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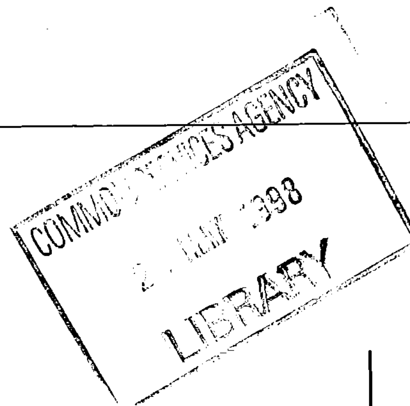

NHS
MEL(1998)40

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

19th May 1998

Dear Colleague

JUNIOR DOCTORS' HOURS: PAY FOR INTENSIVE WORKING PATTERNS

Summary

1. This letter explains new arrangements applying from 1 April 1998 to the pay of junior doctors and dentists working intensive on-call rotas or partial shifts which do not meet the requirements of the New Deal on Junior Doctors' Hours. It builds on the pay arrangements introduced in NHS MEL(1996)23 from 1 April 1996, through which certain juniors working on-call were entitled to receive the higher Class II rate ADH payments.

2. This letter replaces and extends NHS MEL(1996)23 but does not affect the right of junior doctors and dentists to continue to receive payments under the previous arrangements or, where appropriate, to claim payments under that MEL.

Action

3. NHS Trusts should:- from 1 April 1998 - consider claims from junior doctors working on on-call rotas or partial shifts whose work intensity is at *virtually full shift intensity.*

4. Details of what is required are set out in the attached Appendix and Annexes.

Yours sincerely

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APPENDIX

Background

1. The NHS has made great strides in bringing down hours but there is still some way to go. Although action now focuses on the 3 non-hours standards (accommodation, catering and security), reducing *actual* hours of work and work intensity must not be neglected. We plan, therefore, to match intensity with the appropriate working pattern.

2. The Review Body on Doctors' and Dentists' Remuneration (DDRB) recommended in January that action is taken immediately to extend the provisions of NHS MEL(1996)23 to include partial shifts or on-call rotas where the working intensity was virtually that of a full shift. The review body recommended that this issue should be addressed as a matter of urgency. The Government has accepted this recommendation, and it will be implemented from 1 April 1998.

3. These revised arrangements are not designed to increase out-of-hours pay as a substitute for continuing to reduce hours. The aim is simply to encourage action on hours and to provide junior doctors with a rate of pay linked with their work intensity while that action is being implemented. It is vital for all the parties involved, particularly Trust managers and junior doctors, to work closely together to design the most effective working arrangements to suit local needs. Trusts should also continue action to improve the working conditions of junior doctors generally, by providing decent on-call accommodation and out-of-hours catering.

4. Where Trusts have already made local agreements to enhance out-of-hours pay, nothing in the arrangements set out above is intended to disturb such existing agreements.

5. Trust should note that NHS MEL(1996)23 should now be cancelled as its provisions are included in this MEL. The procedures in the attached Annex should now be followed.

WORK INTENSITY SUPPLEMENT: PAYMENT OF CLASS I OR CLASS II ADDITIONAL DUTY HOUR RATES TO INTENSIVE ON-CALL ROTAS AND PARTIAL SHIFTS

1. From 1 April 1998, all doctors and dentists in training covered by the Terms and Conditions of Service, Hospital Medical and Dental Staff and working on-call rotas or partial shifts may be eligible to receive either the higher Class I or Class II ADHs. The existing rights of juniors working intensive on-call rotas are covered in paragraphs 15-16 below.

2. To qualify for this extra payment the intensity of their out-of-hours work must, on a consistent basis, be *virtually equivalent*, respectively, to that expected on a full shift or a partial shift.

Definitions of Full Shift and Partial Shift Work Intensity

3. Some junior doctors are expected to work, on a consistent basis, more intensively than was envisaged for their working pattern. This is usually due to excessive workload being placed on the juniors involved. It is more easily detected when they are unable to rest sufficiently during their periods of duty. A junior should have a reasonable expectation of rest in a duty period, the majority being continuous and within the out-of-hours period. When this reasonable expectation cannot be delivered, enhanced payments at Class I or Class II rates, as appropriate, must be made under the terms of this letter. For example:

- a junior on a partial shift who cannot reasonably expect a period of 4 hours' rest during a duty period of 16 hours is likely to be eligible for enhanced payment at Class I rates;

- a junior on an on-call rota who cannot reasonably expect a period of 4 hours' rest during a duty period of 32 hours is likely to be eligible for enhanced payments at Class I rates;

- a junior on an on-call rota who cannot reasonably expect a period of 8 hours' rest during a duty period of 32 hours is likely to be eligible for enhanced payment at Class II rates.

4. Trusts should identify such posts as part of their ongoing local monitoring. They should decide with thorough documentary evidence from clinical directors and validation from junior doctors' representatives if intensity payments are justified. Enhanced payments introduced without delay can be effective in achieving the key goal - identification and elimination of the most onerous posts outside the New Deal limits.

Criteria for Qualification

5. Class I Payment for Partial Shifts

Where junior doctors are contracted to work on a partial shift, their posts/placements will attract Class I ADHs if:

a. they are required to work the majority of their out-of-hours at a level where work intensity is judged to be virtually equivalent to that normally expected on a full shift complying in full with New Deal requirements (see Annex B); and

b. the partial shift does not comply with the requirement for adequate rest during a period of duty. As a guide, partial shift juniors should have a reasonable expectation of a period of 4 hours' rest during a duty period of 16 hours (*Hours of Work in Doctors in Training: Working Arrangements of Doctors and Dentists in Training 1991, Annex A, paragraph 9*); and

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

6. Class I Payments for On-Call Rotas

Where exceptionally, a junior doctor contracted for an on-call rota is working at an intensity virtually equivalent to that of a full shift, as defined in paragraph 3 above, and this incidence of working occurs *in the majority of out-of-hours periods*, the junior will be able to claim Class I ADHs for all out-of-hours working.

7. Class II Payments for On-Call Rotas

Where junior doctors are contracted to work on an on-call rota, their posts/placements will attract Class II ADHs if:

a. they are required to work the majority of their out-of-hours duty hours at a level work intensity is judged to be virtually equivalent to that normally expected on a partial shift complying in full with New Deal requirements (see summary table at *Annex B*); and

b. the on-call rota does not comply with the New Deal requirement for adequate rest during a period of duty. As a guide, on-call juniors 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*); and

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

Eligibility Arrangements

8. The question whether junior doctors are eligible for the supplement, in line with paragraph 5, 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 employing Trust and/or the clinical directors and junior doctors involved that the posts in the on-call rota satisfy the criteria set out in paragraph 5-7; 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 5 to 7 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 5 above continue to apply.

12. Trusts should instigate the appropriate ADH payment as soon as possible, and with full retrospective payment as defined in paragraph 15 below. Where a Class I claim is made, retrospective payment will *not* apply prior to 1 April 1998. However, any outstanding Class II claims under NHS MEL(1996)23 may be paid retrospectively even if prior to 1 April (see also paragraphs 15 and 17 below).

13. Juniors can appeal against non-payment of the enhanced rates in accordance with paragraph 13 of NHS MEL(1997)71.

Review of Payment

14. 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

15. 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 Payment

16. The new Class I ADH payments introduced in this letter may begin on any date from 1 April 1998 onwards. Class II payments previously agreed under NHS MEL(1996)23, now cancelled, may continue to be paid. Payments should be backdated to the date of application if there is a delay in assessing or approving evidence but no Class I payment can be made for any period before 1 April 1998. Payments should also be backdated to the beginning of a contract of employment where a claim is made within 6 weeks of the beginning of the contract.

17. 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.

18. Some employers may already have made local agreements to pay Class I ADH or Class II intensity payments. There is nothing in the arrangements set out above which is intended to disturb such existing agreements or any payments currently being made under NHS MEL(1996)23 excepting where this letter authorises the payment of Class I ADHs to doctors working on an intensive on-call rota or partial shift as described in this letter.

ANNEX B

THE NEW DEAL HOURS' SUMMARY APPLYING AT 1 JANUARY 1997

Working Pattern	Maximum average contracted and actual duty hours per week (see Notes 1,2)	Minimum rest during duty periods (hours) (see Note 3)	Maximum continuous duty period (hours)	Minimum period off duty between duty periods (hours)	Maximum consecutive duty days	Minimum continuous period off duty (hours)
Full shift	56	Natural breaks	14	8	13	48 + 62 in 28 days
Partial shift	64	4	16	8	13	48 + 62 in 28 days
On-call rota	72*	8	32 (56 at weekends)	12	13	48 + 62 in 21 days

Note 1: Contracted hours should take into account routine early starts, late finishes, time off during the working day (eg half days) and, where applicable prospective cover for annual and/or study leave.

Note 2: **Actual hours of work: Regardless of the contracted hours of duty for individual posts, doctors in training employed on a full-time basis should not be expected to work for more than an average of 56 hours a week.**

Note 3: The rest period for a partial shift working pattern applies to a 16-hour duty period. The rest period for an on-call rota applies to a 32-hour period of duty including a night on-call. The 8 hours rest should be predominantly during the out-of-hours period and the greater part of the rest should be continuous.

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* ***The 'English Clause'.*** *In some circumstances individual higher specialist trainees may continue to contract for duties in excess of a 72 hour maximum average per week (though not for more than a maximum average of 83 hours per week) when it would be to the benefit of their training and they wish to do so, providing proper support staffing exists and providing the duties are not harmful either to the trainees or to patients. But they* ***must not work for more than the New Deal limit of an average of 56 hours a week.***

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