Framework agreement

Exception reporting

Introduction

This framework has been agreed by the Resident Deal Implementation Group (RDI), including representatives from NHS Employers and the British Medical Association (BMA), in order to reform exception reporting (ER) processes through changes to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (2016 TCS), based on the terms of the agreed pay offer of July 2024.

All parties agree that ER is a joint mechanism to ensure that safe working hours are maintained, protecting patients, regulating doctors' workload, safeguarding the delivery of educational opportunities as outlined in the 2016 TCS, and ensuring that doctors receive compensation for all additional work undertaken. Doctors should be enabled and encouraged to exception report. All parties recognise that current practice leads to underreporting exceptions to safe working practice. None of the changes proposed will obstruct the guardian of safe working hours' (GOSWH) ability to undertake their role and identify unsafe working practices.

The underlying ethos to these changes should be to empower and trust doctors to conduct themselves professionally, and to remove wherever possible, and minimise wherever it is not, the time-consuming aspects of the ER process.

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Dr. Melissa Ryan, Co-Chair,
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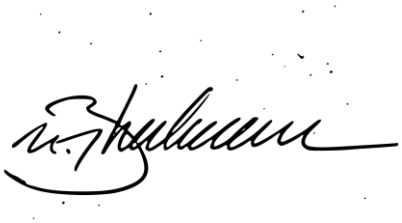

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1. Throughout this framework agreement, the following meanings apply:
   - All days are referring to calendar days.

   - ‘Guidance’ in every case refers to documents both co-produced and subsequently modified only with consensus agreement of BMA and management side stakeholders of RDI. The RDI group will continue to oversee all monitoring and publications produced, including guidance, until the initial implementation phase is concluded, and further ongoing oversight has been agreed between BMA and NHS Employers.

   - Any reference to an LNC refers to the medical staff side.

   - ‘HR’ indicates HR/Medical Workforce HR. Wherever possible, HR involved in the ER process should not be co-located with the clinical workforce.

2. There will also need to be appropriate mechanisms for legitimate concerns defined through mutual agreement by the BMA and management side after further consideration.

Scope

3. RDI’s remit in respect of ER is reform of the 2016 TCS. These changes will apply to all doctors in training who are substantively employed under that contract, collectively referred to in this framework as ‘residents’. As a safety-critical process, it is intended that all doctors in training in England should have access to a GOSWH to ensure safe working hours. It is recognised that the 2016 TCS are widely mirrored in other employment contexts, and we encourage employers in England to make every effort to extend the reforms set out in this framework agreement. For example:

   - Academic trainees who hold a National Training Number/Deanery Number and are substantively employed by universities. For these doctors, RDI encourage that their ER

provision should be extended by clinical employers through a standardised contract.

- Armed forces trainees who hold a National Training Number/Deanery Number.
- Public health trainees.
- Locally employed doctors whose terms of employment substantively mirror the 2016 TCS.
- Locally employed doctors whose terms of employment do not substantively mirror the 2016 TCS, but to whom ER has already been extended at a local level by their employers.

Access (Principle 1)

4. Residents have a contractual right to be able to access and complete ERs. It is recognised that residents not having access to ER is a safety issue. Employers will be instructed to provide access to residents within seven days of starting work, changing work site, employer, or any other related transition. Access should be validated by submission of a 'test' ER within those seven days, monitored by the GOSWH and their deputies. Residents must not be prevented from completing exception reports due to issues with the system, such as errors regarding incomplete rotas or unlisted data. Where rotas are a required selection in the process of ER, the specific name of the relevant rota on the ER system must be listed within a doctor's work schedule.

5. Residents must be provided with a simple way (such as email or quick access link) to raise to the GOSWH and HR after the initial seven days of starting work, changing work site, changing employer, or any other related transition, if they are unable to access the ER system or complete, an exception report. If problems with accessing or completing an exception report are not remedied within seven days of being raised, the GOSWH must levy a fine as outlined in the fines section below. Fines will

then be payable by the responsible party listed below on a recurring seven-day basis until the issue is resolved.

6. For residents working with host employers, including GP practices, their lead employer will carry the responsibility for provisioning the ER process and for any fines incurred as a result. Where residents work across multiple employers, their substantive employer will carry this responsibility, except in cases where the substantive employer is non-clinical, for example, university employees, in which case the clinical employer will carry this responsibility.

7. In addition to local onboarding processes, a list of all eligible employed residents, their contract type and grade must be generated by HR from Electronic Staff Record data (ESR) within a month of major rotation dates and circulated to the GOSWH for cross-validation with a list of doctors with access to ER systems. For those groups outlined in the scope, RDI encourages information to be provided for onboarding to this process, for example through addition to ESR.

Time off in lieu

8. All residents must receive their choice of either payment or time off in lieu (TOIL) for all time worked above contracted hours following ER, except when a breach of safe working hours mandates the award of TOIL. Guidance will detail the specific scenarios where rotation within or across employers precludes direct award of TOIL, and the steps to follow. All resulting payments and TOIL must be facilitated by responsible parties and must not be substituted without residents' consent.

9. When a resident elects to receive TOIL, or TOIL is mandated by the GOSWH, an award of TOIL must be communicated electronically to the resident. The resident will then select an appropriate member of their clinical team to share that communication and enable TOIL to be taken. TOIL must be arranged (that is booked and agreed) within one day of award if

mandatory, and 10 days of award if requested. The resident may escalate to the GOSWH for remediation if these time limits are breached, or if agreed TOIL is not facilitated. After taking TOIL, the resident must record its completion.

10. In those cases where TOIL must be taken immediately to protect patient safety, for example following an overnight breach of safe working hours, residents will directly contact their clinical team, who must facilitate the award. The resident should subsequently record the exception for GOSWH review.

Detriment and information control (Principle 2)

11. The 2016 TCS will be updated to state that residents must not be discouraged from submitting ER and should not suffer detriment as a result of engaging with ER processes. Guidance may be developed to provide resident doctors with information on local grievance processes and procedures and how they can be used in the event of detriment experienced as a result of ER. Categories of detriment may be elaborated on in guidance. To protect residents, ER data must be treated as confidential and cannot be accessed, shared or requested to be shared beyond specific pathways listed in this framework and subsequent guidance without a resident's freely given consent. Proven violations will be subject to information breach penalty.

12. The list of approved categories of individuals who have access to ER data may be added to only by mutual agreement between BMA and management side stakeholders (RDI).

13. Identifiable data for educational exception reports can only be shared with the director of medical education and their deputies (DME) and, at the academic trainees' discretion, a nominated academic supervisor. If remediation of an educational opportunity is possible, the DME will share further information as required for that purpose with the resident's consent.

14. Identifiable data (specifically identifying the individual) related to number or content of exception reports for additional hours

worked may only be shared to or accessed by appropriate HR signatories, GOSWH, their nominated deputies and payroll, unless specifically detailed in a pathway elsewhere in this framework. The list of individuals with direct access to a doctor's ER data must be communicated to the doctor by email at onboarding, and when new individuals are granted access. Details around implementation of ER system notification will be given in guidance.

15. Non-identifiable data derived from ER may be shared for audit and financial purposes to appropriate recipients. Identifiable data, explicitly excluding the exception report number or content, (for example salary) may be used for normal financial management and audit processes and will not be constrained. There are no restrictions on access to those whose job roles are related to professional auditing.

16. Residents must be provided with the identity of the individuals with access to exception report derived data at their request co-ordinated by HR. Information regarding a resident's exception report may not be accessed by individuals outside of this list of people fulfilling these roles (outside of those pathways in this framework agreement).

17. In certain circumstances, a resident may decline to share ER data without prejudice, with details to be set out in guidance.

18. Residents may report a suspected information breach to the GOSWH for investigation, and if proven, the GOSWH must levy a fine per instance per resident as outlined in the fines section below. Residents may be invited to provide additional details on the information breach and may decline. The GOSWH will oversee quarterly surveys of breach of access, breach of information and actual or threatened detriment, with results included in the quarterly GOSWH reports.

19. For residents working in small departments or in community settings, such as GP registrars, broad agreement has been reached that collection and disbursement of fines, payment for

additional hours worked and guidance around rostering, will be implemented to allow improvement of residents' working practices by employers, without breaching confidentiality or risking detriment to residents.

Penalties and distribution

20. Penalties of £500 per resident per instance for proven information breach, and £250 per resident per week for an 'access and completion' breach will be applied from 12 September 2024 to 31 January 2026. Both fines will be set at £500 from 1 February 2026.

21. If approved by LNC or equivalent, an access fine will not be levied where the delay has been caused by an event beyond the control of the employer, for example cyber-attack, as set out in guidance.

22. An 'instance' of information breach is described as follows:

    - If multiple doctors are affected in a single leak, a separate penalty will be applied for each affected doctor.

    - If multiple leaks occur over time related to a single doctor, a separate penalty will be applied for each individual instance.

    - If information related to multiple exception reports from a single doctor is leaked to multiple individuals in a single instance, a single penalty will be applied for that instance.

23. 'Access or completion' fines shall accumulate as a central single pot. The 'information breach' fine will accrue at a granular level unless affected doctors choose for it to go to the central single pot instead. This would take the form of GOSWH managed distinct sub-accounts intended to provide more equitable outcomes, smaller quorums and more agile disbursement. These sub-accounts, for example, should correspond to clinical departments in secondary care or geographical regions for

community settings. Should these more granular fines be unspent within four months of being accrued, they will be transferred to the central pot. Guidance will be provided to support the granular distribution.

Fines cannot be reclaimed by employers for any purpose. Disbursement of fines will be made more flexible, with a focus on initiatives that enhance residents' wellbeing, to be described in guidance. Money paid to the GOSWH fund will not be paid directly to doctors; existing penalty rates paid to doctors will be maintained. Existing accumulated fines via the 2016 TCS will carry over to the GOSWH's single pot. Hourly Penalty Rates paid to doctors under Schedule 02 Paragraph 77 and Annex A of the 2016 TCS will be unchanged. Hourly GOSWH Fines under Schedule 02 Paragraph 77 and Annex A of the 2016 TCS will accrue at a granular level unless affected doctors choose otherwise.

Exception report processing – role and responsibilities (Principles 4, 6, 10)

24. Residents, unless prevented by reasons outside their control as determined by the GOSWH, will be required to submit exception reports as soon as possible but no later than 28 days from the day they occurred. Timings for exception reports involving immediate safety concerns will no longer have a special time submission requirement and residents should continue to follow local processes to raise safety concerns as required. All exception reports must be reviewed independently of budgetary constraints.

25. All submitted exception reports should be reviewed and actioned as soon as possible but no later than 10 days exception reports for more than two additional worked hours should be investigated to ensure safe staffing is maintained and should be subject to a locally determined process, which must be agreed upon with LNC or equivalent. All ER data will be shared directly with the GOSWH for oversight.

26. With reference to exception reports showing that a doctor worked two or less additional hours in one occurrence, the only determination the employer will seek to reach when deciding to pay the doctor is whether or not the additional hours were indeed worked.

27. To maintain financial standards, there needs to be a robust sign-off process but the perceived retrospective merits of the doctors' decision to work the additional hours should not be considered when determining whether to make payment for the additional hours.

28. The doctor will confirm via self-declaration that the information they are submitting adheres to the reasons for exception reporting as currently set out in the 2016 TCS and is accurate.

Processing of ERs by HR for additional hours worked

29. In order to meet the principles above, the following checking process will apply.

Level 0 - To occur in all ER cases and is expected to be sufficient for the vast majority of ER.

A doctor submits an exception report to HR for processing.

- HR will consider three pieces of information:

1) Exception report data confirming category of exception and duration.

2) Evidence of additional hours worked. Time, date and location will be required with further detail to be set out in guidance. In cases where time and location evidencing has been facilitated by employers, but a doctor has declined or cannot do so, they may choose to ask another regulated professional to corroborate their work

done by email, but this corroboration cannot be made a default requirement. This evidence will be provided using a technological solution, for example email, commercial or custom mobile or web app, with implementations expanded on in guidance.

3) The doctor's rota. Current rota information must be accessible to HR for these checks, with mechanisms defined during the drafting of the contract. The RDI strongly encourages employers to move to a system of live rostering which will allow for automatic provision of live roster data and doctors will no longer need to include live rota information.

- HR will cross-check these pieces of information and if the information provided is accurate, they will send information to payroll for processing or approve TOIL. In cases where HR does not have delegated budget holder authority, budget holders will need to be engaged as required.

- If there are errors in the information provided, HR will move to a level one check.

- For instances where a doctor is working off site, such as providing NROC or patient home visits, further guidance on evidence of additional hours worked for ER will be provided. For example, in these instances doctor telephone call log evidence may be used to support the checking process. Until guidance is provided, doctors may not be prevented from completing exception reports on this basis.

Level 1 - Only to occur when the information submitted above provided does not align.

- HR will contact the doctor via email or ER platform to clarify the inaccuracies provided. Guidance will be provided to define the scope of this contact.

- The doctor may then:

  - correct the error and resubmit the ER to HR
  - acknowledge the error and withdraw the ER
  - acknowledge the accuracy of the ER content.

- When errors are rectified, HR will complete the payment/TOIL as per Level 0.
- If the information provided is not satisfactory to progress, HR will move to a level 2 check.

Level 2 - This level is reached only if a doctor states that their ER is accurate (and is continuing to pursue their claim), and HR has rejected its approval as in level 1.

- HR contact the GOSWH to review the exception report.
- The GOSWH may review the submitted evidence and instruct HR to complete the Exception Report at this stage if they believe the evidence is accurate.
- The GOSWH can discuss with HR and may choose to contact the doctor (in-person meeting not required) to discuss the ER.
- If the GOSWH is satisfied following that contact, they instruct HR to complete the ER report as appropriate.
- If the information provided is not satisfactory to progress, the GOSWH will reject the ER.

30. The doctor can choose to withdraw from the ER process at any time, however the ER case data must remain with the GOSWH to allow them to continue in their role and check for potential safety implications and report in their quarterly board reports.

31. Any other contact related to identifiable information related to ER by HR with a doctor's department or practice, or with any excluded individual will incur an information breach fine. The

mechanisms for limiting any other ER related contact outside of the verification process between HR and a resident will be set out during the redrafting of the contract.

32. Queries around patterns of accuracy may be escalated only to the GOSWH. The GOSWH will continue to review the reports as per the current process, to highlight trends or concerns. If during this process HR and the GOSWH have concerns over ER data (not individual ER cases), further checks as per local processes may apply. Please see section on safeguarding public funds for further information.

33. In the temporary absence of an appropriate HR signatory, their ER related duties must be delegated to a nominated HR deputy a member of the GOSWH's support staff or the GOSWH.

34. ER rejections must be recorded on a departmental level in quarterly reports and patterns should be scrutinised and jointly explored by the LNC and employer, to ensure that proper process is being followed.

35. Where an employer is unable to appoint to a GOSWH role they must ensure that alternative arrangements are in place. These arrangements should be jointly produced with LNC and/or RDF and are intended to be interim arrangements with the aim of appointing a GOSWH at the earliest possible opportunity.

Safeguarding public funds

36. As per the current process, the GOSWH will continue to monitor exception reporting data as part of their role. In parallel to the checking hours worked process, all reports will be shared directly with the GOSWH. If, as part of this process the GOSWH has concerns over ER data, including confirming the validity of the reports (to note this process is separate to checking individual reports, which is set out above. Contact via these processes will not incur an information breach fine.

37. If there are concerns with patterns arising in ER data, the GOSWH should take the following steps:

The GOSWH will discuss their concerns with any resident doctor involved to understand the patterns in the reports and ensure that necessary measures are in place to support safe working practices for the doctor.

If following this conversation, the GOSWH has further concerns including, for example, about whether all hours were worked, the GOSWH may ask the resident to nominate a regulated professional to affirm that the claimed hours were worked. The resident may choose to decline. If the nominated professional can verify the claimed hours, this process will conclude.

If the GOSWH has persistent concerns, or the resident declines to nominate, the GOSWH may make contact with a senior clinician in the department to affirm the accuracy of the patterns worked. The GOSWH should make every effort to mutually agree with the resident doctor an appropriate senior clinician to provide relevant information.

If the senior clinician can verify the claimed hours, this process will conclude.

If the senior clinician in the department is unable to verify hours, then the GOSWH can choose to take action to escalate, following local processes and procedures.

38. In the unlikely event there are safeguarding public funds concerns relating to exception reporting, escalation should follow the usual local processes and procedures, such as those outlined in local counter fraud policies.

    The GOSWH should be noted as a key individual within the process and their views should be sought as part of the process.

Local processes (Principle 7)

39. No changes should be mandated that constrain a working local process that enjoys the confidence of the resident doctor workforce and complies with the principles. Such processes may be validated by electronic ballot of the RDF, LNC or equivalent.

Exception report content (Principles 5, 8, 12)

40. Exception report submission must follow a simple, straightforward process that meets agreed accessibility standards. When designing a local system or contracting with a third-party ER provider, compliance with contractual language and guidance must be a factor in the design or choice of provider. Access to ER should be available remotely. Authentication must be user-friendly. ER categories must include at a minimum reports for: an unscheduled early start, an unscheduled late finish, the inability to take contractual breaks, the inadequacy of clinical support, the inadequacy of rostered skills mix, missed educational opportunities, breaches of non-resident on-call patterns, raising concerns of a suspected uncompliant rota pattern, detriment or threat of detriment, information breach, ‘access and completion test’ and optional free text box. Multiple occurrences in a single working shift should ideally be facilitated in a single form.

41. Mandatory input fields will be limited to: an identifier for the doctor, including name and/or email address (unless auto populated), the date of start of shift incurring exception, name of rota, category of exception, immediate safety concern

(retrospective), the minimum information required to calculate the hours claimed, and choice of payment or TOIL if reporting additional hours worked, with additional mandatory fields requiring mutual agreement from all parties. Further optional fields to add context on review may be agreed in national guidance or agreed at a local level, but such fields cannot be required for completion. Checkboxes and elements of auto population will be encouraged. Systems must be assessed for accessibility and equity in use. NHS Employers and the BMA will engage with software providers on the necessary changes.

Non-resident on call (NROC)

42. All hours worked NROC above what is stated in the work schedule will be subject to ER. If no hours are stated, then all NROC hours are subject to ER. The HR signatory pathway for up to two additional hours in one occurrence is explicitly affirmed as applicable to NROC.

Educational exceptions (Principle 9)

43. Reports of a solely educational nature are sent to DME, or DME deputies. The DME can take action to replace or reinstate any missed educational opportunities. If HR or the GOSWH identifies an educational component in other reports, they must obtain the resident's explicit consent before any communication with the DME. Academic residents with national training numbers/deanery number must have recourse to educational ER if clinical activities impinge on academic time. Employers should encourage departments and practices to roster adequate time for educational and ARCP outcomes. Doctors have the right to exception report for additional hours worked on Quality Improvement and other required activities as outlined in the 2016 TCS.

Monitoring, audit and implementation (Principle 3)

44. Monitoring of the implementation of these reforms will fall to the RDI until the initial implementation phase is concluded and consensus is reached on ongoing oversight. The GOSWH's quarterly reports (including annual summary reports) will be standardised to a national template co-produced in guidance to allow central data processing. Guidance will be provided that specifies the data to be included in these reports, including detriment, the perceived threat of detriment via survey, and confirmed information and access breaches. Quarterly reports must be made available by all employers to agreed national stakeholders, including RDI (or its successor, as per our RDI terms of reference) on completion and made available online to the public as soon as practicable but no later than one month after the report was generated. Quarterly reports must be sent directly to the LNC Chair, at least one nominated LNC resident, and to RDF representatives on completion.

Implementation and review

45. The latest date of full implementation of these reforms for every employer and under any circumstance will be 12 September 2025.

46. Should employers be able to do so, they can adopt the provisions early ahead of this date. Guidance will be produced as quickly as possible, to an agreed publication plan in order to provide information to employers and doctors as soon as is practicable. The RDI group will continue to oversee all monitoring and publications produced until the initial implementation phase is concluded and further ongoing oversight has been jointly agreed upon as per RDI terms of reference. Local monitoring may involve collaboration between employer-based task forces and BMA representatives, for example LNC. These ER reforms will be evaluated by the Department of Health and Social Care, the BMA (represented by the UKRDC), NHS Employers (and employer representatives) and NHS England starting from August 2027, with any resulting changes to contract or guidance requiring all-party consensus.