WORKING TIME DIRECTIVE 2009

PUBLICATIONS SERIES

Rota Design for 2009

EWTD Medical Workforce Development Team

NHS North West

NHS

National Workforce Projects

part of Skills for Health

Author biographies

Dr Masood Ahmed MBBS

Masood Ahmed has a long standing love affair with the New Deal and Working Time Directive (WTD). He graduated from Charing Cross and Westminster Medical School in 1997 and after moving to the West Midlands he became involved in medical politics. In 2003 he started as project manager, then associate medical director to the West Midlands Deanery Action Team. Masood has since held positions as deputy chair of the British Medical Association's (BMA) junior doctors committee (JDC) and chair of the JDC negotiating sub committee. He led the team that negotiated the current ST pay scales and national banding appeals advice. Masood is currently completing his training in general practice and is proud father to seven children, so workforce planning is a concept he takes seriously both in the workplace and at home and rota design is never far from his heart.

Dr Yasmin Ahmed-Little MBChB, MA (Merit)

NHS North West/North Western Deanery/Mersey Deanery

Yasmin Ahmed-Little is currently leading a team of 7 junior doctors on an ambitious project to implement WTD targets one year ahead, by August 2008, across NHS North West, NW & Mersey Deaneries. She graduated from Manchester Medical School in June 2000 and joined the North West Regional Action Team shortly after completing her house-jobs. She has since led on issues relating to junior doctors' hours and working lives, implementing New Deal and WTD 2004, and now working towards full WTD 48hr compliance. Yasmin is a member of the Working Time Directive Programme Delivery Board and was recently elected to the BAMMbino Board. She has completed a Masters in Health Services Management, will commence as CMO clinical adviser to NHS North West in September 2008 and is due to start her ST1 in Public Health in August 2009.

Contents page

1. Introduction **2**
1. Setting the scene 2
2. Importance of good rota design 3
3. Caveats/assumptions 4

2. Basic New Deal and WTD Revision **6**
Financial Implications 7

3. Rota Design Life Cycle **8**
Seven steps to success 9
1. Problem Identification 9
2. Feasibility study 10
3. Analysis 10
4. Design 14
5. Implementation 15
6. Evaluation 15
7. Review 16

4. Good practice guidance **18**
Handover 18
Bleep policies 18
Exception reporting 18
Rota information at induction 18
Trust WTD policies 20
Natural break policy 20
Approval to change band proforma 20
Approval to change band/work pattern 22
Agreement of trainees to proposed change in work pattern 24
Agreement of improving junior doctors' working lives team to proposed change in work pattern 25
Educational approval for proposed change in work pattern 26
Improving junior doctors' working lives team – Trust evidence to support stage 3 27

5. Pitfalls to avoid **28**
Rotas monitoring into higher pay bands 28
On call rotas 28
24 hour partial shifts 28
Management of Leave 29
Use Of Junior Doctor Rota Masters 29
Monitoring of trainees working away from the main trust site 29

6. Banding Appeals **30**
Official guidance 30
At Banding appeal 32

7. Additional Advice **34**

8. Support, Evidence and guidance already available **38**
1. Royal college guidance 38
2. BMA 38
3. NHS 38
4. 'Cell Of 11' 38
Normal working day 39

Conclusion 41

9. Appendices
Appendix A – Software tools available to support rota design 42
Appendix B – Example Bleep Policies 43
Appendix C – Sample WTD policy 52
Appendix D – Example natural break policy 60
Appendix E – Banding Appeal Guidance 62
Appendix F – Further information 65

10. References **66**

1. Introduction

1. Setting the scene

The implementation of Working Time Directive (WTD) in August 2004 presented the first challenge to junior doctors hours in meeting the UK wide legislation that has been in place since 1998 . This was the first step in a staged introduction of WTD. August 2009 sees the full implementation of the rules and regulations that will bring junior doctors' hours in line with the rest of the UK.

WTD 1998
UK wide implementation of 48 hour working week excluding junior doctors and deep sea divers but applied to most NHS staff

Planning for robust and sustainable solutions for August 2009 requires careful consideration of service delivery, education and training and resources/hours available. These three aspects of the 'WTD triad of patient care' provide the foundation for success.

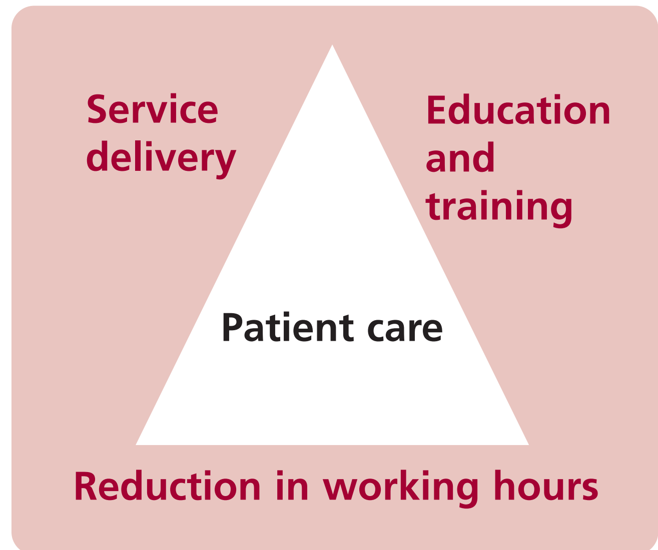


Fig 1 'WTD triad of patient care'

It may be easy to construct legally viable rotas compliant with New Deal and WTD. However it's far more challenging to create compliant rotas which also meet service delivery and educational needs. In many instances, previous 2004 solutions have been unsustainable and had a subsequent detrimental effect as they eroded training opportunities and lowered morale. A more considered approach is essential for 2009 and long term success.

This guide is aimed at equipping key stakeholders with a range of tips and tools to prepare them in the run up to August 2009 and the implementation of the 48 hour working week. There are no set rules, meaning what works for one trust may not work for another. However this guide can provide a framework for a systematic approach to the problems that may be faced within an organisation as it prepares for WTD.

Early planning is key and good rota design is a major contributory factor. Poor rota design threatens training, service delivery, work/life balance, morale and ultimately patient care.

Good rota design underpins all sustainable WTD 09 plans.

2. Importance of good rota design

i. The benefits of good rota design

It's recognised that WTD compliance and reduction of junior doctors' hours cannot be achieved purely through rota redesign

However good rota design can lead to:

- More efficient use of human resource, maximising service delivery
- More efficient use of financial resource
- Maximising education and training potential, safeguarding the quality of medical workforce and future consultants
- Minimising fatigue for a happier, more productive workforce
- Minimising the risk of banding appeals and referrals to the Health and Safety Executive (HSE).

ii. Penalties of poor rota design – impact upon service delivery, education and training

The greatest impact of August 2004 WTD implementation was upon daytime presence of junior medical staff. Traditional on call rotas disappeared as a consequence of the SiMAP and Jaeger rulings and the need to provide continued resident 24/7 cover in most specialties led to widespread changes in the way teams were structured and care delivered.

> The SiMAP judgement confirmed all time spent on work premises counted as 'work'.

Trusts relied on the implementation of full shift work patterns to meet WTD requirements and service delivery needs, however the components of the 'WTD triad of patient care' were given limited consideration and subsequently many junior doctors raised training issues. It was at the SpR grade that the impact was most significant. An increase in 'Hutton' numbers was part of the solution, but this led to difficulties with longer term workforce planning. A 'Hutton' bulge is anticipated as these trainees attain CCT in the near future and there is no corresponding increase in the consultant workforce.

> The Jaegar judgement reinforced SiMAP and confirmed compensatory rest must be issued immediately.

This approach highlighted that throwing additional doctors into a rota may not always be the best solution. Poor rota planning meant some juniors were working shifts, being away from wards and clinics for a week at a time as they worked night shifts and also received compensatory time off. This had an obvious impact upon service delivery but also education and training, as a large proportion of formal and supervised training opportunities occurs during the daytime (see cell of 11 section).

> **What was a Hutton number?**
> Additional locally funded WTD SpRs created to support 2004 WTD implementation

3. Caveats/assumptions

i. WTD theoretical hours and incorporation of PC

The rules for calculating average working hours under New Deal guidelines and WTD differ. New Deal requirements include the provision of prospective cover (pc) ie an allowance within the hours to accommodate the fact that the junior doctors are required to arrange appropriate cover in advance of taking leave and swap any out of hours shifts, working their allocation before or after their holiday. There are several ways to calculate prospective cover but the two most common methods can be found as follows:

- Department of Health (DH) guidance on working patterns for junior doctors, November 2002
- BMA junior doctors' handbook 2005/6.

Hours calculations under WTD take leave into account but use a different methodology. The calculation applicable from the European Union (EU) directive is given opposite.

Most organisations will use New Deal's hour calculations as an estimation of WTD hours of work. In reality this should be a reasonably safe approach as the inclusion of pc hours should prevent any under-estimation, however this should always be double checked as exceptions can arise due to the differing definitions of work and rest between WTD and New Deal. For example some Band 1 rotas are not automatically WTD compliant. Doctors may have been monitored to demonstrate less than 48 hours of actual work (due to the deduction of rest from the hours of duty) whilst resident for more than 48 hours therefore not meeting WTD 2009 requirements. Another example is where an individual junior doctor starts and ends their reference period working night shifts. This can take their average working hours over the WTD reference period of 26 weeks above 48 hours. However, under New Deal calculations the hours of work are averaged over a different reference period of the rota cycle and this may show the same individual as working less than 48 hours. It's important to remain conscious of possible exceptions. Calculations conducted by the Workforce Review Team suggest a possible 10% error when using New Deal pay bands as a proxy for WTD compliance.

(6) For the purposes of this regulation, a worker's average working time for each seven days during a reference period shall be determined according to the formula:

$$\frac{A + B}{C}$$

Where:

- **A** is the aggregate number of hours comprised in the worker's working time during the course of the reference period
- **B** is the aggregate number of hours comprised in their working time during the course of the period beginning immediately after the end of the reference period and ending when the number of days in that subsequent period on which they have worked equals the number of excluded days during the reference period
- **C** is the number of weeks in the reference period.

(7) In paragraph (6), 'excluded days' means days comprised in:

(a) Any period of annual leave taken by the worker in excess of his entitlement under regulation 13

(b) Any period of sick leave taken by the worker

(c) Any period of maternity leave taken by the worker

(d) Any period in respect of which the limit specified in paragraph (1) did not apply in relation to the worker by virtue of regulation 5.

2. Basic New Deal and WTD Revision

New Deal vs WTD: Who wins?

This area causes a great deal of confusion. It's important to appreciate the difference but understand that both sets of requirements **must** be fully met.

	New Deal	WTD
Requirement for compliance	Contractual obligation (junior doctors' contract 2000)	Law (health and safety legislation)
Penalty for non compliance	Financial – band 3 payments	Intervention by health and safety executive, improvement notices, possible fines to trust and legal action against CEO. Breach of the Corporate Manslaughter Act 2007. Possible litigation following clinical errors by non-compliant doctors

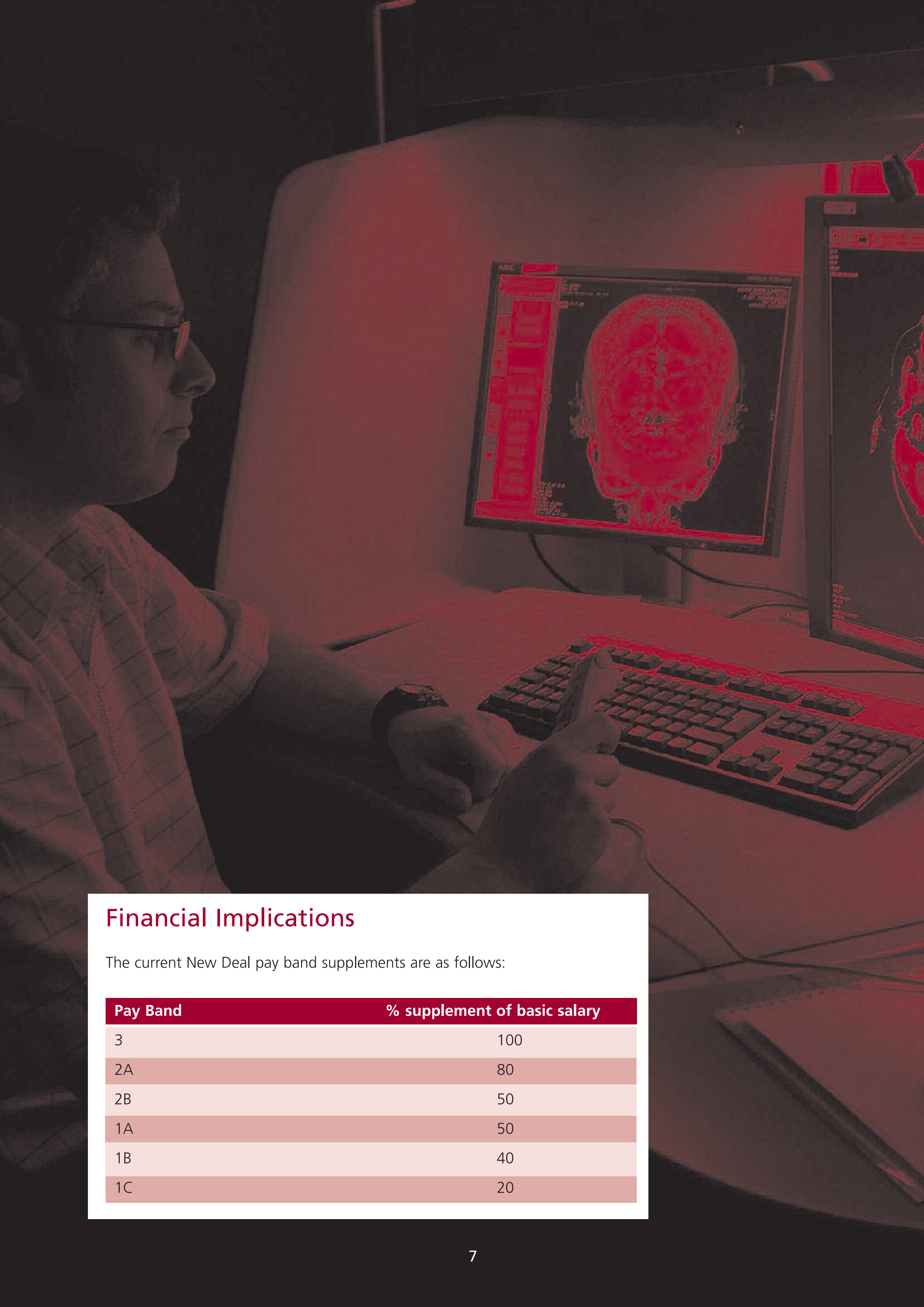
New Deal requirements were agreed in 1991 and a formal requirement for compliance incorporated in the national junior doctors' contract since 2000 . All trainees are required to be fully New Deal compliant and since August 2003 any failure to do so is a breach of contract and attracts a financial penalty of Band 3 payments = 100% supplement of the juniors' basic salary.

A typical eight doctor rota at Band 1A monitoring as non compliant (Band 3) will result in the trust having to pay over £140,000 per annum in additional salaries, with further potential financial liabilities resulting from pay protection of up to £85,000 [calculated using PC(MD) 7/2007].

WTD requirements were introduced for all NHS staff in 1998[1] however junior doctors were exempt. The regulations were extended to include staged introduction of WTD for junior doctors as follows:

Deadline	Maximum average working week
August 2004	58 hours
August 2007	56 hours
August 2009	48 hours

WTD is health and safety legislation and as such falls within the remit of the HSE to respond to any complaints relating to non compliance. WTD is not linked to pay but is intended to safeguard hours of work and mandatory daily and weekly rest requirements.



Financial Implications

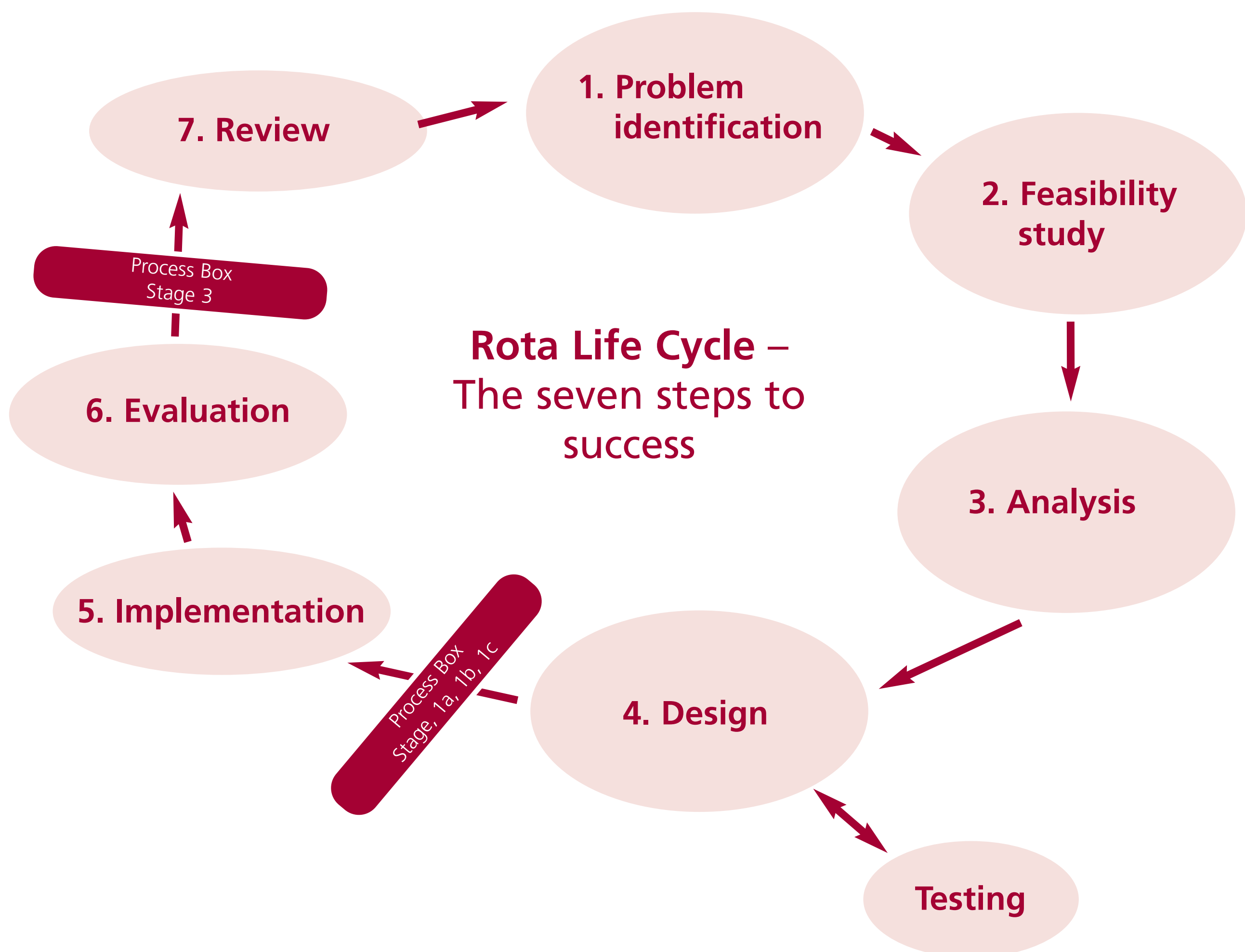
The current New Deal pay band supplements are as follows:

Pay Band	% supplement of basic salary
3	100
2A	80
2B	50
1A	50
1B	40
1C	20

3. Rota Design Life Cycle

Rota design has long provided a challenge to those responsible for rota management. Whilst many possess the skills and the knowledge for effective rota design there is often a framework missing that encompasses the different contributions made for successful rota design, implementation and maintenance. The problem is that there are no right answers, what works at one trust may not work at another. However, underpinning every problem are the principals that need to be followed for our goals to be met.

This Life Cycle is a concept designed to provide a systematic approach to rota design. It will facilitate the development and establishment of rotas by looking at the foundations needed for success, as well as providing information that can be reflected upon at a later date as the workforce evolves in an ever changing NHS.



Seven steps to success

1. Problem identification
2. Feasibility study
3. Analysis
4. Design and testing
5. Implementation
6. Evaluation
7. Review

1. Problem Identification

The starting point for any rota redesign should always be the existing rota. While it's easy to focus on what the problems are, it's usually more productive to begin with the aspects that are successful. It's vital that the strengths of the current rota are considered and possibly incorporated in any rota redesign and to establish the reasons for their success. Only when you have confirmed what is successful should you move onto what the problems may be. Again, careful consideration must be given as to why the rota does not work – is it because of the lack of numbers or perhaps issues regarding policy for example bleep policy, or referral policy? Are there multi disciplinary limitations that prevent effective teamwork and cross cover? Are there physical barriers such as split sites or allied services within a hospital which are located at a distance from each other? Are there difficulties with consultant numbers or senior supervision? These are just some of the issues which may hinder a rota from running at its peak potential.

For each stage a systematic approach is advisable. This can be done using the '5W's' method.

What	Why	Who	HoW	When
Identify the problems	Why is it a problem?	Who should be involved?	How can the problem be solved?	When are you aiming to have the answers?
	What impact does this have on other aspects of the service?	Which stakeholders can offer solutions?	Is there good practice elsewhere?	
		Who is directly affected?	Suggestions from stakeholders	
			Resources required, internal vs external expertise	
Worked example				
Shift over runs	*Potential WTD non compliance*	*Junior doctors, consultants, nursing staff, directorate managers*	*To be completed at analysis stage of the cycle*	*Before commencing design stage*
	Potential New Deal non compliance			

2. Feasibility study

After identifying the major problems, the next stage is to investigate the feasibility for designing a new rota. The following must be considered:

- Is there support within the organisation for change?
- Has time and human resource been allocated to focus on the project?
- Has funding been made available if extra resources are required?
- Are the software tools available for rota development? (see Appendix 1)
- Does the current team possess the skills to redesign the rota?

By identifying these factors at an early stage it's possible to determine what limitations may apply and this information can be used to formulate proposals for resources that will ensure the success of the project. Some organisations may not be able to provide additional resources immediately but by identifying these issues they are equipped with evidence to inform a business case.

3. Analysis

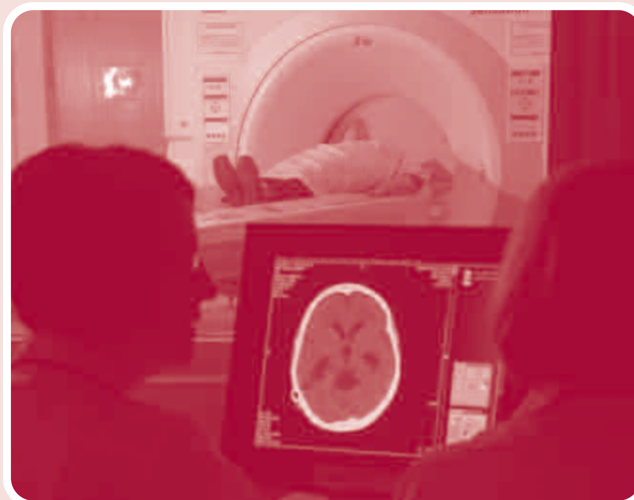
This is the fact finding stage of the cycle, during which it will be possible to identify the needs of the service in addition to the education and training needs of the junior doctors. Also at this stage the rota designers will have the opportunity to identify other problems, as well as put forward potential solutions ie populate the 'Ho**W**' column (see problem identification stage).

This collection of knowledge can be carried out in a number of ways depending on the resources available and time pressures. The team may decide to use questionnaires with focussed questions relating to the problems already identified and with open-comment boxes to give interviewees the opportunity to highlight other issues of concern. A more time consuming, but in depth analysis, can occur if resources are available for interviewing key staff including consultants, nurses, ward administrators and junior doctors.

By collating this information it should become possible to determine a list of user requirements whereby essential skills, processes and policies are identified. Much of this information will be subjective, but by acting on locally identified problems staff will have ownership of service reconfiguration and this is more likely to lead to long term success.

Pulling together all the facts will result in a rota specification that can then be used as a template for the rota design. For example:

Rota Specification – FY1 General Medicine, Trust X	Essential	Desirable
10 doctor rota	✓	
Normal working day 8:30am-5pm	✓	
Some exposure to out of hours working	✓	
Some exposure to weekend working		✓
Some exposure to night shift working		✓
Prospective cover	✓	
Handover	✓	
Band 1 rota	✓	
Band 1B rota		✓
Protected teaching Thursday afternoons	✓	
Clinics Monday and Wednesday morning		✓
Consultant ward round	✓	
Exposure to emergency admissions	✓	



This exercise may include the use of the workload analysis grid as follows:

Workload analysis grid

i) Blank Workload Analysis Grid To be Completed By Relevant Stakeholders

Ask key staff to complete the blank grid using a traffic light system to identify perceived workload pressures for the specialty and grade in question at different times of the day. The use of four hour slots will assist with management of natural breaks but the grid can be adjusted as needed.

		Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	9am–1pm							
2	1pm–5pm							
3	5pm–9pm							
4	9pm–1am							
5	1am–5am							
6	5am–9am							

Key:
Workload Busy Moderate Quiet

ii) Worked example – data collected relating to subjective assessments by different stakeholder of F1 workload in general medicine at trust X

CONSULTANT		Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	9am–1pm							
2	1pm–5pm							
3	5pm–9pm							
4	9pm–1am							
5	1am–5am							
6	5am–9am							

+

F1s		Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	9am–1pm							
2	1pm–5pm							
3	5pm–9pm							
4	9pm–1am							
5	1am–5am							
6	5am–9am							

+

WARD NURSES		Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	9am–1pm							
2	1pm–5pm							
3	5pm–9pm							
4	9pm–1am							
5	1am–5am							
6	5am–9am							

+

A&E/MAU		Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	9am–1pm							
2	1pm–5pm							
3	5pm–9pm							
4	9pm–1am							
5	1am–5am							
6	5am–9am							

iii) Worked example: Analysis

Methodology

1. What does the department need and when

Analysis by day
Mondays are often busy following weekend on call as investigations are pending and most support services resume activity
There is a lull in activity mid week after 5pm

Analysis by time slot
F1 presence is crucial during 9am-5pm during the week
At weekends morning activity (9am-1pm) for F1s is lower

2. Possible sources of data for analysis

Quantitative
HAN data/iBleep data

Qualitative data
- Completed workload analysis grids
- Interviews
- Questionnaires

Results – this is achieved by pulling all the available data together to formulate conclusions

	Data	Evidence available at Trust A
Qualitative	**Consultants**	Believe F1s presence is needed at all times but mainly until midnight
	F1s	Believe best emergency exposure is from midday to midnight most days, and elective exposure 9am-5pm
	Ward nursing staff	Need F1 presence before lunch on weekdays, other staff can assist on weekend mornings eg phlebotomists, assistant practitioners
	A&E/MAU staff	Need F1 presence after lunch through to 9pm most days, with cover later in to the night on Fridays and Saturdays
Quantitative	**HAN data**	Clear need for significant F1 presence Monday-Friday 9am-5pm
		Friday-Monday twilight support is essential
		Tuesday-Thursday twilights are clearly quieter
		Friday and Saturday nights are clearly busy with a lull in activity post midnight
		Weekend mornings are busy on the wards but quiet in admissions

Final workload analysis grid – this provides a template upon which to base the rota design

		Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	9am–1pm							
2	1pm–5pm							
3	5pm–9pm							
4	9pm–1am							
5	1am–5am							
6	5am–9am							

4. Design

"There cannot be a 'one size fits all' solution, as individual situations will differ in many ways" (Rota Design Made Easy, BMA) [9].

When all the strands of the previous stages have been pulled together you should have a clear rota specification upon which to base your design. Depending on the expertise available you can approach rota design in three ways:

1. Start from scratch to give a bespoke, best-fit solution
2. Modify existing local templates
3. Utilise example templates from the NWP database/other external sources.

There is extensive material available to provide further support for this stage 9.

The worked example used earlier for the F1 rota in General Medicine at Trust X could produce the following example rota template, based on the data gathered during the analysis stage.

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
1	C: Long day 09:00 – 21:30	C: Long day 09:00 – 21:30	C: Long day 09:00 – 21:30	C: Long day 09:00 – 21:30	C: Long day 09:00 – 21:30		
2	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00		
3	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	B 09:00 – 21:30	B 16:00 – 00:00	B 13:00 – 21:00
4	E 18:00 – 21:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00		
5	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00		
6	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	C: Long day 09:00 – 21:30	A 09:00 – 17:00	A 00:00 – 17:00
7	Stnd day 08:00 – 17:00	Stnd day 08:00 – 17:00	Stnd day 08:00 – 17:00	Stnd day 08:00 – 17:00	Stnd day 08:00 – 17:00		
8	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00		
9	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00		
10	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00	Stnd day 09:00 – 17:00		

Testing

With each rota design, software tools can support validity testing however the following areas should be considered and some require human judgement.

- Is it legal (WTD compliant)?
- Is it affordable (New Deal compliant and within expected pay band)?
- Is it realistic?
- Is it socially acceptable (start and end times, weekend frequency, 'Improving Working Lives')?
- Is it educationally acceptable?

Process Box

Complete stage 1a, 1b, 1c of re banding proforma

5. Implementation

Only after the initial paperwork has been signed off and approved by the action team at the Strategic Health Authority, or successor body, can plans be made for implementation.

An appropriate implementation date should be agreed in partnership with all key stakeholders. Implementation prior to August 2009 will allow full evaluation of the rota with time to make any modifications required to ensure compliance. Implementation at handover in August 2009 will require, where appropriate, stage 2 provisional banding approval prospectively, prior to recruitment and implementation.

At this stage it is also advisable to agree a date for monitoring post-implementation. Please note if stage 2 provisional banding has been agreed, monitoring must take place within six weeks of implementation of the rota, otherwise the provisional rebanding is invalidated.

Process Box

Consider whether stage 2 provisional approval of the re banding proforma is required

6. Evaluation

Following implementation a rota must be monitored so that the rebanding process can be completed at stage 3. Results from all monitoring exercises should be published within 15 working days of receipt of a valid return[5]. In addition to this the six monthly monitoring exercise provides a useful evaluation of the sustainability of the rota. But monitoring should not be the only form of feedback if the rota cycle is to be used effectively for the evolution of rotas. Feedback may be obtained through questionnaires, exception reporting and by regular follow up with those involved with the rotas (for example at mess meetings, teaching sessions or multi-disciplinary meetings).

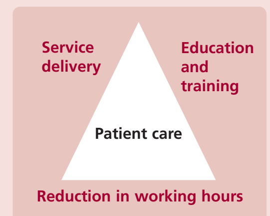
Process Box

Submit monitoring results to action team (or successor body) for completion of stage 3 of the re banding proforma

There are four criteria which must be considered for detailed evaluation:

Suitability

- Does the new rota provide an appropriate solution?
- Is the WTD triad of patient care achieved?
- Does the rota meet the rota specifications?



Effectiveness

- Does the rota work in reality?
- Does it meet WTD requirements?
- Is it compliant with the New Deal?
- Are there any problems?

Usability

- Is the rota easy to follow?
- Is it confusing for doctors/ward staff?
- Is it flexible enough for leave and sickness?
- Is there a work/life balance?
- Is there a training/service balance?

Maintainability

- Is the rota robust in the long term?
- can it cope with seasonal pressures/leave?
- Are there any limitations?
- Are modifications required?

By carrying out a detailed evaluation following implementation, it's possible to highlight potential problems and be proactive with rota review rather than wait for problems that may eventually impact on patient care, service delivery or training needs.

7. Review

The three possible outcomes at this stage are:

1. Success. Congratulations! The rota is compliant and stable
2. Needs slight tweaking and re monitoring
3. Significant problems, may be non compliant, back to stage 1 of the cycle.

By bringing together all the information from monitoring and evaluation it's possible to report on any issues or limitations of the new rota, and to see how these might compare with the original objectives and specification. The audit trail provided by the Rota Life Cycle will evidence decisions taken regarding any issues highlighted earlier in this process, allowing any further necessary modifications to follow an informed and transparent process. If the problems are new then the cycle can be repeated by returning to the problem identification or analysis stage and using the 5Ws.

SUMMARY

Seven steps to success: Rota Life Cycle

1. Problem ID, 2. Feasibility, 3. Analysis, 4. Design, 5.Implementation, 6. Evaluation, 7. Review

'5W's'

What, Why, Who, HoW, When

Triad of Patient Care

Service, Training, Hours

One goal

Patient care

Rota Design Life Cycle

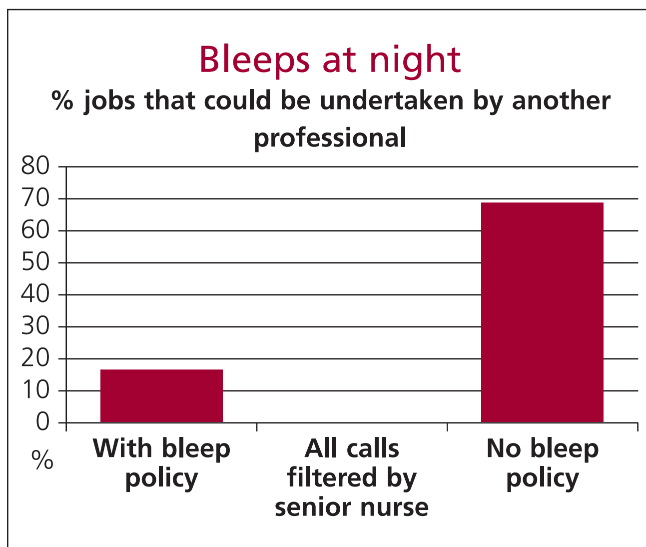
4. Good Practice Guidance

Handover

Most rotas will require a minimum handover of 15 minutes, usually 30 minutes and in some instances even longer. Handover is critical for safe transfer of patient information to deliver continuity of care and good quality patient management. In 2004 the BMA in conjunction with NPSA and many other stakeholders created a detailed and useful guide to handover[11].

Bleep policies

These are an effective way of managing overall junior doctor workload, minimising/eliminating the number of inappropriate referrals made freeing up the doctors to tackle appropriate areas of clinical need. Bleep policies provide an agreed framework for nursing staff to follow when assessing the need to bleep a doctor. In some instances for example it may be more appropriate to contact a nurse practitioner in the first instance to take bloods or triage a stable patient. National Hospital at Night data also clearly demonstrates the reduction of inappropriate referrals made when a bleep policy is in place and that where all overnight calls are filtered by a senior nurse, no inappropriate calls at all are made to junior doctors.



Some examples of bleep policies currently in operation are attached in Appendix B.

Exception reporting

Successful implementation is often seen at sites where a true partnership approach between juniors and the trust has been taken when implementing new working patterns. In order to foster a cooperative approach it's worth considering a system of exception reporting for possible WTD and New Deal infringements on junior doctor rotas. The health and safety of trainees is better protected in this manner and encourages ongoing service improvement.

This requirement can be included within trust or directorate policies, giving clear rules for and lines of reporting. In addition to this it is beneficial to issue these guidelines at induction (see section d).

Rota information at induction

It is highly recommended that rota template details are issued to all junior doctors at induction with a record of receipt documented. It's important that HR, the directorates, consultants and ward staff all know the agreed work pattern. It's often reported at banding appeal that the juniors were never aware that the rota included half days off etc. Issuing the master template at induction would limit rotas falling in to Band 3 as a consequence of poor communication. Furthermore this opportunity can be used to request juniors report any unauthorised changes to their working hours as soon as they arise (see above, section c re exception reporting).

The following is an example template used to provide this information at induction:

NHS trust X

Agreed rota template for circulation to all junior doctors at induction/
start of new post

Site A
General medicine
F2 and junior ST rota template as at 1st August 2008

Working pattern – full shift rota
Rest requirement – natural breaks (min 30 mins continuous rest after approx four hours' duty)
New Deal pay band – Band 1B

	Mon	Tues	Wed	Thur	Fri	Sat	Sun
1	N 21:00 – 09:30	N 21:00 – 09:30	N 21:00 – 09:30	N 21:00 – 09:30	Zero Hours		
2	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	N 21:00 – 09:30	N 21:00 – 09:30
3	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	N 21:00 – 09:30		
4	Zero Hours	Zero Hours	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00		
5	D: Long Day 09:00 – 21:30	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00		
6	Stnd Day 09:00 – 17:00	D: Long Day 09:00 – 21:30	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00		
7	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	D: Long Day 09:00 – 21:30	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00		
8	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	D: Long Day 09:00 – 21:30	Stnd Day 09:00 – 17:00		
9	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	D: Long Day 09:00 – 21:30	D: Long Day 09:00 – 21:30	D: Long Day 09:00 – 21:30
10	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00	Stnd Day 09:00 – 17:00		

I can confirm that I have received a copy of the rota template above and understand that this is the current working pattern I should be following.

I also agree to exception reporting ie I will alert the medical staffing department at trust X if I find I am regularly working hours different to those given above, eg if I am not able to attend formal teaching sessions, not receiving half days/full days off duty as specified within the rota template, working regular early starts and/or late finishes or I am not meeting the rest breaks as detailed above etc.

Name:

Position:

Date:

Signature:

Trust WTD policies

There are many areas in the interpretation of WTD rules that have not yet been tested legally, for example around the provision of compensatory rest. Many organisations have therefore agreed trust policies around junior doctors' hours, monitoring, New Deal and WTD. The following areas may be included:

- A trust may require staff to monitor their working hours twice a year in response to the request of the HR department (not just junior doctors in training)
- Clarity around the trust's position on compensatory rest including whether this should be taken in paid or unpaid time.

An example of such a policy has been included in Appendix C. This is by no means exhaustive nor does it cover all possible interpretations, it merely offers an example of one view point. Trusts are advised to seek their own legal advice.

Natural break policy

Where organisations have struggled to ensure natural breaks are taken by all junior doctors they have implemented policies to highlight the joint responsibility in achieving this. This can reassure the juniors that trusts do expect them to be able to take their breaks at all times unless they are involved in a life threatening scenario. Equally it can raise awareness amongst nursing staff who can then manage elective and emergency workload around the need for juniors to take breaks.

An example of such a policy is attached in Appendix D.

Approval to change band proforma

When implementing changes to any junior doctors working patterns that result in a change in pay band, it's a requirement to complete the 'approval to change band' process and proforma. This document was agreed between the DH and the BMA in April 2002. The agreement to document these stages in the form of the official proforma resulted from great variation in approach across the country.

The completion of this proforma and careful documentation of each stage is critical. If a trust is challenged on the pay band of a rota and they do not possess this documentation to prove the pay band, they are left in a difficult position at banding appeal and will inevitably lose irrespective of any other worthy arguments they may wish to debate.

As such NHS North West have devised a series of templates and local version of the 'approval to change band' proforma to provide consistency in approach and documentation across the patch and ensure all required written documentation has been captured. In the following pages the national proforma and copies of the NHS North West templates have been provided as an example of good practice.

National 'Approval to change band' proforma agreed with the Department of Health & BMA

APPROVAL TO CHANGE BAND

Trust:		Hospital:	
Specialty(ies):			
Numbers of Doctors in Working Arrangement by Grade			
PRHO:	SHO:	SpR:	Other:
Working Pattern:			
Current Banding:		Proposed Banding:	Effective Date:

Stage	Evidence Required	Documentation	Confirmed Y/N
1a. Consult post-holders on proposed changes and obtain agreement of the majority participating in the working arrangements.	Approval of majority of current/incoming post-holders	Template signed by Trust junior doctor representative confirming agreement of majority of current/incoming post-holders	
1b. Submit details of the new working arrangements to the Action Team for information and invited comment.	Full details of proposed working arrangements and/or rota summary (eg from ND2000 software)	Letter signed by Action Team Chair or delegated authority confirming theoretical compliance of working arrangements	
1c. Obtain agreement from Clinical Tutor for education purposes.	Full details of proposed working arrangements Comments of Action Team	Letter signed by Dean or delegated authority confirming educational acceptability of working arrangements	

If exceptionally and because of the impracticality of full implementation of new working arrangements a Trust wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the Regional Action Team (or its equivalent) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements.

Stage	Evidence Required	Verification	Confirmed Y/N
2. Submit request for provisional approval of working arrangements to Action Team	Signed letter from Trust giving reasons for inability to fully monitor before rebanding. Evidence of full or partial testing/monitoring of proposed arrangements	Letter signed by Action Team Chair or delegated authority authorising an offer of provisional banding.	
Current Banding:	Provisional New Banding:	Implementation Date:	
Action Team Signatory		Date:	

Stage	Evidence Required	Verification	Confirmed Y/N
3. Monitoring of working pattern and confirmation of banding	Completed monitoring returns from 75% of doctors on rota over full 2 week period Summary of monitoring results	This signed template	
Previous banding:	Verified New Banding:	Effective Date:	

Trust Signatory ______________________ Date: __________
(Designation)

Rota Signatory ______________________ Date: __________
(Junior Doctor LNC representative)

Action Team Signatory ______________________ Date: __________
(Designation)

Approval to change band/work pattern (NHS North West)

Trust:			**Hospital:**
Specialty(ies):			
Numbers of Doctors in Working Arrangement by Grade			
PRHO:	**SHO:**	**SpR:**	**Other**
Working Pattern:			
Current Banding:	**Proposed Banding:**		**Effective Date:**

Stage 1	**Evidence Required**	**Documentation**	**Confirmed Y/N**
1a.Consult post holders on proposed changes and obtain agreement of the majority participating in the working arrangements.	Approval of majority of current/incoming postholders	Template signed by trust junior doctor representative confirming agreement of majority of current/incoming post holders	
1b.Submit details of the new working arrangements to the action team for information and invited comment.	Full details of proposed working arrangements and/or rota summary (eg from ND2000 software)	Letter signed by action team chair or delegated authority confirming theoretical compliance of working arrangements (see below)	
I confirm that the proposed working arrangements submitted to the action team are theoretically compliant with the New Deal (To be completed by the action team) Name………………………………………………………..Signature…………………………………………… Designation…………………………………………………………………………...Date ………………………			
1c. Obtain agreement from clinical tutor for education purposes.	Full details of proposed working arrangements comments of action team	Letter signed by dean or delegated authority confirming educational acceptability of working arrangements	

Stage 1	**Evidence Required**	**Documentation**	**Confirmed Y/N**
3. Monitoring of working pattern and confirmation of banding	Completed monitoring returns from 75% of doctors on rota over full two week period Summary of monitoring results	This signed template	
This Action Team Authorisation at Stage 3 is based on the information supplied by the Trust. Any innacuracies in the data provided including analysis / interpretation of monitoring data may render this rebanding invalid.			
Previous banding:	**Verified New Banding:**	**Effective Date:**	
Trust Signatory (Designation)		Date:	
Rota Signatory (Designation)		Date:	
Action Team Signatory (Designation)		Date:	

Trust:	Hospital:	Specialty(ies):

Provisional Rebranding

If exceptionally and because of the impracticality of full implementation of new working arrangements a Trust wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the Regional Action Team (or its equivalent) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements.

Stage 2	**Evidence Required**	**Documentation**	**Confirmed Y/N**
2. Submit request for provisional approval of working arrangements to action team	Signed letter from trust giving reasons for inability to fully monitor before rebanding. Evidence of full or partial testing/monitoring of proposed arrangements (See Below)	Letter signed by action team chair or delegated authority authorising an offer of provisional banding. (See Below)	

2a. **Reasons for inability to fully monitor before rebanding (to be completed by trust)**

Name……………………………………………………..Signature……………………………………………

Designation……………………………………………………………………………Date ……………………

2b. **I confirm authorisation of a provisional new banding (to be completed by action team)**

Name……………………………………………………..Signature……………………………………………

Designation……………………………………………………………………………...Date ……………………

Current Banding:	Provisional New Banding:	Implementation Date:
Action Team Signatory:		Date:

STAGE 1A

Agreement of trainees to proposed change in work pattern

NHS North West

Proposed work pattern for the .... [insert grade]........ [insert specialty] ....at .... [insert hospital]

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Anticipated band of rota (subject to confirmation): [Insert band here]
Number of doctors on rota [Insert number here]
Type of working pattern [Insert work pattern]
Expected implementation date [Insert date here]

The aim of this document is to confirm for the purposes of rebranding, including where a work pattern is to be changed within the same band, that the majority of current or incoming post holders have been consulted about the proposed rota changes and that they find them acceptable.

This document will be sent to the Improving Junior Doctors' Working Lives team at Greater Manchester Strategic Health Authority as part of our evidence in the rebranding process. The rebranding process is outlined in paragraph 22 m of your terms and conditions of service which can be found online at:
http://www.nhsemployers.org/docs/terms_conditions_service.pdf

Declaration
We the undersigned represent the majority of the current/future postholders on the above rota. We agree that this is an acceptable rota and would be willing to work these arrangements at the given band, provided banding is confirmed through monitoring of the rota within six weeks of implementation.

Full Name	Signature	Position	Date

STAGE 1B

Agreement of improving junior doctors' working lives team to proposed change in work pattern

NHS North West

Proposed work pattern for the .... [insert grade]........ [insert specialty] ....at .... [insert hospital]

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Anticipated band of rota (subject to confirmation):	[Insert band here]
Number of doctors on rota	[Insert number here]
Type of working pattern	[Insert work pattern]
Expected implementation date	[Insert date here]

Declaration
On behalf of the improving junior doctors' working lives team at Greater Manchester Strategic Health Authority, I hereby confirm that the proposed working arrangements, outlined above, are theoretically compliant with the New Deal hours and rest requirements and consistent with Band [insert theoretical New Deal band].

Signature...Date..........................

Name...

Position..

STAGE 1c

Educational approval for proposed change in work pattern

NHS North West

Proposed work pattern for the .... [insert grade]........ [insert specialty] ....at .... [insert hospital]

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Anticipated band of rota (subject to confirmation): [Insert band here]
Number of doctors on rota [Insert number here]
Type of working pattern [Insert work pattern]
Expected implementation date [Insert date here]

Declaration (to be completed by delegated authority of the dean)
I confirm that the above rota meets educational and training requirements for junior doctors' training at this grade within this specialty.

Signature……………………………………………………Date………………………

Name……………………………………………………....

Position……………………………………………………..

STAGE 3

Improving junior doctors' working lives team – Trust evidence to support stage 3

NHS North West

Monitoring evidence in support of a request for 'approval to change band'

Trust	
Specialty	
Grade	

Monitoring Attempt 1	
Monitoring dates	
% Return	
Monitored band	
Contracted hours	
Actual hours	
Natural break compliance %	
Rest compliance (If applicable)	
Are all other requirements of the New Deal met?	Yes No
If no please give further details/explanation and attach supporting evidence.	
Please sign and date here on behalf of the trust to confirm you have input and analysed the monitoring data with accuracy and believe it supports stage 3 of this 'approval to change band' request	

Monitoring attempt 2	
Monitoring dates	
% Return	
Monitored band	
Contracted hours	
Actual hours	
Natural break compliance %	
Rest compliance (if applicable)	
Are all other requirements of the New Deal met?	Yes No
If no please give further details/explanation and attach supporting evidence.	
Please sign and date here on behalf of the trust to confirm you have input and analysed the monitoring data with accuracy and believe it supports stage 3 of this 'approval to change band' request	

5. Pitfalls to avoid

Rotas monitoring into higher pay bands

i. New Deal maximum shift duration

When planning towards WTD compliant rotas it's critical to be mindful of New Deal rules that may trip you up leading to Band 3 claims you had not expected. The most challenging of these are often the rules in relation to the maximum shift duration permissible on different working patterns.

On call rotas

The 32 hour and 56 hour rule has caused havoc on many non resident rotas in the surgical sub-specialties in particular, but also in specialties such as Oncology. As WTD rules do not stipulate any limits on non resident duty hours, these areas are often overlooked when planning WTD compliant rotas.

Essentially these rules exist to ensure that after a weekday or weekend on call the junior doctor leaves on time eg 5pm following a 9am start the preceding day for a weekday on call. This of course presumes a 9am start although it's common practice for surgeons to start their normal working day at 8am.

The knock on impact of this is that surgical trainees must finish early on the day post on call, for example by 4pm, to avoid breeching the 32 hour and 56 hour rule. In reality this can be difficult to achieve if the trainee is in theatre or a clinic. It's important to note that this New Deal rule is absolute, ie it must be adhered to on 100% of occasions, so a single breech can lead to a successful Band 3 claim.

Certain provisions may be considered to minimise possible breeches:

- Ensure when a junior doctor is on call they are not rostered for a theatre list or out patient clinic on the following afternoon, which may prevent them from leaving work on time

- Roster in a half day off duty post on call to ensure the junior doctor has left work before 4pm. In reality half days are often poorly communicated by trusts and rarely taken by juniors so proceed with caution. In particular some trusts have continued to roster junior doctors for clinics and theatres on their half days off, making it impossible for the juniors to leave early. It is often far more effective to roster a full day off after on-call but this does of course have repercussions for training and the service

- If additional time off is rostered on the rota eg half days off or full days off, ensure this is communicated clearly to all the teams within the department, including junior doctors, senior doctors and nursing staff. If possible incorporate the requirement for the trainees to be off duty after eg 2pm post on call, within a departmental policy

- Consider a late start for the first day on call eg instead of coming to work at 8am roster the junior doctor to start at 10am. This would accommodate for late finishes the following day up to 6pm, without breeching the 32 hour and 56 hour rule. It is also easier to comply with a late start, compared to trying to leave early on the day post on call. The educational and service impact of late starts must be taken into account as handover and ward rounds could possibly be missed.

24 hour partial shifts

The maximum possible shift duration on these rotas is 24 hours and again this rule is absolute and so must be fulfilled on 100% occasions otherwise the rota may default to Band 3.

This makes handover on such rotas challenging and a range of different solutions are available:

- Written handover
- Electronic handover
- Creating an extended shift whereby one trainee each week comes to work 30 minutes early to take the handover from the doctor finishing their 24 hour shift before they leave.

Where resident 24 hour partial shift rotas are in operation or being considered for use, trusts must conduct their own local risk assessment in relation to the WTD compliance of these working patterns.

ii. Unbanded posts attracting pay bands supplements on monitoring

Increasing numbers of unbanded posts are being implemented at foundation level and above. Rotas with a maximum of 40 hours or less of actual work per week between the hours of 8am to7pm, Monday to Friday are paid at basic salary with no entitlement to a banding supplement. However any early starts, late finishes or shift over runs on such rotas may attract a Band 1B supplement of 40%. Therefore clear rules must be put in place to control the working hours on such rotas and if it's suspected that early starts, late finishes or shift over runs may occur from time to time, it's safer to prospectively roster in half days off on the rota to ensure the average actual hours of work never exceed 40.

This appears to particularly affect particularly foundation posts in General Practice, Psychiatry, Paediatrics and Obstetrics and the Pathology rotas in the more senior grades.

iii. Rotas monitoring in to a different band

- Band 2B to 2A; Band 1B to 1A

There are some full shift rotas that are theoretically Band 2B but when monitored can fall in to Band 2A. The latter part of the pay band represents the antisocial nature of the rota. Most people tend to judge Band A from Band B on the basis of weekend frequency. Whilst this does form the basis of part of the assessment, the other element of this assessment, known as the 'out of hours proportion', can flip a rota from Band B to Band A on monitoring.

For example, full shift rotas running on a 1:7 frequency fall in to Band 2B on theoretical analysis on the basis on the weekend frequency being 1 in 3.5, the cut off for Band 2A being 1 in 3 weekends or more frequent. However as there are so few doctors on the rota (7) the out of hours proportion is often very close to the cut off point of less than a third. When leave is factored in and these rotas are monitored they will often demonstrate an out of hours proportion of greater than a third and therefore monitor in to Band 2A. Adding more days off on these rotas does not help, in fact it further exacerbates the problem! **If planning a Band 2B full shift rota it is safer to work with rota sizes of 8 upwards.**

When planning for WTD compliance it's important to note a similar situation arises with Band 1B full shift rotas monitoring in to Band 1A. A 1:9 full shift rota will demonstrate a theoretical pay band of 1B on the basis that the weekend frequency is 1 in 4.5, with the cut off to Band 1A being 1 in 4 weekends or more frequent. However on monitoring, once leave is taken in to account, a 1:9 rota is likely to monitor in to Band 1A due to the proportion of out of hours duty. **If planning a Band 1B full shift rota it is safer to work with rota sizes of 10 upwards.**

Management of leave

Some departments manage proposed leave at the start of all rotations. All juniors meet at the start of their post and agree in advance which weeks of leave they would like to take. This ensures everyone is able to take their full leave entitlement during their posts and fewer swaps need to be made later to provide prospective cover. It is also very helpful to have a central coordinator for leave and on call swaps.

Use of junior doctor rota masters

Many trusts use junior doctor Rota Masters to facilitate the daily management of rotas. It's recommended, where trusts are planning to use junior doctors as rota masters, to ensure that:

- The junior doctors be issued with a job description outlining their role and specific responsibilities, including appropriate lines of referral and additional support available. Any remuneration should also be agreed
- They are issued with detailed training on New Deal, junior doctors' contract, pay banding and WTD requirements.

Monitoring of trainees working away from the main trust site

With Modernising Medical Careers (MMC) there are now more trainees working in placements outside the acute trusts but remaining on acute trust contracts eg foundation posts in psychiatry, general practice, academia and public health. Local agreements must be in place as to which NSH organisation will be coordinating the monitoring of these juniors. This includes distribution, collection and analysis of monitoring diary cards, in addition to the return of these juniors monitoring results twice a year to NHS Employers as part of the ministerial return on junior doctors' hours of work.

Monitoring of all junior doctors twice a year is a contractual obligation. This responsibility is likely to fall upon the employing authority and as such they must ensure monitoring arrangements are in place. Failure to monitor junior doctors can place those posts into New Deal non compliance [5].

6. Banding Appeals

The following section includes some operational advice for when trusts decide to take a rota through the banding appeal process, as per the national terms and conditions of service.

Official guidance

Excerpts from all official documents referring to the mechanisms of a Banding Appeal have been given below for reference. The DH have issued further practical guidance attached in Appendix E.

AL (MD) 1/01
Mechanism For The Allocation Of Banding

23. All junior doctors will complete the banding questionnaire. All junior doctors sharing the same rota, shift or partial shift will be assigned the same banding. Where junior doctors do not have identical duties and responsibilities as the others on the rota or shift system, however, they should be assessed separately.
24. At this first phase, regional improving junior doctors working lives action teams (or equivalent) could be involved to help resolve difficulties and to ensure consistency.
25. Where agreement is reached on banding, the employer should notify the outcome in writing to the junior doctors concerned and any relevant consultants and clinical directors. Copies of all documentation should be available to the regional improving junior doctors working lives action team (or equivalent) which will give its opinion in any case where there is a dispute or in other cases at its discretion. Where agreement cannot be reached during the initial phase, the parties will record the issues to be resolved.
26. If either party does not accept the regional improving junior doctors working lives action team's (or equivalent) opinion, there will be a right of appeal – on the grounds of fact – which will be the responsibility of the employer to operate fairly and transparently. Appeals will be heard by a local trust committee which should be convened as soon as possible and trusts are expected to do so while the doctors remain in post. The appeal panel should be constituted of two representatives of the trust nominated by the chief executive or the medical director (one of whom will chair the panel), a junior doctor representative from the trust (agreed with the junior doctor appellant) conversant with the working patterns involved, a junior doctor from a regional list supplied by the UK JDC and an independent external assessor nominated by the regional improving junior doctors working lives action team (or equivalent). No member of the panel should have been involved in the original banding allocation decision. The decision of the panel is final. The effect of the decision will be backdated to the date of the change, or to 1 December 2000, whichever is applicable.

Terms and Conditions of Service, Version 8, July 2007
22 l. Where either the employing authority or the practitioner rejects the opinion of the regional improving junior doctors working lives action team (or equivalent) in any case where there is a dispute regarding the allocation of posts to pay bands or in cases where the regional improving junior doctors working lives action team (or equivalent) finds it necessary to intervene, there is a right of appeal:

i. Appeals shall be heard by a local committee that shall be convened as soon as possible and employing authorities shall be expected to do so while the practitioner remains in post.

ii. The appeal panel shall be constituted of the following, none of whom shall have been involved in the earlier decision: two representatives of the employing authority nominated by the chief executive or medical director of the employing authority (one of whom shall chair the panel); a representative from the SR, SpR, R, SHO or HO grades from the same employing authority conversant with the working arrangements applicable to the case; a representative from a regional list supplied by the BMA's Junior Doctors Committee; an independent external assessor nominated by the regional improving junior doctors working lives action team (or equivalent)

iii. Decisions of the appeals panel which confirm the appellant(s) had been underpaid shall lead to the practitioner(s) receiving appropriate reimbursement backdated to the date of the change, or to 1 December 2000, whichever is applicable

iv. Decisions of the appeals panel which confirm the trust's original decision shall lead to the trust receiving appropriate reimbursement backdated to the date of the change, or to 1 December 2000, whichever is applicable.

At banding appeal

1. There is little point in pursuing a banding appeal if the trust is not in possession of a completed copy of the 'Approval to Change Band' proforma and all supporting documentation (see section 4g) including the following:

   i. Written confirmation of stage 1a agreement from the junior doctors
   ii. Written confirmation of stage 1b agreement from the Action Team or successor body confirming New Deal compliance and appropriate allocation to the proposed pay band
   iii. Written confirmation of stage 1c agreement from an appropriate delegated authority of the dean confirming educational approval
   iv. Written confirmation of stage 2 provisional re banding approval from the action team or successor body.

2. Always ensure that you have obtained an independent opinion from the regional action team or successor body prior to going to banding appeal. This opinion may save the time and resources involved in organising a banding appeal.

3. Consider carefully your choice of panel members representing the chief executive or medical director. Panel members should not have had prior involvement in the case but there is no specific stipulation that they must be employees of the trust. In instances where you feel detailed knowledge of the New Deal and pay banding structure would be useful, it's worth considering nominating an external representative with New Deal expertise or even a regional action team lead from a different health authority. Whilst there may be a cost involved with this approach this is minimal in comparison to losing your case on the basis that the trust representatives on the panel were unable to argue against the expertise of either the JDC or action team representative. Please note all JDC representatives will have undergone training to sit on banding appeals.

4. Consider whether you require expert representation of your case. Often trusts will lose banding appeals as their case is poorly presented and key arguments are not made. Also be prepared to cross examine juniors during the banding appeal to clarify points of information.

5. If you wish to dispute the content of monitoring data it is vital that written evidence is included in the statement of case submitted by the management side at least one week before the appeal. Do submit as much evidence as you can gather in support of any allegations you might wish to make against the validity of any data.

6. It's advisable only to take those cases to banding appeal that you are confident to pursue to an employment tribunal (ET) should you lose. Most cases taken forwards by the BMA are lodged for ET even before the banding appeal is heard.

Banding Appeals

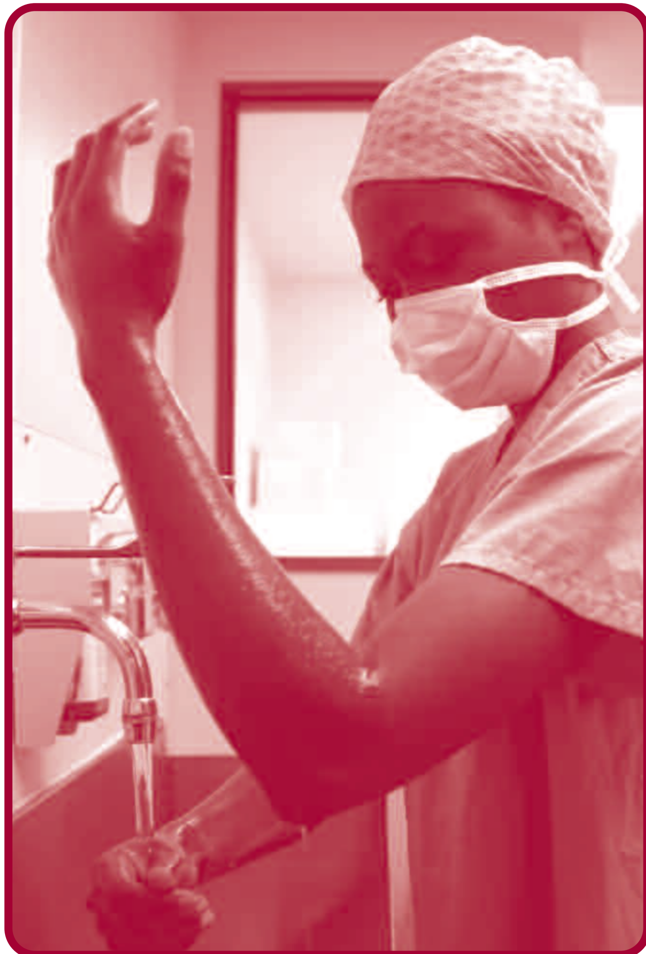
7. Additional Advice

1. If trusts employ junior doctor rota masters they must ensure that:

    i) Detailed training is provided on the New Deal and WTD requirements as well as covering areas such as pay banding and the junior doctors' contract
    ii) The junior doctor is given clear written instructions as to what is required of them from this post and the support that is available to them, including appropriate lines of referral, to enable them to deliver on the agreed outcomes.

2. Trusts should consider issuing the rota templates agreed with the SHA at induction to all junior doctors. Occasionally departmental rotas covering on call requirements have failed to make it clear that the juniors have rostered half days or full days off on the main rota template agreed with the SHA. Consequently rostered time off is not taken and the rota monitor's into Band 3. As the juniors were never formally notified of the time off on the rota these cases usually rule in favour of the juniors. A template of the type of document that could be issued to all juniors at induction is included in section 4d.

    When the juniors are issued with these templates at induction it's recommended that trusts keep a signed record of delivery and get agreement from all juniors to exception reporting, ie that the juniors will report any issues that lead to a deviation from the issued work pattern. This will allow trusts to identify problems on rotas rather than awaiting routine bi annual monitoring data and encourages a proactive partnership approach in modifying the rota.



3. Trusts should implement clear department policies specifying the expected start and finish times for junior doctor rotas within the department for the normal working day and all out of hours shifts, as well as the rostered time off on the rota. An escalation policy in line with exception reporting procedures should be included and be circulated to juniors on induction.

4. It may be possible to consider alternative resident working patterns where local trust WTD policies allow compensatory rest to be given in unpaid time and New Deal requirements are likely to be met

5. Remember that different stakeholders see the rota from a different perspective.

Quantifying the risks - What the managers see:

Potential Risk	Full Shift	PS24 (resident)	On call (non-resident)
Financial New deal non compliance Failure to meet o/n rest			
Financial New deal non compliance Breech max shift length			
Clinical goverance issues			
Challenge by HSE			
Challenge by juniors	Variable		

What the clinicians see:

Potential Risk	Full Shift	PS24 (resident)	On call (non-resident)
Loss of education and training opportunities			
Loss of the 'firm'			
Poor continuity of care			
Increased workload for consultants			
Challenge by juniors	Variable		

Points to consider with other working patterns

- Must meet New Deal requirements, avoid Band 3
  - Rest (note this will be paid time)
  - Shift length.
- Local WTD policy regarding compensatory rest
  - Paid vs unpaid time
  - Is a planned breech (PS24) legal?
- Clinical governance issues
  - Non resident working, is it safe?
- Different juniors prefer different rotas.

For the craft specialties specifically

- Full shift working with optimal cell numbers where the *true* OOH workload intensity means no other working pattern is possible
- Resident PS24 where OOH is quieter but resident cover is required
- Non resident OCR where OOH is very quiet and non resident working is safe
- Hybrid rotas are complicated but may provide the balance required for the WTD triad of patient care
- Remove overnight cover if it's demonstrated that junior doctors are not required.

Additional Advice

8. Support, evidence and guidance already available

1. Royal college guidance

In anticipation of full WTD implementation in 2009 many of the Royal Colleges have already issued helpful advice. In relation to minimum 'cell' sizes on full shift rotas these colleges have issued specific advice:

Royal College	Minimum Suggested Cell Size for 48 Hour Compliant Full Shift Rota
Royal College of Physicians [6]	10
Royal College of Anaesthetists [7]	8
Royal College of Surgeons [8]	8

2. BMA

The BMA published a useful rota design booklet in 2004[9] accompanied by guidance on monitoring[10] and handover[11].This further clarifies the New Deal rules and possible rota patterns.

3. NHS

To support WTD implementation in 2004 the former NHS Modernisation Agency issued rota design guidance to the service[12].

4. 'Cell Of 11'[13]

Studies were undertaken within NHS North West to understand the impact of different rota patterns, and more specifically, full shift working upon normal working day availability. Anecdotal reports were that juniors' presence was felt to be reduced but there was a need to quantify this perception. Given most training opportunities and service delivery takes place during the daytime it also seems sensible to try and maximise daytime availability on 48 hour rotas being planned for WTD compliance.

In addition to this there are many sensible reasons as to why we should be reducing the exposure of individuals to night shift working:

1. Performance is poorer overnight, individuals are more likely to make errors particularly when working consecutive night shifts [6 14]
2. Learning potential is poorer overnight [13]
3. Negative impact upon health of working shifts but particularly night shift working.

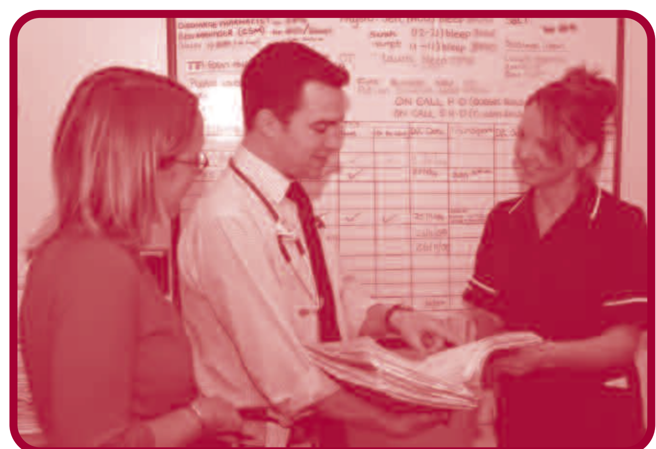
Minimise exposure to night working

How?

- Increase pool of doctors providing cover overnight
  - Hospital at Night
  - Reconfiguration or services
  - Employ more juniors.

- Improve rostering to minimise number of consecutive night shifts worked by any individual

- Structured rest may compensate for sleep loss and published literature on coping with shift work.



The Normal Working Day

The results from 'normal working day' (NWD) analyses on different working patterns is given below. These results demonstrated in order to meet the NWD availability on an eight person full shift rota at 56 hours, as per the minimum recommendation by the Academy of Royal Colleges and the BMA in 2004, at least 11 doctors would be required on a 48 hour full shift rota.

On call vs 56 hour and 48 hour full shift rotas
– NWD availability over six months

Number of Doctors/Rota	Days available 9-5 in 6 months (full shift) 48	Days available 9-5 in 6 months (full shift) 56	Days available 9-5 in 6 months (resident on call)
6	44	65	100
7	55	74	100
8	**64**	**80**	**100**
9	71	83	100
10	74	84	100
11	**79**	86	100
12	83	87	100
13	86	88	100
14	87	89	100
15	90	90	100

On Call vs 56 Hour and 48 hour Full Shift Rotas
– NWD availability per week

Number of Doctors	48 hour week	56 hour week	On call rota
6	1.68	2.51	3.85
7	2.13	2.85	3.85
8	**2.47**	**3.10**	**3.85**
9	2.74	3.18	3.85
10	2.85	3.25	3.85
11	**3.03**	3.3	3.85
12	3.18	3.35	3.85
13	3.31	3.38	3.85
14	3.35	3.42	3.85
15	3.45	3.45	3.85

Taking this methodology further the NWD availability on different resident and non resident working patterns were also compared.

Comparison NWD availability across different working patterns

- Non resident
- As expected NWD increases on patterns with longer permissible shift lengths.

	56 hour rota		48 hour rota							
Rota type	Full shift (56hrs)		Full shift (48hrs)		PS16 (non-res)		PS24 (non-res)		On-call (non-res)	
Number of juniors on rota	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months
6	65.3	2.5	43.7	1.7	65.3	2.5	69.7	2.7	82.7	3.2
7	74.0	2.8	55.4	2.1	74.0	2.8	77.7	3.0	88.9	3.4
8	80.5	3.1	64.3	2.5	77.3	3.0	83.8	3.2	93.5	3.6
9	82.7	3.2	71.1	2.7	79.8	3.1	85.6	3.3	94.2	3.6
10	84.4	3.2	74.0	2.8	81.8	3.1	87.0	3.3	97.4	3.7
11	85.8	3.3	78.7	3.0	83.5	3.2	88.2	3.4	100.0	3.8
12			82.7	3.2						
13			86.0	3.3						
14			87.0	3.3						

Comparison NWD availability across different working patterns

- Resident
- The NWD availability on the resident rotas are fairly comparable and perhaps more favourable with a 24 hour partial shift.

	56 hour rota		48 hour rota					
Rota type	Full shift (56hrs)		Full shift (48hrs)		PS16 (non-res)		PS24 (non-res)	
Number of juniors on rota	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months	Days present 9-5 per 6 months
6	65.3	2.5	43.7	1.7	48	1.8	48.0	1.8
7	74.0	2.8	55.4	2.1	55.4	2.1	59.1	2.3
8	80.5	3.1	64.3	2.5	64.3	2.5	67.5	2.6
9	82.7	3.2	71.1	2.7	71.1	2.7	71.1	2.7
10	84.4	3.2	74.0	2.8	76.6	2.9	78.8	2.9
11	85.8	3.3	78.7	3.0	78.7	3.0	81.1	3.1
12			82.7	3.2	82.7	3.2	84.8	3.3
13			86.0	3.3	86.0	3.3	88.0	3.1
14			87.0	3.3	87.0	3.3		

Conclusion

Good rota design is not easy, and can be a time consuming exercise when done well. Hopefully it has been clearly demonstrated that time invested in rota design is time well spent. It's hoped this booklet will provide useful information to support NHS trusts in the move towards full WTD 48 hour compliance for all junior doctors.

Best of luck to you all.

Yasmin and Masood

9. Appendices

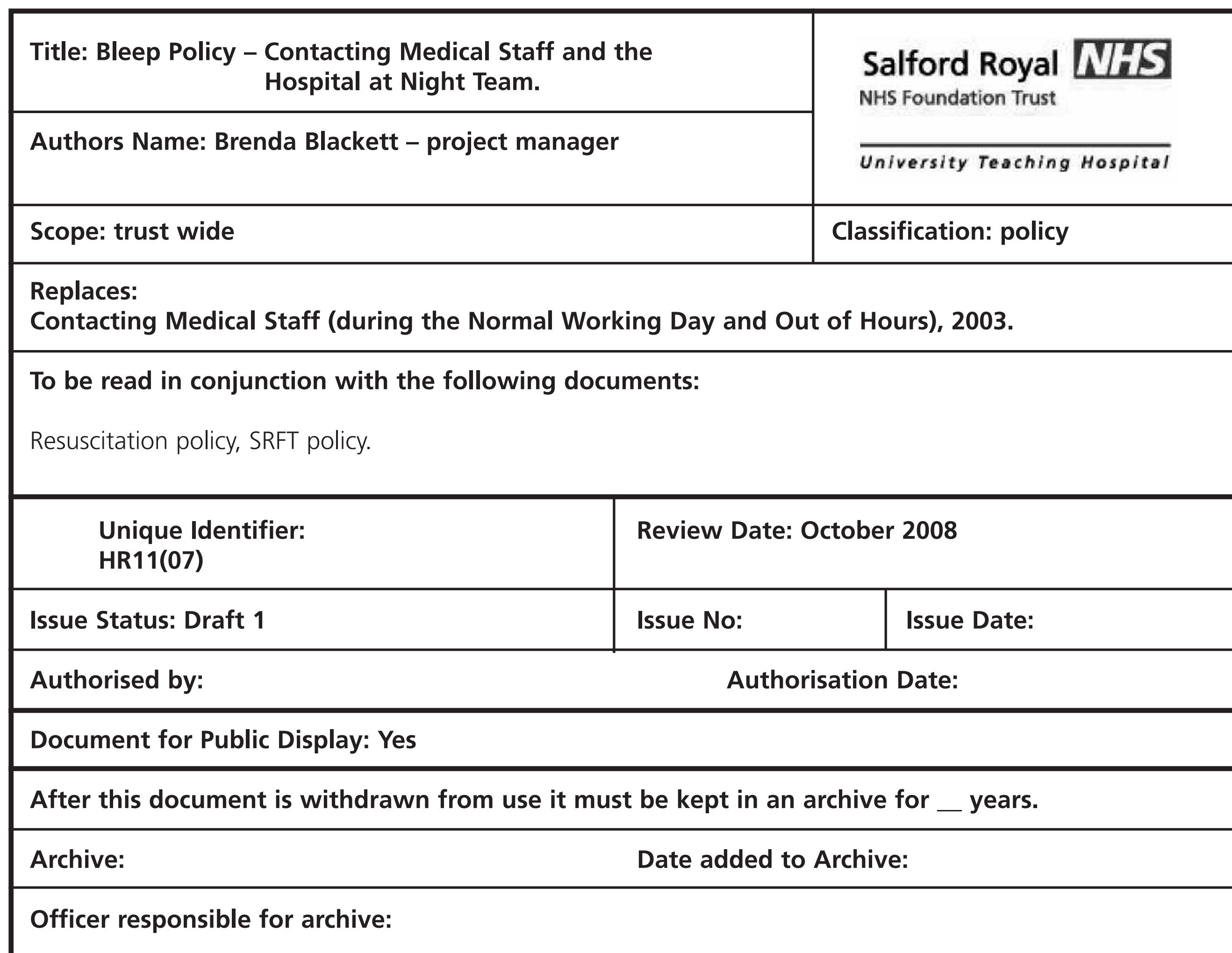
Appendix A
Software tools available to support rota design

Doctors Rostering System
www.drsusers.com

‘Rotaworks’, Zircadian
www.zircadian.com

Appendix B Example Bleep Policies

Example bleep policy 1



Title: Bleep Policy – Contacting Medical Staff and the Hospital at Night Team.	Salford Royal NHS NHS Foundation Trust University Teaching Hospital
Authors Name: Brenda Blackett – project manager	
Scope: trust wide	**Classification: policy**
Replaces: **Contacting Medical Staff (during the Normal Working Day and Out of Hours), 2003.**	
To be read in conjunction with the following documents: Resuscitation policy, SRFT policy.	

Unique Identifier: HR11(07)	Review Date: October 2008	
Issue Status: Draft 1	**Issue No:**	**Issue Date:**
Authorised by:	**Authorisation Date:**	
Document for Public Display: Yes		
After this document is withdrawn from use it must be kept in an archive for __ years.		
Archive:	**Date added to Archive:**	
Officer responsible for archive:		

Policy Statement

Medical staff should be available via their bleep or pager to ensure registered professionals are able to contact them as a matter of urgency. However as doctors working hours are being reduced in line with the WTD 2009 the inefficient use of the bleep system can disrupt their workload, and as a consequence routine tasks take longer to complete with the effect of those not completed being passed inappropriately to the out of hours service.

There need to be guidelines for contacting medical staff during normal working hours, and in conjunction with the Hospital at Night project for contacting medical staff during the out of hours service, in order to consolidate existing good practice relating to effective communication and patient safety between the multidisciplinary teams.

1.0 Roles and responsibilities:

1.1 The executive medical director and executive nurse director are responsible for ensuring trust wide compliance with the policy.
1.2 All medical staff are responsible to the executive medical director to ensure individual compliance with this policy.
1.3 Deputy director of nursing and governance, ADNS and matron are responsible to the executive nurse director to ensure the policy is implemented within each directorate across the trust.
1.4 Ward/ department managers have a responsibility to the ADNS and matron for implementing the policy at local level and ensuring compliance.
1.5 All trust staff have a responsibility to comply with the policy.

2.0 Protocol

2.1 Crash calls and life threatening emergencies.
- The crash call procedure is initiated by the switch operator on receipt of a **2222** call from any ward or department.

2.2 Contacting Medical Staff during Normal Working Hours.

During normal working hours medical staff should only be bleeped between their routine visit to the ward for genuine urgencies.

In order to reduce the need to use the bleep system guidelines have been developed to enhance effective communication between the medical staff and clinical areas.

- The doctor should communicate the next planned visit to the clinical area to the coordinator
- The doctor is responsible for informing the clinical area coordinator of any bleep free time (for breaks, study, attendance of handover etc)
- There should be a communication system in the clinical area (book, whiteboard etc) where all tasks and nonurgent work for medical staff can be logged for the next planned visit
- Medical staff can also leave nonurgent messages or comments using the above method.
- All nonurgent routine work should be completed by the ward based team during normal working hours to reduce the amount of uncompleted work passed on to the out of hours' team
- The doctor must contact the coordinator of the clinical area on arrival and before departure.

If there is the need to bleep the medical staff for urgent reasons the following guidelines should be used:

- If possible the ward coordinator or shift leader should be responsible for contacting and communicating with the doctor
- The trust EWS algorithm should be followed if a patient has a score of three or above
- All bleeps made to doctors should be logged with time, bleep number and reason for the bleep in the patient's care record by the nurse responsible for bleeping and communicating with the doctor.

2.3 Contacting medical staff out of hours.

- Between the hours of 5pm and 9pm weekdays and daytime at weekends from 7.30am until 9pm the Medical Staff must only be bleeped for urgent calls, as during normal working hours, with routine jobs being allocated to the on call teams planned visits
- Wards must utilize staff with extended role skills to complete patient care where appropriate (venepuncture, cannulation, catheterization etc) calling for medical assistance only when a patients' condition determines the need for medical input
- Out of hours between the hours of 9pm and 7.30 am the Hospital at Night Team is responsible for the review of patients across the trust (excluding specialty services which will continue to use the bleep method for contacting their on call team), and all calls must be filtered through to the night site coordinator via the rapid response system or bleep 3092, to allow the priority of patient care and the allocation of each request to the most appropriately competent member of the available Hospital at Night Team.

- The Hospital at Night team consists of:
    - Medical and surgical on call doctors from 9pm until 7.30am (excluding specialty services)
    - The night site coordinator
    - The bed manager
    - nurse clinician
    - clinical support.

All bleeps/calls to medical staff, nurse clinician and clinical support must be directed to the night site coordinator between the hours of 9pm and 7.30 am (via the Rapid Response System or Bleep 3092). Any bleep directly to the above members of the hospital at night team between these hours will be redirected by the individual to the night site coordinator.

- Bleep filtering is a key component of Hospital at Night as it minimizes the inappropriate bleeping of doctors and helps redistribute work effectively. See Appendix 1 for Hospital at Night bleep filtering Chart.

- The process of Bleep Filtering will be assisted by the Trust rapid response Bleep Filtering System in conjunction with the Hospital at Night project.

3.0 Policy implementation plan

3.1 This Policy will be placed on synapse for information.

3.2 All ADNS, matrons, lead nurses and ward managers will be responsible for the distribution and implementation of the policy in their clinical area.

3.3 The executive medical director will be responsible for the dissemination of the policy to all doctors/ medical staff within the trust.

3.4 A date for the commencement of the bleep filtering will be set between the project manager, night site coordinator and the Hospital at Night team, with the ADNS, matrons, lead nurses, ward managers and clinical areas aware of a live date ensuring all staff comply with the policy.

3.5 The ward managers need to ensure adequate numbers of staff are trained where appropriate in enhanced roles and that these skills are then utilized in accordance with the policy.

4.0 Monitoring and review

4.1 It's the responsibility of medical and nursing staff to monitor the compliance with this policy on an ongoing basis, reporting any noncompliance to their clinical lead.

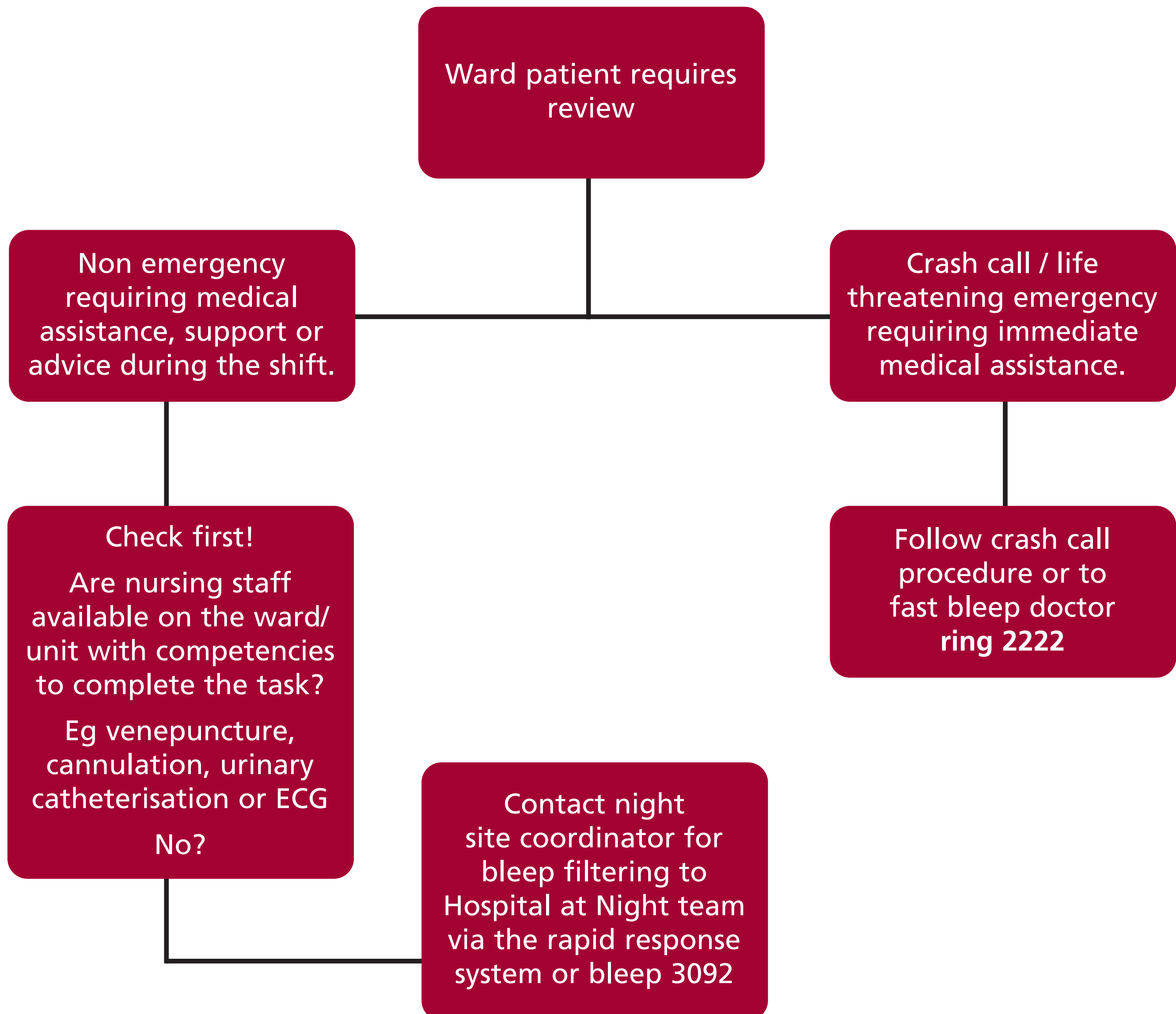
4.2 The night site coordinator has a responsibility on a regular basis to evaluate the effectiveness of the bleep filtering in conjunction with the Hospital at Night Team.

On implementation of the rapid response system in the trust accurate audit data will be available from the system for review.

Bleep Filtering Chart

Hospital At Night bleep filtering between 21.00hrs and 07.30 hrs

All ward staff must follow this chart between these hours. Any call directly to individual members of the Hospital at Night Team will be redirected by the individual to the Hospital at Night site coordinator.



Endorsed by:		
Name of lead clinician/manager or committee chair	Position of endorser or name of endorsing committee	Date
Bob Young	medical consultant	May 2007
Chris Ward	ADNS critical care	April 2007
Stephen Waldeck	executive medical director	April 2007

<table>
<tr><td colspan="5">Record of Changes to Document - Issue number: 3</td></tr>
<tr><td colspan="4">Changes approved in this document by - Corporate Governance and Risk Management</td><td>Date: 7/7/05</td></tr>
<tr><td>Section Number</td><td>Amendment
(shown in bold italics)</td><td>Deletion</td><td>Addition</td><td>Reason</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Example bleep policy 2

Hospital At Night and iBleep Policy

All outstanding ward requests to be entered on iBleep from 20:00.

General Surgery

- Handover at 20:00 SHARP
- An all doctor bleep will go out at 19:50
- Assemble in night team office
- Night coordinator will lead the handover
- No one may leave until the handover is completed, this will be enforced
- Night coordinator to record all sick patients and all outstanding jobs on the night proforma
- Needs full name first (SHO) will cross cover with urology
- Needs full name first (SpR) is non resident from 22:00
- All request for SpR calls via switch after this time.

Urology

- Handover at 20:00 SHARP
- An all doctor bleep will go out at 19:50
- Assemble in night team office
- Night coordinator will lead the handover
- No one may leave until the handover is completed, this will be enforced
- Night coordinator to record all sick patients and all outstanding jobs on the night proforma
- SHO will cross cover with general surgery
- SpR is non resident from 22:00
- All request for SpR calls via switch after this time.

Trauma And Orthopaedics

- Handover 20:00
- An all doctor bleep will go out at 19:50
- Assemble in night team office
- Night coordinator will lead the handover
- No one may leave until the handover is completed, this will be enforced
- Night coordinator to record all sick patients and all outstanding jobs on the night proforma. Note: As of 5th August, there is no cross over
- SpR is non resident from 22:00
- All request for SpR calls via switch after this time.

Remember, if you request the registrar to attend, let the night coordinator know when the registrar is on site

Example bleep policy 3

Manchester Mental Health and Social Care Trust

Junior Doctors Bleep Procedure

Introduction

This policy seeks to consolidate existing good practice relating to communication between nursing and medical staff.

A bleep is a device that enables urgent contact to be made with junior doctors (needs to be explicit). It's counter productive if used for routine, non urgent calls. In general a bleep should not be used unless there is a good reason to call the doctor immediately.

Aims

- To make the most effective use of junior doctor clinical time
- To enable junior doctors to take the necessary breaks to comply with the New Deal and Working Time Directive (WTD)
- To aid communication between medical and non medical staff
- To ensure that the bleep system is used for urgent calls only.

Protected Hours

Particular care should be taken when bleeping doctors between the following times, to ensure that natural breaks and continuous rest (in order to comply with the New Deal and WTD) are achieved:

12:00 – 14:00
17:00 – 19:00
22:00 – 08:00

Within these hours doctors should only be bleeped for urgent calls (defined below).

Life Threatening Emergencies

In this situation, the crash team should be called according to procedure. Where the crash call has been replaced with a 999 call the junior doctor should be bleeped.

Urgent Calls

Urgent calls are defined as:

- Any major change in a patient's general condition that will not wait until the doctor's next routine visit
- Distressing symptoms, which may cause the patient undue suffering if not dealt with before the next routine visit of the doctor to the ward
- Relatives requiring to speak with the doctor because of deterioration in a patient's condition
- The arrival of an urgent admission
- A & E presentations
- Suicide presentation
- Overdoses

This list is not exhaustive.

Non Urgent Calls

Good planning can reduce the need for non urgent bleeps. Junior doctors should take care to communicate with nursing staff during the day to ensure that all routine ward work, which cannot be delayed until their next planned visit, is completed.

When bleeping a doctor it should be considered whether the issue could wait for the next planned visit of the doctor. To facilitate this:

- The ward should be aware of the doctors next planned visit. A system should be in place so the ward will have a readily available record of the doctor's next visit

- Out of usual working hours medical staff should visit all wards at pre arranged time(s) to deal with queries or problems. Although it's recognised that unforeseen events and emergencies will take precedent and therefore delays to visits are possible

- Each ward should keep a list or book to communicate requirements/tasks for the junior doctor at the next ward visit. Nursing staff should list all the routine and non urgent tasks for the doctor to carry out. The doctor should confirm with the nursing staff that an item has been completed and sign the list or book for verification.

Junior doctors should not be called to deal with the following matters, particularly within the protected hours defined above:

- If a patient suffers a mild fall (and the nursing team is confident there has been no injury) or is briefly missing, where there is a member of the nurse management team available to deal with this
- The writing/rewriting of prescription charts. It's therefore essential that junior doctors ensure they have written up or rewritten any necessary prescription charts before the end of their shift
- To take routine bloods.

This list is not exhaustive.

Bleep Holders Duties

Bleep holders have a duty to answer calls promptly. If this is not possible, ask someone else to answer for you, take a message and determine if the message is urgent or not. When a patient is seen, a note should be made in the patients record of the time, date, details and any action taken.

Using a Bleep

Between 09:00 and 17:00 a designated member of the nursing team within a ward will be responsible for coordinating the usage of the bleep system. It will be decided locally who will take on this responsibility. This should avoid unnecessary duplication of calls.

Between 17:00 and 09:00 the night manager will coordinate all calls to the bleep. The night manager will be responsible for ensuring that the doctor is bleeped according to this policy (at Manchester Royal Infirmary between 17:00 and 09:00 the doctor will continue to be bleeped by a designated member of the nursing team within a ward).

All managers must ensure that those responsible for bleeping doctors comply with this policy.

Monitoring

The effectiveness of this policy will be monitored through the six monthly Department of Health Ministerial Returns. These returns will highlight whether there is an improvement in compliance with the rest requirements of the New Deal and WTD.

Appendix C
Sample WTD policy

South Manchester Hospitals (NHS) Trust
Monitoring Of Hours Policy – Junior Doctors

1.0 Introduction

South Manchester Hospitals NHS Trust is committed to safe working practices for all junior doctors in training. The New Deal as set out in HSC 1998/240 and the Working Time Directive (WTD) that came into effect on 1st August 2004, set down standards that put limits on the hours that junior doctors work, thus ensuring that adequate rest is taken.

It's recognised that a continuous and robust system of monitoring junior doctors' hours and work intensity is established that involves all junior doctors within the trust. Monitoring of hours is a mutual obligation for both the employer and the junior doctor.

The implementation of the new pay banding system in December 2000 was dependent upon the capture of timely and accurate monitoring data. The arrangements set out in this policy will ensure that where possible pay banding will accurately reflect the intensity and hours that the doctors actually work.

2.0 Who The Policy Applies To

The policy applies to all junior doctors who work at South Manchester Hospitals NHS trust. It also includes doctors who participate in rotas which include junior doctors in training, so that an accurate assessment of the doctors' workload can be made. This includes researchers, and staff grades.

3.0 Method Of Monitoring

3.1 Paper work diaries will be issued to each doctor participating in the work study

3.2 The study of all rotas will be performed over a six month period starting April and October each year

3.3 Monitoring will be undertaken for a period of 14 days to include two weekends, or for a period agreed with the clinical director

3.4 If there is disagreement about the outcome of a work study, or if the results are inconclusive, a further exercise will be taken within the specialty.

4.0 Analysis And Evaluation

4.1 The information received from the work intensity studies will be analysed by the medical personnel department and a summary report will be submitted to each division, directorate, the improving junior doctors working lives (IJDWL) team at the strategic health authority (SHA), the executive board and the trust board.

5.0 Pay Banding

5.1 Pay banding for additional duty hours will be dependent on the results of monitoring.

5.2 Pay bands are allocated as Appendix One.

5.3 Where a pay band is disputed, junior doctors must:
- Monitor their working pattern for a period of 14 days, to include two weekends
- The findings will then be discussed at a hearing. The panel will include, the clinical director, the directorate manager, the medical personnel manager and at least one junior doctor from the rota.

5.4 If following monitoring, a decision to reduce a pay band is made on the basis of change to working practice, the following information must be sent to the IJDWL team:
- Details of any change in working practice
- The monitoring data analysis
- The agreement of the post holder(s)
- The agreement of the clinical tutor.

5.4 Where a pay band is changed to a lesser amount, junior doctors will have their pay protected as per Appendix Two.

6.0 Responsibility Of The Medical Personnel Department

It's the responsibility of the medical personnel department:

- To examine, advise and provide solutions on junior doctor rotas
- To facilitate monitoring studies for each junior doctor rota
- To summarise and analyse studies in accordance with NHS Executive guidelines
- To compare results of monitoring with New Deal and WTD criteria and highlight areas of non-compliance
- To facilitate the pay banding process. Decisions should be made on the basis of valid and accurate monitoring studies
- To ensure that senior and junior doctors, managers and nursing staff are educated and aware of the New Deal.

7.0 Responsibility Of The Division

7.1 It's the responsibility the division to ensure that every junior doctor participates in the work intensity studies as set out in terms and conditions of service. Sanctions in the event of failure to monitor are set out at Appendix Three.

7.2 Clinical Directors and Directorate Managers will work with the doctors participating on the junior doctor rota to address any difficulties, exploring alternative arrangements and working patterns with the aim of finding solutions in order to ensure that rotas comply with the New Deal and WTD.

7.2 The Medical Personnel Manager will provide assistance where needed, offering support and advice to divisions.

8.0 Responsibility Of The Junior Doctor

It is the responsibility of the junior doctor to:

- Record data on hours worked when asked to do so by the trust as set out in the terms and conditions of service
- Forward recorded data to the medical personnel department promptly for analysis and evaluation
- Work with the trust to identify appropriate working arrangements or other organisational changes in working practice, when changes to a rota are deemed to be necessary
- Comply with changes to working practice when implemented
- Be proactive about taking rest and natural breaks as set out in the New Deal and WTD
- Make the trust aware if they work hours that are different than those set out in the rota.

9.0 WTD And Compensatory Rest

9.1 The WTD stipulates that 11 hours continuous rest should be achieved as a minimum period off duty between duty periods. Where 11 hours continuous rest is not achieved, junior doctors will be expected to take compensatory rest in unpaid time as soon as their duty is complete.

Pay Banding Supplements

Band: average hours	From 1/12/00	From 1/12/01	From 1/12/02
3 non compliant with New Deal	62% (1.62)	70% (1.72)	100% (2)
2A 48-56 hours most intense	50 (1.5)	60% (1.6)	80% (1.8)
2B 48-56 hours least intense	42% (1.42)	42% (1.42)	50% (1.5)
1A 40-48 hours most intense	42% (1.42)	42% (1.42)	50% (1.5)
1B 40-48 hours middle intensity	30% (1.3)	30% (1.3)	40% (1.4)
1C 40-48 hours least intense	20% (1.2)	20% (1.2)	20% (1.2)

The total salary of junior doctors will comprise of a base salary to which a non pensionable supplement calculated. The figure in brackets shows the total salary expressed as a multiple of the base salary.

Appendix D
Example natural break policy

Title: Junior Doctor Hours and Breaks Breach Policy

Purpose:
To ensure junior doctors hours of work comply with the requirements and limits of working as set out under New Deal and European Working Time Directive.

Documentation Application:
This policy relates to all junior doctors.

Responsibilities For Implementation:
Trustwide responsibility is required for the success in the implementation of this policy. Directorate managers are required to investigate a breach of shift or natural break.

Date Issued:
August 2007

Date Revised:
n/a

Review Date:
August 2008

Author:
Noreen Akram, human resources

References (If Applicable):

Intranet Category For Location:
Human resources

Background

1.1 Under terms and conditions of service, all junior doctors in training (includes junior doctors in non training posts participating on the rota and referred to as junior doctors hereafter) are required to comply with the requirements and limits on hours of working as set out in HSC 1998/240 and HSC 2003/001. The trust and junior doctors have a duty to ensure that junior doctors work within the approved working pattern for their grade and specialty.

1.2 Junior doctors and the trust have a joint responsibility to ensure that they do not commence or finish work later than the agreed start and end times. In addition, it sets out the responsibilities of the junior doctor to take whatever action is necessary to ensure a natural break is taken and the process to follow in the situation where a natural break cannot be taken within the timeframe outlined in section 3 below.

1.3 It's imperative that the each division introduces such mechanisms to safeguard not only the health and safety of its junior doctors but also to ensure that they are well rested to provide the highest quality of care to our patients. Failure to implement this policy effectively also puts junior doctor posts at risk of becoming non compliant and attracting pay band 3.

Shift lengths

2.1 It's not uncommon for junior doctors to arrive at their workplace earlier than the start time of their shift, often to avoid traffic or to attend consultants meetings. Unless instructed to do so by an authorised and senior member of the trust, they should not declare this as time in work as this is their own free time.

2.2 Similarly to 2.1 above, where a junior doctor does not leave their workplace at the end of their shift time, it should not be declared as time in work unless instructed to do so by an authorised and senior member of the trust.

2.3 Doctors working on an on call rota providing on call duties Monday to Thursday nights are required to be on duty no more than 32 hours at a stretch. For this to be possible, finishing times on the day following on call must adhere to the following principles:

2.3.1 Any doctors presenting themselves earlier than 9.00am at the commencement of their on-call day, do so at their own volition and must notify the Directorate Manager of their reasons for doing so.

2.3.2 Doctors providing on-call that day, who have commenced duty at 9.00am, must complete their duties at 3.00pm the following day. They are not required to be present after that time.

2.3.3 If due to clinical commitments, it appears likely that the shift will extend beyond the required finishing time, the junior doctor must notify their consultant for advice no later than an hour before the scheduled finish time. The directorate manager should also be notified who will record this fact (see Appendix A – Hours Breach Report) and any agreement made with the consultant on behalf of the trust to extend the finish time. Any extension to the finishing time must be solely for emergency clinical work.

2.4 Wherever possible, junior doctors shall not be rostered for commitments such as clinics, post on-call. If they are, the trust must ensure that they can leave that clinic early. For example if the end of shift time is 3pm, post on call, and the junior doctor is required to attend clinic in the afternoon, they must leave clinic at 3pm. Failure to do so will result in the post becoming non compliant and Band 3.

2.5 In most circumstances, the junior doctor will be required to finish at their designated time. Only in exceptional circumstances will they be required to continue working after this time.

Natural Breaks

3.1 Junior doctors must ensure that they take the required half hour break for their working pattern. For example, for a standard working day of 9am – 5pm, a natural break should be taken between midday and 2.00pm Monday to Friday.

3.2 It will be the junior doctors' responsibility to take a continuous suitable break of 30 minutes, notifying their immediate clinical team that they are taking a break and that they are not to be contacted except in an emergency.

3.3 Junior doctors should notify the directorate manager when it has not been possible to take a suitable break, citing the reasons for this. The directorate manager will record each breach (see Appendix B – Natural Break Breach Report). These incidents will then be taken up with the relevant consultant team by the directorate manager to ensure full compliance with this aspect of the junior doctors' hours regulations.

3.4 Theatre and clinic overruns will become the responsibility of the consultant where they are required to relieve junior doctors of their duties so that they can take a natural break. The consultant must make it explicit to the junior doctor that they are required to take a break.

3.5 If the junior doctor wishes to forfeit their natural break for their own reasons, they may do so but this will not be at the behest of the trust, and cannot form the basis of a failure by the trust to comply with Working Time Directive (WTD) or New Deal, nor can it result in posts being allocated pay band 3. If a junior doctor forfeits their natural break of their own volition, they must also report this on every occasion to the directorate manager where it will be recorded accordingly.

Responsibilities

4.1 All directorate managers in conjunction with their consultant team should ensure mechanisms are in place to support the taking of natural breaks. As part of this process, notices on wards and ward phones should inform other ward staff of the requirement for junior doctors to take natural

breaks and set out 'bleep free' periods when ward staff should refrain from contacting junior medical staff (except in an emergency).

4.2 It will be the junior doctors' responsibility to take a suitable break, notifying their immediate clinical team that they are taking a break and that they are not to be contacted for a period of 30 minutes, except in an emergency.

Communication

5.1 The above requirements will be communicated widely to all consultant teams, nursing staff, directorate managers, divisional general managers and the wards. Explicit reference to these arrangements will be made at junior doctor induction with a hard copy handed out to all new appointments.

5.2 Each directorate will feedback to junior doctors regularly regarding overruns and incidents which precluded junior doctors from taking a natural breaks and complying with the working pattern.

Agreement and Review Date

6.1 This agreement has been reached with the divisions and representatives of the (needs full unabbreviated names first) SHO and SpR grade.

6.2 This policy will be reviewed annually following each period of monitoring or earlier if the need arises.

6.3 This policy has been approved by the capital and workforce planning meeting held on 6th July 2007.

Implementation date: 1st August 2007
Review Date: Following annual monitoring of junior doctor hours or earlier if required

Hours Breach Report

Name		Bleep number	
Grade		E mail	
Department		Consultant	

Day		Date	

Working pattern		
		Full shift
		On call rota
		No on call
		Other (specify)

Shift type		
		Normal working day
		Long day
		Night shift
		Other (specify)

Type of breach *(tick as many as applicable)*		
		Early start (than agreed start time)
		Late finish (than agreed finish time)

Was the breach voluntary?	Yes	No

Who did you notify?		
		Ward sister
		Directorate manager
		Consultant
		SpR
		SHO
Name		

Why did you start earlier/finish later than your agreed start/finish time? *(this section must be completed in detail)*

What action was taken by the person you notified?

Please forward this form to your medical staffing department within 24 hours of your failure to take a natural break.

For office use	Referred to	DGM	DD	DM	CD	Other *(specify below)*
	Other action taken					

Hours Breach Report

Name		Bleep number	
Grade		E mail	
Department		Consultant	

Day and date		Shift times	

Shift type		
		Normal working day
		Long day
		Night shift
		Other (specify)

Type of breach *(tick as many as applicable)*		
		Lunch break
		Early evening break (for doctors on long days)
		Night shift break (early 20:00 to 02:00)
		Night shift break (late 02:00 to 08:00)

Was the failure to take a natural break voluntary?	Yes	No

Who did you notify?		
		Ward sister
		Directorate manager
		Consultant
		SpR
		SHO
Name		

Why was it not possible to take a break? *(this section must be completed in detail)*

What action was taken by the person you notified?

Please forward this form to your medical staffing department within 24 hours of your failure to take a natural break.

For office use	**Referred to**	DGM	DD	DM	CD	Other *(specify below)*
	Other action taken					

Example natural break policy 2

Guidance on Directorate Protocols For Natural Breaks Do You Give Your Junior Doctors A Break?

Under the New Deal Regulations for house officers, senior house officers and specialist registrars, the following applies to the provision of 'natural breaks'.

"Within full shifts natural breaks will be needed away from clinical duty. It is reasonable to provide at least a 30 minutes break after approximately four hours' continuous duty. Trusts should devise working practices which allow proper cover for these absences (these natural breaks must also, of course, be provided during the normal working day, for doctors on on call rotas or partial shifts and should not be considered part of their rest periods)." – Quote must be cited

This is a new requirement, and a change of culture, and needs the trust to manage not just the work but the breaks of the doctors. For normal working days, it means getting a lunch break of at least 30 uninterrupted minutes at some time ideally between 12pm and 2pm. Also for those doctors working a longer duty say 9am to 11pm, it means both a lunch and 'teatime' break. Uninterrupted means bleep free (except for emergencies / crash bleeps).

Directorate Checklist

- Do junior doctors in your directorate have written protocols in place for these breaks?
- Are these protocols robust and working in practice? For instance, what is done to ensure that the on call doctor receives their breaks?
- Is the trust bleep policy adhered to, so that lunch time break is protected apart from emergency bleeps?
- Are new doctors in February and August briefed and aware of the requirements and encouraged to observe their breaks as part of the process of having their duty patterns fully explained?
- Have other colleagues been briefed where appropriate ie senior colleagues and nursing staff, to expect and respect that junior doctors will be taking these breaks?
- Since education is counted as work under the New Deal, if lunches are provided in connection with teaching sessions, are these lunches at least a half hour duration, and before the commencement of the formal teaching?
- Travelling between sites is counted as work and not as a break. Is traveling time allowed for in addition to time for natural breaks when considering when morning duties end and afternoon fixed commitments begin?
- Have the directorate's written protocols on natural breaks been copied to the New Deal project officer for reference when carrying out New Deal monitoring of the junior doctors?
- Is there a mechanism for reporting any problems the juniors may have in taking these breaks? Who should they report to? Is this included in the written protocol?

Why Treat This As Important?

As the overall hours targets are met for junior doctors, the focus shifts to the rest targets under New Deal, and to the requirement to be able to take breaks. Breaks must be taken to meet New Deal.

From August 2003 they are a contractual requirement for all junior doctors. The trust monitors junior doctors' hours at least once every six months and this includes the taking of natural breaks. They must be taken on at least 75% of occasions, during every type of duty that the doctor works.

If natural breaks are not taken as required, the trust could face a claim for Band 3 pay banding for all junior doctors on that duty pattern. This is a significant financial penalty. Also continual non compliance of posts and/or no action to resolve could lead to the postgraduate dean removing training recognition temporarily and ultimately taking this away forever. This would lead to the loss of 100% basic salary funding and difficult to recruit to trust grade posts.

The trust directorate management needs to firmly implement these breaks, and work with the doctors to improve the protocols where they do not prove

practical, asking the doctors to flag up any problems, in writing to the directorate, as soon as possible.

Role of Medical HR

At the juniors trust induction day, natural breaks are discussed in the context of New Deal regulations and monitoring. We will point the doctors in the direction of being aware of and adhering to their directorates protocols and policies in this regard.

Any problems revealed through the regular monitoring carried out by medical HR will be reported to the directorate.

Please find enclosed a poster which may be used as part of the directorates induction process, or within the directorates written protocols, including for doctors joining at times other than the August/February changeover dates ie specialist registrars etc.

Roland Turner
New Deal project officer - medical HR

JUNIOR DOCTOR – TAKE YOUR BREAKS

It's A Natural Break!

IT'S A NATURAL BREAK !
AT LEAST 30mins EVERY 4 HOURS

DO YOU KNOW AND ADHERE TO THE BREAK PROTOCOLS WITHIN YOUR DIRECTORATE? IT IS REQUIRED IN YOUR CONTRACT, UNDER THE NEW DEAL RULES, TO TAKE THEM (EXCEPT IN EMERGENCY OR EXCEPTIONAL CIRCUMSTANCES).

NOT TEN MINUTES SNACKING A QUICK SANDWICH WHILST FILLING IN THE PAPERWORK AND GULPING DOWN A QUICK DRINK ON THE WARD, BUT A PROPER BREAK !

For all Junior doctors, the following applies, to the provision of "**natural breaks**".

"Within full shifts natural breaks will be needed **away from clinical duty**. It is reasonable to provide **at least a 30 minutes break after approximately four hours' continuous duty**. Trusts should devise working practices which allow proper cover for these absences. (These natural breaks **must** also, of course, **be provided during the normal working day**, for doctors on on-call rotas or partial shifts and should not be considered part of their rest periods.)"

SO FOLLOW THE PROTOCOL AND TAKE A BREAK. IF THE PROTOCOL ISN'T WORKING – LET THE DIRECTORATE KNOW IN WRITING AS SOON AS POSSIBLE, SO ACTION CAN BE TAKEN.

Appendix E
Banding Appeal Guidance

Protocol for the rebranding of Training grade posts

Issue

1. There has been some confusion and variable quality of process during the exercise to bring PRHO posts into compliance for the 1st August 2001. As a result, the national issue of further joint guidance and documentation is felt necessary.

Action

2. Regional Action Teams must:

   Ensure that in all instances where rebanding of posts is carried out, the process as laid out in the attached proforma document is followed in all cases, and recorded using the proforma a copy of which will be retained by the Regional Action Team together with supporting documentation.

Background

3. The procedure for re-banding existing posts is laid out in Advance Letter AL(MD)2001/01, in Terms and Conditions of Service, and added to by Steve Barnett's letter to the service of 12 March 2001. The department and the BMA agree that a mechanism which rebands posts using in-post monitoring, rather than assessment of compliance on paper or using other theoretical means, is the proper way of proceeding in the vast majority of cases. Such rebanding is most effectively carried out midpost in, for example, May or November, to allow rotas to bed in and to allow 'fine tuning' after monitoring. Both sides accept, however, that there will be a few occasions, where significant changes to rotas or staffing levels make it impractical to fully implement changes to working practices before new staff come into post, where it will be necessary to assess the likely banding of a rota in advance of its implementation, to allow an employer to offer posts to new employees on a realistic basis.

4. Such occasions will be rare. It cannot be taken for granted, for example, that full shifts will always be compliant as natural breaks may not be achieved or shifts may overrun. Similarly, the rest requirements of other types of rota pattern cannot be assumed and it will therefore not be appropriate to assume that particular working patterns can be offered at a predicted band. However where for example service reconfiguration or merger means that it is not possible to implement and monitor a full rota before it's proposed date of introduction, the facility is needed to allow an employer to offer a post at an expected band. This must be dependant upon the employer demonstrating to the satisfaction of the Action Team that it was not possible to implement a full rota in advance, although the employer should where possible make arrangements to test in advance those parts of the new arrangements most likely to be non compliant. It also places a responsibility on the employer to monitor and confirm the banding within a fixed timescale following the introduction of the new working arrangements.

5. The proforma attached covers the normal rebanding process, with the facility to allow for the provisional rebanding of a post in advance of practical monitoring.

6. As with all instances of backdating pay under the banding system, repayment where a lower band that has been paid is subsequently found to be inappropriate must be paid from when salaries at the provisional lower band were first paid

Notes

1. The proforma should be used both as a checklist to ensure that all the necessary stages of the rebanding process have been adhered to, and as a record of the process for payroll purposes.

2. Column headings are to be interpreted as:
   - Stage: a step in the process which must be completed
   - Evidence required: documentation/data/input that must be available in order to facilitate a decision at the relevant stage
   - Documentation: the formal confirmation that the stage has been followed through to successful completion.

3. In the proforma, references to the action team should be taken to refer to the Regional Improving junior doctors working lives action team or any successor body.

4. Where a decision from the Action Team is indicated, such a decision must be agreed by at a minimum, both a junior doctor employee and a BMA junior doctor representative, and will be coordinated by an officer acting with the full authority of, and nominated by the Action Team Chair.

5. The order of the stages in the Proforma does not follow the order stated in AL(MD)1/01; this is to follow a logical process. It would for example be appropriate in most cases for the Action Team to discuss and agree revised arrangements with juniors and their employers in advance of seeking educational approval.

6. In recognition of the range of different monitoring processes used in the regions and not wishing either to duplicate current practices or to create an unnecessary burden on trusts we do not propose to be prescriptive in the way supporting monitoring data is to be presented. However:

   - evidence of monitoring must conform to the requirements of the documentation issued as guidance accompanying HSC 2000/031

   - monitoring and/or analysis data produced by some software packages such as ND2000 will be acceptable for the purpose of this exercise – further guidance will be issued in due course.

7. Where provisional banding is authorised monitoring should take place within six weeks of the implementation of new working arrangements, and all necessary actions taken to ensure that the results of the monitoring are reflected in banding and salary.

Approval To Change Band

Trust:		**Hospital:**	
Specialty(ies):			
Numbers of doctors in working arrangement by grade			
PRHO:	**SHO:**	**SpR:**	**Other**
Working pattern:			
Current banding:	**Proposed banding:**		**Effective date:**

Stage	**Evidence required**	**Documentation**	**Confirmed Y/N**
1a. Consult post holders on proposed changes and obtain agreement of the majority participating in the working arrangements.	Approval of majority of current/incoming postholders	Template signed by trust junior doctor representative confirming agreement of majority of current/incoming post holders	
1b. Submit details of the new working arrangements to the action team for information and invited comment.	Full details of proposed working arrangements and/or rota summary (eg from ND2000 software)	Letter signed by action team chair or delegated authority confirming theoretical compliance of working arrangements	
1c. Obtain agreement from Clinical Tutor for education purposes.	Full details of proposed working arrangements Comments of Action Team	Letter signed by dean or delegated authority confirming educational acceptability of working arrangements	

If exceptionally and because of the impracticality of full implementation of new working arrangements a trust wishes to offer future posts at an expected banding in advance of actual monitoring, approval must be sought from the regional action team (or its equivalent) in advance of making any such offer. Any offer made in these circumstances will be strictly provisional, and must be confirmed by monitoring following the implementation of new working arrangements.

Stage	**Evidence required**	**Verification**	**Confirmed Y/N**
2. Submit request for provisional approval of working arrangements to Action Team	Signed letter from trust giving reasons for inability to fully monitor before rebanding. Evidence of full or partial testing/monitoring of proposed arrangements	Letter signed by Action Team Chair or delegated authority authorising an offer of provisional banding.	
Current Banding:	**Provisional New Banding:**	**Implementation Date:**	
Action Team Signatory		**Date:**	

Stage	**Evidence required**	**Verification**	**Confirmed Y/N**
3. Monitoring of working pattern and confirmation of banding	Completed monitoring returns from 75% of doctors on rota over full 2 week period Summary of monitoring results	This signed template	
Previous banding:	**Verified New Banding:**	**Effective Date:**	

Trust signatory Date:
(Designation)

Rota signatory Date:
(Designation)

Action team signatory Date:
(Designation)

Appendix F
Further information

New Deal Information

http://www.dh.gov.uk/PolicyAndGuidance/HumanResour cesAndTraining/ModernisingPay/JuniorDoctorContracts/J uniorDoctorContractsArticle/fs/en?CONTENT_ID=40538 73&chk=77RU2U

WTD Information

http://www.healthcareworkforce.nhs.uk/workingtimedir ective.html

http://www.berr.gov.uk/employment/employment-legislation/working-time-regs/index.html

Hospital at Night

http://www.healthcareworkforce.nhs.uk/hospitalatnight

Handover

http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFs afehandover/$FILE/safehandover.pdf

NWP Rota database

http://www.healthcareworkforce.nhs.uk/working_time_ directive/rotas%2c_handover_and_escalation_tools/wtd _compliant_rotas.html

Rota Design

http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFr otadesign/$FILE/rotadesign.pdf

Rota Monitoring

http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFr otamonitoring/$FILE/rotamonitoring.pdf

10. References

[1] HSC 1998/204. *Working time regulations: Implementation in the NHS*. Department of Health.

[2] European Court of Justice, Case C-303/98, Sindicato de Médicos de Asistencia Pública (Simap) and Conselleria de Sanidad y Consumo de la Generalidad Valenciana

[3] European Court of Justice, Case C-151/02, Landeshauptstadt Kiel and Norbert Jaeger

[4] Department of Health (1991) *Junior doctors' hours: the new deal*. London: Department of Health.

[5] HSC 2000/031 & appendices. *Modernising pay and contracts for hospital doctors and dentists in training*. Department of Health.

[6] Horrocks, N, Pounder, R (2006) Designing *safer rotas for junior doctors in the 48-hour week*. Royal College of Physicians.
www.rcplondon.ac.uk/pubs/contents/09446ffc-7f46-4f18-a1d0-fb5b8607b0c4.pdf.

[7] Royal College of Anaesthetists (2007) *Working Time Directive 2009 and shift working: ways forward for anaesthetic services, training, doctor and patient safety.*

[8] Horrocks, M, Cripps, J, Ahmed-Little, Y, Johnston, M (2008) *Working Time Directive 2009: Meeting the challenge in surgery.* Royal College of Surgeons of England and NHS North West.

[9] Junior Doctors Committee (2004) *Rota design made easy.* British Medical Association

[10] Junior Doctors Committee (2004) *Rota monitoring – the essentials. A doctor's guide to rota monitoring.* British Medical Association

[11] Junior Doctors Committee (2004) *Safe handover: safe patients. Guidance on clinical handover for clinicians and managers.* British Medical Association.

[12] Modernisation Agency (2004) *Rota design with the European Working Time Directive.*
Some questions and illustrations to aid local thinking. Department of Health.

[13] Ahmed-Little, Y, Bluck, M. The European Working Time Directive 2009. *British Journal of Healthcare Management* 2006; 12(12): 373-376.

[14] Horrocks N, Pounder R. *Working the night shift: preparation, survival and recovery*. London: Royal College of Physicians, 2006.
www.rcplondon.ac.uk/pubs/books/nightshift/nightshiftbooklet.pdf

[15] Ahmed-Little, Y. Impact of shift work for junior doctors. *British Medical Journal* 2007;334:777-778.

Notes

Notes

National Workforce Projects
part of Skills for Health

3000 Manchester Business Park
Aviator Way, Manchester M22 5TG

Tel: 0161 266 2300
Fax: 0161 266 1001
Email: communications@nwpnhs.org.uk
www.healthcareworkforce.nhs.uk

WTD-0809-011