THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1996)23

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

8 March 1996

Dear Colleague

JUNIOR DOCTORS' HOURS - PAY FOR INTENSIVE ON-CALL ROTAS

Summary

This letter notifies employing bodies that junior doctors employed on hard-pressed on-call rotas may be eligible for payment of class II ADHs.

Action

1. NHS Trusts should:

- take action to monitor the work intensity of their juniors employed on hard-pressed on-call rota posts;
- pay Class II rates of payment for ADHs for those on-call rota posts where the work intensity is equal to that of a partial shift;
- supply returns on those posts to the Management Executive.

2. Details of what is required are set out in Annex A attached.

Yours sincerely

M R Sibbald

M R SIBBALD
Director of Human Resources

Addressees

For action:
Chief Executives, NHS Trusts

General Managers, Health Boards

General Manager, Common Services Agency

General Manager, State Hospital Board for Scotland

For information:
Executive Director, Scottish Council for Postgraduate Medical and Dental Education

Postgraduate Deans and Directors

General Manager, Health Education Board for Scotland

Enquiries to:

Directorate of Human Resources
NHS Management Executive
Room 61A
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2476
Fax: 0131-244 2837

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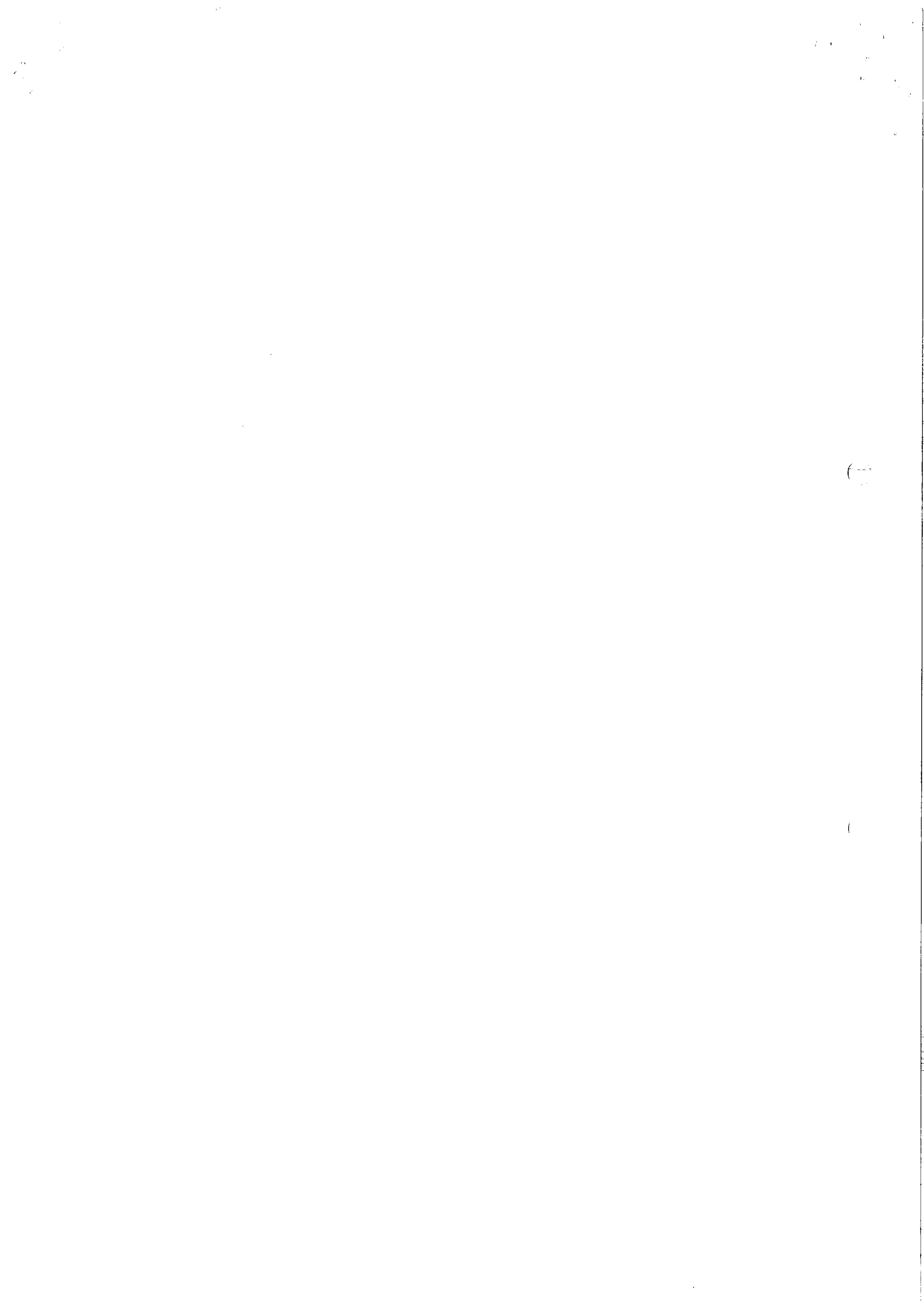


ANNEX A

JUNIOR DOCTORS' HOURS OF WORK

Work intensity supplement: Payment of Class II Additional Duty Hour rates to on-call rotas

1. From 1 April 1996, all doctors in training covered by the Terms and Conditions of Service of Hospital Medical and Dental Staff and working on on-call rotas may be eligible to receive Class II ADHs. To qualify for this extra payment the intensity of their out-of-hours work must be comparable to that expected on a partial shift.

The New Deal

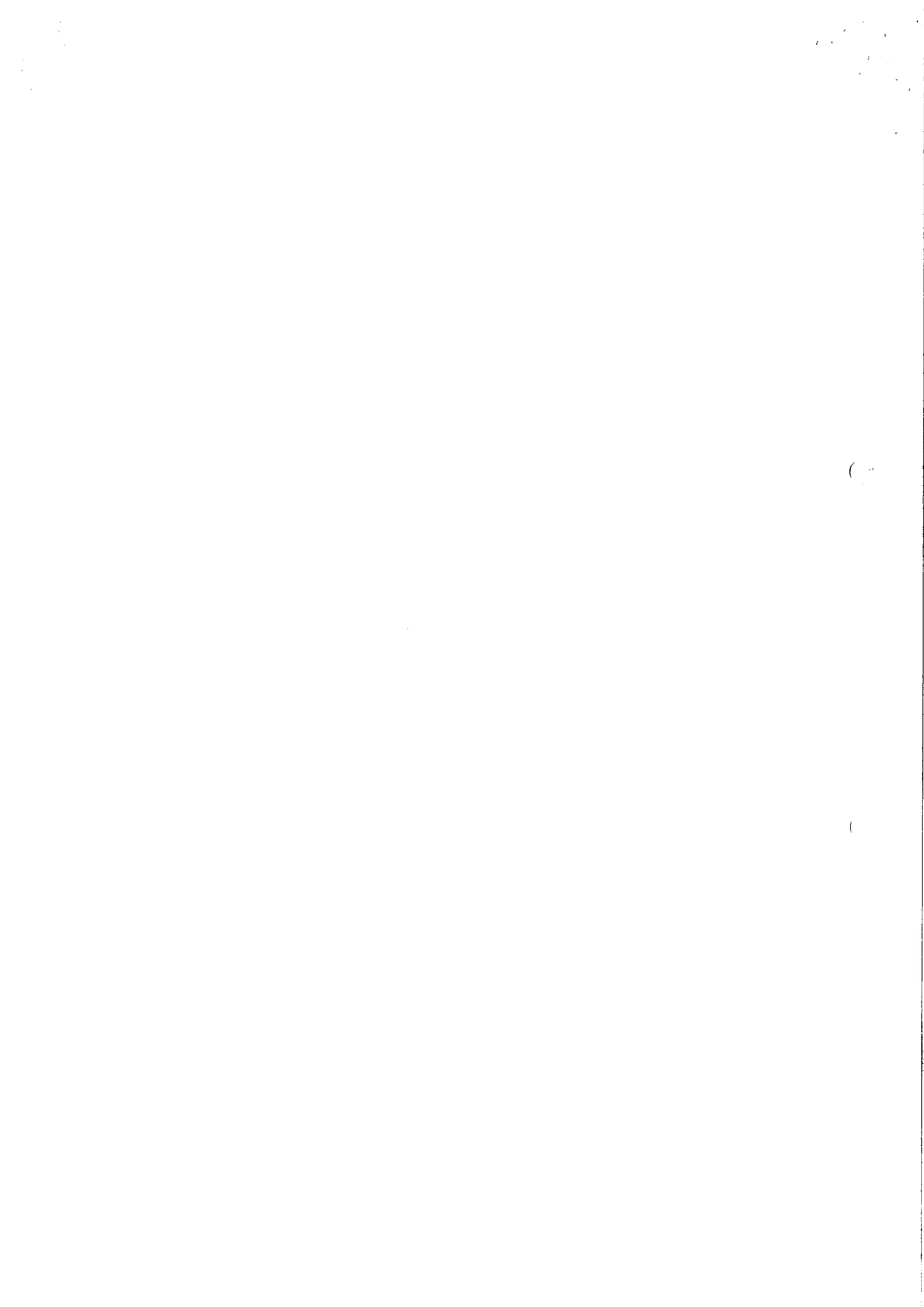
2. The NHS has achieved significant improvements since the New Deal on Junior Doctors' Hours was launched in 1991. Trusts have done remarkably well in meeting targets for contracted hours. The central thrust of continuing action is to secure reductions in actual hours of work and work intensity. That is to match intensity with the appropriate working pattern.

3. It remains clear that there are still junior doctors who are working hours which cannot be reconciled with the limits set out in the New Deal and in their terms and conditions of service. In many placements, mainly in the acute specialties, the amount and quality of rest for many juniors on-call is inadequate. Rest periods may be of short duration and may be interrupted frequently. As a consequence, intensity of work is higher than the goals we set in the New Deal. This MEL recognises that the changes necessary to reduce juniors' hours in terms of organisation, working practices and, indeed, attitudes are far-reaching and cannot be achieved quickly or easily.

4. Payment of Class II ADH rates will have financial implications for Trusts and Health Boards, until work intensity has been reduced. The payment of Class II rate of payment for ADHs for those on-call rota posts where the work intensity is consistently comparable to that of a partial shift is not a device to increase out-of-hours pay as a substitute for continuing to reduce hours. It is to add momentum to the New Deal. It is essential for all the parties involved, particularly Trust/DMU managers and junior doctors, to work together to design the most effective working arrangements to suit local needs.

Definition of partial shift work intensity

5. *"Doctors in training working on partial shifts work normal weekdays most of the time but at intervals work a different duty, for instance a week on nights every fourth week. Partial shifts are appropriate for much medical work where there is a significant routine workload during the day and where doctors in training are required to work for a substantial proportion of their contracted hours above the standard working week for full-time posts of 40 hours. Doctors in training working partial shifts should have adequate rest during a period of duty. As a guide, they should have a reasonable expectation of a period of 4 hours rest during a duty period of 16 hours."* ***Hours of Work of Doctors in Training: Working Arrangements of Doctors and Dentists in Training, 1991, Annex A, paragraph 9.***



Criteria for qualification

6. Where junior doctors are contracted to work up to an average of 72 hours a week on an on-call rota, that rota will attract Class II ADHs if:

a. They are required to work the majority of their additional duty hours at a level where work intensity is judged to be comparable to that normally expected on a partial shift complying in full with the requirements of paragraph 5 above;

b. The on-call rota does not comply with the requirement that: *"Doctors in training working on-call rotas work a normal day from Monday to Friday and are on-call in rotation for the rest of the 24 hour period and for weekends. The frequency of on-call duty depends on the number of doctors providing cover and is normally expressed as 1:3, 1:4 etc. On-call rotas are appropriate for those posts where the workload is of such a nature that doctors on-call, whether in hospital or at home, are not required to work for a substantial proportion of their contracted hours above the standard working week for full-time posts of 40 hours. Doctors in training working on on-call rotas should have adequate rest during a period of duty. As a guide, they should have a reasonable expectation of 8 hours rest during a period of 32 hours duty, principally within the on-call period. Where possible the greater part of this rest period should be continuous". **Hours of Work of Doctors in Training: Working Arrangements of Doctors and Dentists in Training, 1991, Annex A, paragraph 3.***

c. the incidence of working at an intensity comparable to that of a partial shift occurs in the majority of out-of-hours duty periods.

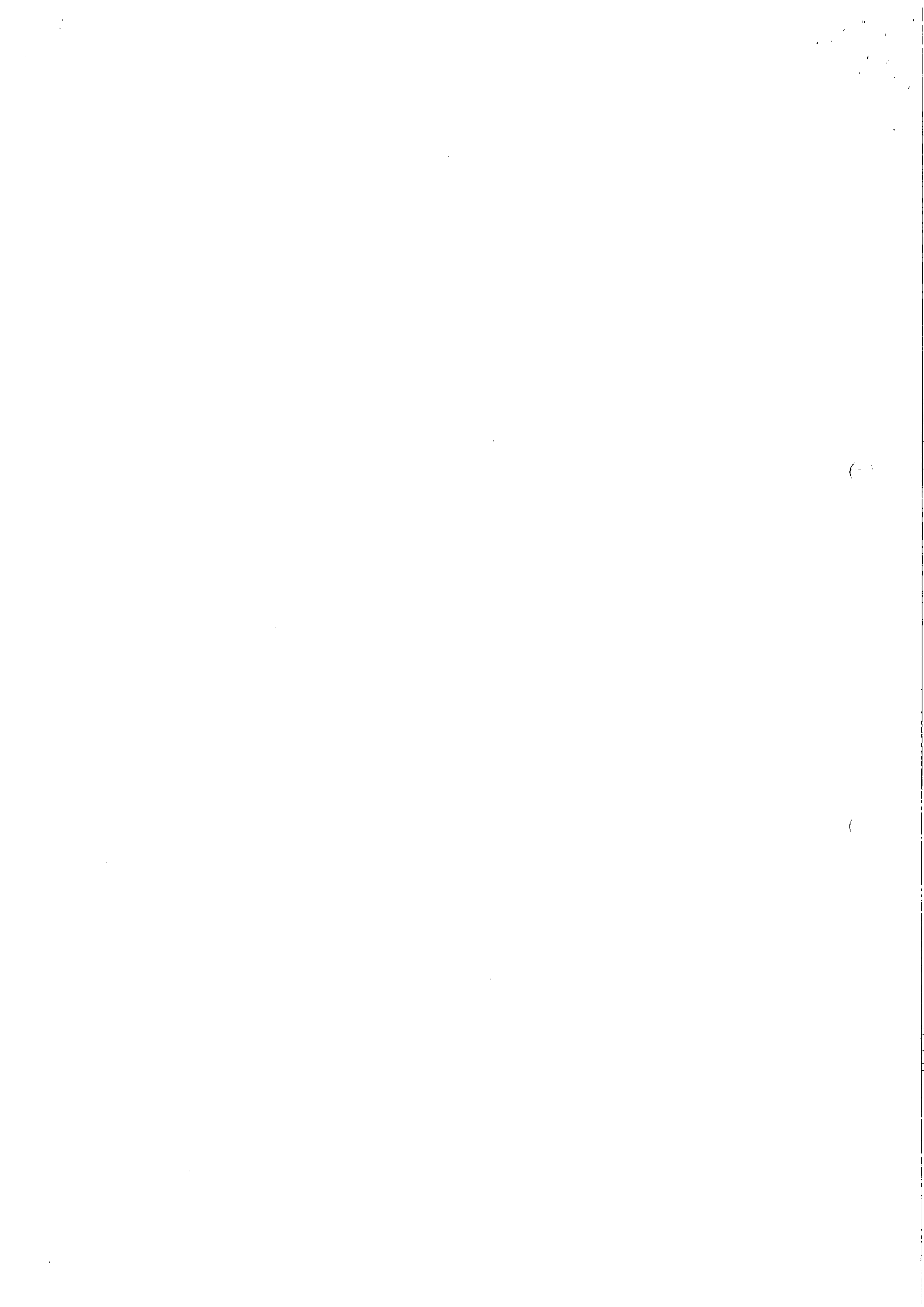
Non-hard-pressed on-call posts

7. Should any junior doctors working on non-hard-pressed posts satisfy the criteria in paragraph 6, their posts should be reclassified as hard-pressed and they would become eligible for the work intensity supplement.

Eligibility arrangements

8. The question whether junior doctors are eligible for the supplement, in line with paragraph 6, should be decided by the Trust (or DMU in the Western Isles or the Northern Isles) in which they are employed on the basis of thorough, documented evidence supplied by clinical directors or the Medical Director and validated by junior doctors' representatives. Payments should be made only in the following circumstances:

a. where full evidence can be provided by the clinical directors and junior doctors involved that the posts in the on-call rota satisfy the criteria set out in paragraph 6; and



b. where all the junior doctors working the on-call rota in question agree formally to work with their employer to identify appropriate working arrangements that they will adopt to reduce work intensity to an acceptable level.

Applications

9. In the first place, junior doctors should approach their employers if they believe that they may qualify for the supplement. Trusts should then consider whether the conditions in paragraphs 6 to 8 are met.

10. The supplement cannot be claimed by or paid to junior doctors on an individual basis without it applying to their colleagues on the same rota. The supplement should, therefore, be paid to all junior doctors on the same rota unless there are significant differences in out-of-hours intensity. An example would be where a higher specialist trainee may not be first on-call with the same frequency as more junior colleagues and, therefore, is not subject to the same intensity of work in the majority of out-of-hours duty periods.

11. Payments relate to the post or placement, not to the individual doctor, and can, therefore, apply to subsequent occupants of the post for as long as the criteria for qualification in paragraph 6 above continue to apply.

Review of payment

12. Where the supplement is in payment Trusts should review the arrangements regularly. They should ensure that payment is part of a programme to reduce working hours or work intensity and is not simply a pay supplement. The payments should not be stopped simply because proposals to alter working patterns have not come to fruition.

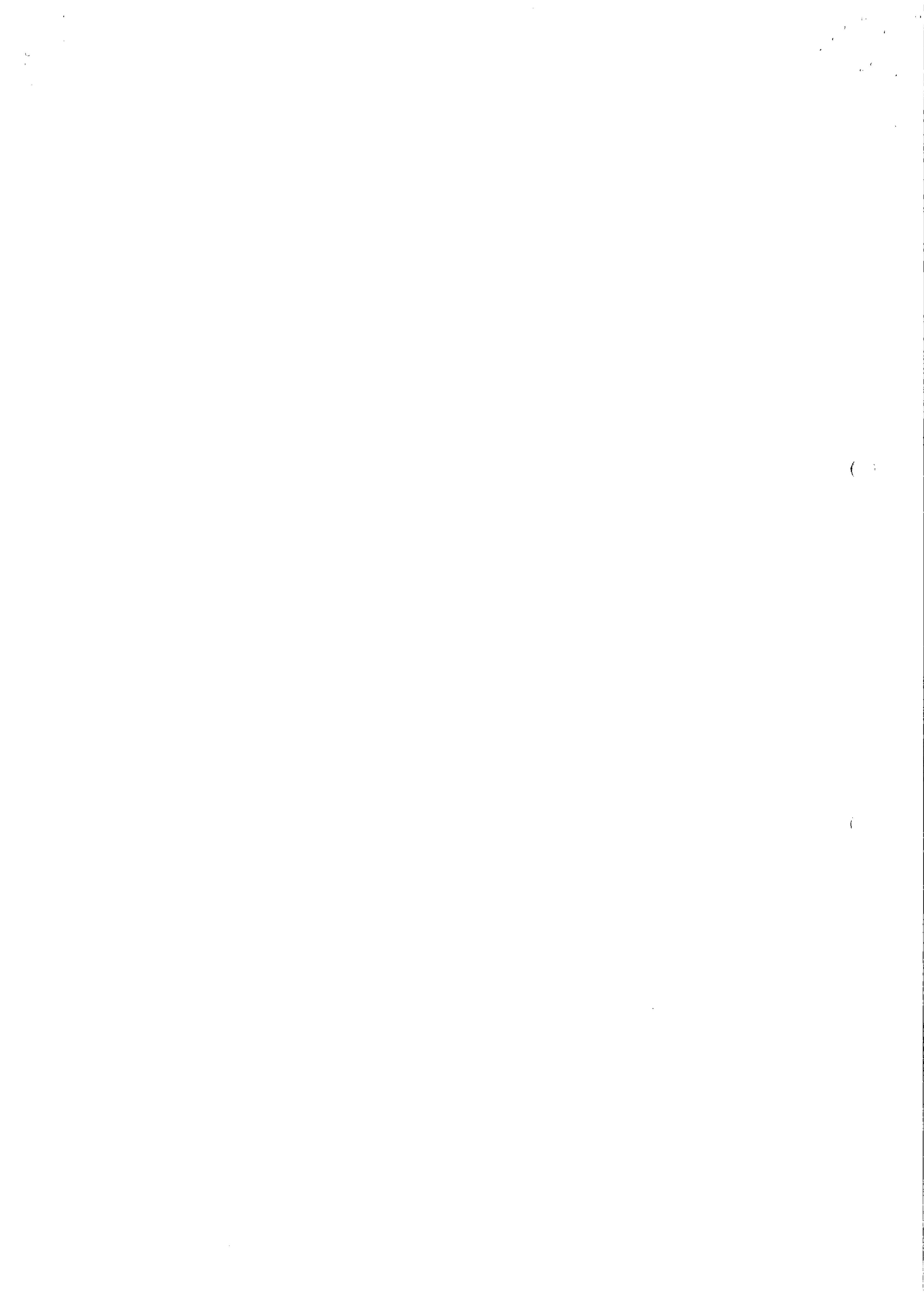
Monitoring

13. Trusts should have arrangements in place to monitor the take-up and cost of these provisions, to evaluate their effect and to report on it to the NHS Management Executive within 3 months. They will also be required to report regularly thereafter on progress to the NHS Management Executive. This should be included with the 6 monthly statistical returns on juniors' hours of work.

Starting date for payments

14. Payments can begin on any date after 1 April 1996 as soon as the Trust agrees that the evidence supports payment of the supplement. Payments should be backdated to the date of application if there is a delay in assessing or approving evidence but no payment can be made for any period before 1 April. Payments may also be backdated to the beginning of a contract of employment (but not before 1 April 1996) where a claim is made within 6 weeks of the beginning of the contact.

15. Some employers may have already made local agreements to enhance their out-of-hours pay. There is nothing in the arrangements set out which is intended to disturb such existing agreements.



16. This arrangement should last until such time as Trusts are satisfied that work intensity has been reduced to acceptable levels through the introduction of more appropriate working patterns or other organisational changes. Such arrangements have financial implications for Trusts. It is therefore important that purchasing boards work with Trusts to ensure that junior doctors are working at levels of intensity which do not jeopardise high quality patient care.