a group of residents, the Guardian will consider the number of residents affected and will determine a proportionate level of penalty. In addition, where significant and regular levels of additional work or exception reports are being reported in a department, the Guardian shall have the discretion to issue a fine at stipulated penalty rates if, following investigation and intervention there is no improvement in the department.

Where a concern is raised that a resident job plan or rota has not been provided within the contractual time limit, or that access has not been provided to the additional work reporting

system or exception reporting system within the contractual time limit, Guardian of Safe and Flexible Working will levy a fine of £500 per resident, per week until the issue has been resolved.

The money raised through fines will be ringfenced for uses that benefit the education, training and working environment of residents. The Guardian will collaborate with the host employer and resident doctor forum (RDF) to allocate the funds. The funds should not be used to ensure that the host employer meets the minimum facilities standards set out in Fatigue and Facilities Charter.

7.7 Job plan reviews

The resident, their educational supervisor, their manager, or the Guardian of Safe and Flexible Working may request that a review of the resident job plan takes place if they have concerns regarding its compliance with contractual rota design requirements, or where educational objectives are not being achieved, leave allowance is not able to properly utilised, actual working patterns vary consistently from the job plan, or training opportunities are consistently being missed due to clinical commitments.

The resident's educational supervisor will discuss the need for a review with them as soon as possible following receipt of the request, ideally no later than 7 working days. Where the request is in response to a serious concern that there was an immediate risk to patient and/or staff safety, this must be followed up within 7 working days.

The conversation between the resident and the educational supervisor will lead to one or more of the following outcomes:

a. No change to the resident job plan is required.
b. Prospective documented changes are made to the resident job plan.
c. Compensation or time off in lieu is required.
d. Organisational changes, such as a review of the timing of ward rounds, handovers and clinics, are needed.

If the resident is dissatisfied with the outcome of the review, they may request a level 2 review, setting out their areas of disagreement with the original outcome and the outcome they are seeking. This review will be composed of a meeting between the educational supervisor, the resident, a service representative and a nominee either of the director of postgraduate medical education (where the request pertains to training concerns) or of the Guardian of Safe and Flexible Working (where the request pertains to safe working concerns).

If the resident is dissatisfied with the outcome of the level 2 review, they may request a final stage review. The final stage for a resident job plan review will be a formal hearing, in accordance with the ACAS Code of Practice on Discipline and Grievance and the final stage of the Respect and Resolution Policy, with the provision that the Director of Medical Education or nominated deputy must be present as a member of the panel. Where the resident is appealing a decision made by the Guardian of Safe and Flexible Working, the panel will include a representative of the BMA.

8 Modernised terms and conditions

8.1 Additional capacity and locum work

Where a resident wishes to undertake additional hours of paid work as a locum, they are strongly encouraged to offer this first to the NHS, so long as work is available appropriate to their grade and competencies.

The resident will have a professional duty to ensure that any additional work they undertake for their host employer, or another NHS organisation does not exceed the safety and rest requirements of the new contract.

Locum work undertaken will be paid separately and in accordance with the relevant pay circular.

As part of this framework agreement, BMA Cymru Wales, NHS Wales Employers and Welsh Government have agreed to develop either a set of payment rates, or a suitable and consistent methodology for determining these rates. In addition, BMA Cymru Wales have agreed to cease promotion of the BMA 2002 contract rate card unless a future dispute arises or talks on agreed rates do not conclude successfully.

8.2 Fee-paying services

Fee-paying work should normally be carried out in the resident 's own time. However, it will be permissible for the resident to undertake fee-paying work and retain the fee where undertaking the work entails minimal disruption to the NHS (1 hour per month).

Where the work requires more time than this, the employer may request that the resident remit the fee to the employer unless they choose to undertake an equivalent duration of compensatory work outside of their normal rostered hours or they authorise their employer to reclaim the salary for the time during which the fee-paying work was undertaken.

8.3 Introduction of common schedules

The following sections from the *NHS Terms and Conditions of Service Handbook* will be introduced as part of the new contract. Where the relevant sections are updated via existing procedure, these will be reflected in the TCS for resident doctors and dentists in training.

- Section 15: Leave and pay for new parents
- Section 16: Redundancy pay (Scotland, Wales and Northern Ireland)
- Section 17: Reimbursement of travel costs
- Section 18: Subsistence Allowance
- Section 22: Injury allowance
- Section 23: Child bereavement leave
- Section 25: Time off and facilities for trade union representatives
- Section 26: Joint consultation machinery
- Section 30: General equality and diversity statement
- Section 32: Dignity at work
- Section 33: Balancing work and personal life
- Section 34: Employment break scheme
- Annex 26: Managing sickness absences – developing local policies and procedures

8.4 Facilities

Host employers will be responsible for providing minimum standards of facilities in line with the *NHS Wales Fatigue and Facilities Charter* and the *Standards for Hospital Resident Accommodation and Associated Support Facilities*.

The host employer will have to provide options for a range of foods via vending machines or other arrangements during periods where restaurant facilities are not open.

The host employer will have to provide sufficient and reasonably accessible parking which has well-lit, safe and timely routes to and from the hospital/site for staff expected to travel after dark. Safety assessments should be undertaken to ensure that car parking provision meets the needs of staff working shifts, on-call and at night.

8.5 Expenses

Standard reimbursement rates set out in the NHS Terms and Conditions Handbook (Section 17 and 18) for reimbursement of travel, subsistence, and other business-related expenses will replace the General Whitley Council provisions currently in place. These reimbursements are intended to cover actual costs incurred during official duties and are not considered part of salary or pensionable pay.

8.6 Study leave reforms

The MDBG will establish a dedicated working group to scope and assess the implications of proposed changes to study leave arrangements.

The following changes will be made as soon as practical (and in any event prior to implementation of the contract):

- Clarification that the five days' study leave available for each exam is per sitting, not per exam.
- Increasing the study leave budget cap to £1,000, with regular uplifts each year thereafter, aligned to an agreed measure of inflation (the same will apply to the Excess Travel and Relocation budget cap)
- Rollover of unused study leave budget, aligned with the duration of the training programme.
  Enabling reimbursement of course expenses at the point of expense submission

In the medium-term (i.e. during the implementation of the contract), the following changes will be taken forwards:

- Introduction of automatic approval for mandatory courses
- Move towards a system where individual study budget caps are solely for the purposes of discretionary training, with mandatory courses funded outside of the cap.

This work will include engagement with key stakeholders and a financial impact assessment to support informed decision-making and effective implementation.

8.7 Understanding and tackling bottlenecks in training

The MDBG will establish a dedicated working group to investigate the existence, location, and causes of bottlenecks within training programmes (including clinical academic places). The focus will be on understanding where these bottlenecks occur and why they arise.

Where bottlenecks are identified, the group will work collaboratively with the Welsh Government to explore options for increasing training posts in the affected areas, ensuring that training capacity meets service and workforce needs.

8.8 Locally employed doctors

The MDBG will explore the development of a clear and consistent process for locally employed doctors to secure permanent employment on the specialty doctor TCS, subject to eligibility.

This initiative recognises the mutual benefits for both doctors and employers: supporting career development for doctors whilst providing workforce stability and funding continuity for organisations.

In the longer term, MDBG will examine the overall funding arrangements for resident rotas, ensuring that funding is allocated most effectively to maximise the number of training places available in each rota and reduce reliance on local appointments and locum doctors.

9 Implementation and transitional arrangements

9.1 Onboarding

The new contract will be subject to a multi-year programme of implementation.

In August 2026, it is intended that residents commencing the foundation programme and residents in specialty training programmes whose rotas do not attract bandings in the 2002 contract will be placed under the new terms and conditions. From this point onwards, the 2002 contract will be closed to new entrants. However, its pay levels will continue to be uplifted each year as part of the annual pay review process until such time as it is no longer in use.

After this time, new starters in other training programmes will also begin such employment under the new terms and conditions. Where they were previously in another training programme in Wales within the last two years, they will be pay protected if required. Where time has elapsed since their last such employment, their most recent rota in a training programme in Wales will be used for the purposes of calculation of their pay protection, albeit utilising pay scale values contained in the most recent pay circular. Where the resident has most recently been employed in the NHS in Wales in a role whose TCS mirrors that of the 2002 contract, their pay and banding in that employment will be used for the purposes of this calculation.

By August 2027, all residents training in the foundation programme and all new starters in specialty and core training will have been appointed on the new TCS. At this point, all remaining residents already employed in core prior to August 2026 will also be transferred to the new TCS. Residents already employed in speciality training prior to August 2026 will have the option of transfer to the new contract from this point. Where all residents on a rota agree to transfer to

the new TCS, they will be prioritised over individuals within rotas where not all residents wish to transfer. This will be managed locally.

In August 2028, with the exception of those within 12 months of CCT, all remaining specialty registrars will be transferred to the new contract. Further criteria for exceptional consideration will be developed in partnership as part of implementation.

Locally employed doctors should be transferred to the new contract alongside their equivalent training groups. However, employers will be afforded some leeway to prioritise residents in formal training programmes over locally employed doctors on a temporary basis where justified. In any event, all locally employed doctors in scope must be transferred to the new contract by August 2028, and no new locally employed doctor should be employed on terms mirroring the 2002 TCS from August 2026 onwards.

The precise detail of these arrangements will be determined in social partnership as part of the implementation programme and will be subject to robust readiness assessments in advance of each transition point and routine monitoring and oversight by all parties until completion of implementation.

Date	**Transition**
August 2026	2002 TCS closes to new starters
	New appointments at all levels on new TCS
	Existing residents at foundation levels transfer
	Residents in specialties with unbanded rotas (see below) transfer
August 2027	Remaining residents within core training level transfer
	Transition opens to residents in higher training level
August 2028	All remaining residents with more than 12 months to CCT except those meeting exception criteria transfer

Specialties on unbanded rotas are as follows (*this list is not exhaustive*). As they will see the most benefit from the increase in basic pay, their transfer is being prioritised above other specialty training programmes.

Restorative Dentistry	Special Care Dentistry
Paediatric Dentistry	Pharmaceutical Medicine
Public Health medicine	Rheumatology
Histopathology	Orthodontics
Clinical genetics	Audio Vestibular Medicine
Immunology	Clinical Neurophysiology
Oral Medicine	Rehabilitation
Genito-Urinary Medicine	Sexual Health

9.2 Transitional pay protection

Residents moving from the 2002 contract onto the new contract as part of implementation will see their pay protected by a cash floor or 'no-detriment' arrangement based upon their salary, including banding, the day prior to their transfer.

Pay protection arrangements will be subject to review following completion of implementation to assess the utilisation of the pay protection and consider the reinvestment of funding freed-up by the diminishing need for pay protection as residents progress up the new pay structure.

9.3 Monitoring and contract maintenance

An implementation programme will be conducted to manage the complex and significant changes required to implement the new contract. This will be overseen in social partnership by Welsh Government, NHS Wales Employers and BMA Cymru Wales.

A subgroup reporting to the MDBG will allow ongoing development of the contract according to the needs of residents and Welsh NHS employers. The contract will be subject to a review one year following implementation to assess its operation against expectations. A review will also be conducted on the operation of transitional pay protection to assess the ongoing need for the arrangements and the appropriate use of funds previously allocated to pay protection until all residents have migrated to the new contract or completed training on current contract.