Implementation Support Group

The New Deal

for Junior Doctors in Scotland

Report to

Minister for Health and Community Care

August 2002
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1. INTRODUCTION

The New Deal Implementation Support Group was established in September 1999 as a partnership between the Scottish Executive Health department (SEHD) and the Scottish Junior Doctors Committee (SJDC). Since its inception, the group has continued to support Trusts in their efforts to secure New Deal compliance for training grade doctors.

The past year has seen significant changes in the composition and staffing of ISG. Each of the regional teams now consists of a training grade doctor and a non-medical with healthcare experience. This has been a productive development and the Group has benefited from the additional depth and breadth of knowledge afforded by these appointments. The chairman has maintained personal continuity over this period. More recently the Human Resource Department (HRD) of the SEHD has seen significant restructuring with the ISG now placed within the National Workforce Unit.

In addition to New Deal implementation, the future medical workforce in Scotland will be shaped by the first implementation phase of the European Working Time Directive for doctors in training and the recommendations of Future Practice: A review of the Scottish Medical Workforce. It is envisaged that the new HRD structure will allow the knowledge and experience in ISG to feed into wider workforce issues while protecting the ‘hours only’ remit of the ISG.

In light of the current and possible future changes in the structure and delivery of healthcare in Scotland, an emerging imperative is the need to balance training requirements with service need within the limits of legislation. This continues to be the focus of discussions within Trusts, Colleges and Government both at a Scottish and UK level. More work is needed and will be further informed by the publication of the SHO modernisation review.

While taking cognisance of wider and more medium term workforce issues, the role of the ISG and the focus of Trusts must be to implement the New Deal for all grades of junior doctors by August 2003. Recognition of the progress achieved in the past year is reassuring yet much can be learnt from the recent slippage in compliance.
figures. The considerable efforts of all charged with New Deal implementation must be maintained and developed in the next year if New Deal compliance is to be achieved across the board.

It is the view of the ISG that a core number of rotas will remain where compliance will not be achieved through simple rota redesign work or by provision of enhanced support services. In these cases compliance may be achieved through a combination of service redesign and increased staff resources.

This report will: -

- update how effectively Trusts have implemented the ISG recommendations contained in the March 2001 report;

- detail the support work undertaken by the ISG to ensure compliance with the New Deal across all grades;

- report the current levels of compliance and indicate where specific difficulties exist in securing New Deal compliance;

- detail the future direction of the ISG in its work to support Trusts and in meeting its objectives set within the terms of reference framework.
2. EXECUTIVE SUMMARY

The considerable efforts of Trusts, management, medical and nursing staff with the support of the ISG has resulted in a significant improvement of the PRHO compliance figures since the last report. Disappointingly however, the proportion of PRHOS working New Deal compliant posts has decreased in the past months. This is due in part, to a shift in focus of all involved to achieving compliance for all grades of junior doctor. Refocusing of efforts will be required to ensure that the benefits of efforts to date are consolidated and improved.

Substantial development of Trust infrastructure has occurred during the past year, with most Trusts in Scotland holding regular Implementation Group meetings. Several Trusts have appointed dedicated New Deal Officers to facilitate efforts to secure New Deal compliance. In general, significant further development is required in terms of Trust New Deal infrastructure, training, dedicated personnel and ownership of hours of work issues.

Whilst knowledge of the New Deal has improved the level of expertise is, across the country in general, insufficient to effectively discharge the Trusts’ responsibilities to secure New Deal compliance. As a result, ISG has, over the past year, assisted Trusts in a more intensive and practical way than outlined in the Groups remit. This has resulted in a substantial increase in the Groups work to the point that, on occasions, the ISG has struggled to deliver.

With the impending date for the final banding multiplier increase in December 2002, and the requirement for all grades of doctors in training to be working New Deal compliant posts by August 2003, further demands will be placed on ISG in the coming year. Furthermore, the ISG focus will expand to become cognisant of the first implementation phase of the European Working Time Directive in August 2004.
While there is scope to increase the efficiency of the ISG and its interaction with Trusts, the expansion in workload will place added strains on the work of the Group. It is clear that the ISG will need to realign itself more closely with its terms of reference if it is to continue to provide the levels of support required by Trusts in Scotland.
3. SUMMARY OF RECOMMENDATIONS

1. SEHD to develop the New Deal compliance Trust Position Statement to incorporate details of rest achieved in line with EWTD requirements.

2. Trusts reassess the composition, attendance, objectives and progress of their Trust Implementation Groups to ensure they are fit for purpose.

3. SEHD to issue guidelines, by Autumn 2002, outlining the level of involvement required from lead clinicians at individual rota level in taking forward issues of New Deal non-compliance; and to consider further how this standard should feature in the New Deal accreditation process.

4. SEHD to issue guidance to Trusts regarding the appointment of individual(s) to take the lead in implementing the New Deal, and that they are of an appropriate grade, have appropriate experience and training; and that these factors feature in the New Deal accreditation process.

5. Trusts ensure that doctors in training are educated about hours of work legislation that exists to protect their health and safety and that of their patients.

6. ISG declare, by end August 2002, whether the rota design software currently being evaluated is fit for purpose. If not, that ISG undertake to evaluate other products currently available.

7. ISG evaluate the capacity of all available products to incorporate both New Deal and EWTD limits and make a recommendation of a software solution that will address these needs, by Spring 2003.

8. ISG to consider the best approach to support software design company to deliver workshops aimed at promoting rota design and hours
monitoring software products deemed fit for purpose by ISG. The SEHD outline the cost and resource implications as well as the level of available training support in their use and application.

9. The option of central negotiation by SEHD of any licences, which would be purchased by NHSS Trusts.


11. ISG to ensure that a decision on fit for purpose hours monitoring systems be made by Autumn 2002.

12. ISG to identify an IT solution that will support Trusts in their analysis of diary card monitoring systems.

13. Using information from the February 2002 TPS returns, SEHD to serve, by September 2002, improvement notices to all NHSS Trusts for rotas that have not been monitored since August 2001. The affected posts to attract Band 3 rates if improvement notices are not actioned within 6 months of being served.

14. SEHD, after discussion with the ISG project board including SJDC, to issue to NHSS Trusts by end September 2002 an interpretation of current guidance as it applies to training grade doctors failing to participate in monitoring exercises.

15. SEHD to consider how best the devolvement of monitoring responsibility to clinical directorates should be facilitated and to consider the issue of separate instruction to Trusts on this matter. To cross-reference to best practice guidelines on monitoring as recommended earlier in the report and to incorporate these same standards into the future assessment of New Deal accreditation.
16. Any Trust that considers devolvement of monitoring responsibility to clinical directorate teams to be inappropriate will be required to submit a case to the SEHD outlining their rationale.

17. SEHD to produce a single New Deal accreditation framework document by end 2002 which collates all existing standards against which Trusts are to be assessed for New Deal accreditation.

18. The SEHD survey, with appropriate validation, the current state of laboratory communication systems within Trusts in NHSS by end 2002.

19. SEHD to
   • address the difficulties in phlebotomy recruitment and retention through the Scottish Personnel Group.
   • undertake a bi-annual assessment exercise, with appropriate validation by SEHD, to monitor the extent of 7-day phlebotomy across NHSS.

20. ISG to
   • Develop a system to allow sample validation of the extent to which phlebotomy is delivered at ward level.
   • Validate SEHD survey by Autumn 2002 and validate all subsequent phlebotomy surveys at ward level.
   • Disseminate examples of novel provision and best practice in relation to phlebotomy services.


22. ISG to facilitate the delivery of on-going and regular education workshops using the revised Education and Training Guide as the basis for promoting the concepts and principles of rota design and assessment of New Deal compliance. ISG to publish detail of events in terms of dates and location by autumn 2002.
23. The ISG to utilise the web site to disseminate news and best practice cases to Trusts.

24. The SEHD to establish a New Deal Network in conjunction with ISG, the membership of which are drawn from representatives of Primary Care and Acute NHSS Trusts, to meet at an appropriate frequency to discuss New Deal issues; share best practice; and to discuss issues of general concern. These Trust representatives to work in support of ISG by providing a front-line New Deal advice service within the "home" Trust.

25. ISG review all PRHO rotas by November 2002

26. ISG review all flexible trainee rotas by November 2002.

27. ISG review all Primary Care rotas by Feb 2003

28. ISG feed in to Scottish level discussions regarding hours of work and rest requirements and read across to training and service delivery.

29. SEHD and BMA support Trusts in developing a strategy to achieve compliance for all doctors in training by August 2003, and that the SEHD, after consultation with the ISG Project Board, develop a mechanism to target areas where this has not been achieved.

30. The ISG investigates the use of a paper-based solution to improve ISG communication with Trusts.

31. The ISG to maintain links with appropriate taskforces throughout the UK.
4. ISG TERMS OF REFERENCE

To support the work of NHS Trusts in meeting New Deal hours of work targets and accommodation, catering and security standards for training grade doctors throughout the NHS in Scotland by working closely with trust staff to help them overcome obstacles to compliance and identifying and promoting best practice. To use skills and expertise gained through work on the New Deal for doctors in training to inform work on achieving compliance with the Working Time Regulations. In particular the ISG will:

· Work with trusts to ensure progress towards full compliance with hours of work targets.
· Identify and promote examples of best practice in the provision of accommodation, catering and security and work with trusts to ensure that New Deal standards are met.
· Provide training and disseminate examples of best practice on issues related to achieving compliance with New Deal hours of work targets.
· Provide training and disseminate examples of best practice on issues related to monitoring compliance with New Deal hours of work targets.
· In exceptional circumstances, having regard to practical considerations and only with full agreement of all parties, have the potential to agree any limited derogations from full compliance with the New Deal targets and standards.
· Consider the arrangements in place to monitor the hours worked by training grade doctors and work with trusts to improve the accuracy and coverage of these arrangements.
· Develop, introduce and maintain a system of accreditation relating to performance in achieving New Deal hours targets and other standards.
· Undertake specified functions in the implementation of the new contract for Doctors in Training.
· Use knowledge and experience gained on New Deal compliance to feed into wider work on achieving compliance with Working Time Regulations.
· Provide training and disseminate examples of best practice on issues related to achieving compliance with Working Time Regulations hours of work targets.
· Provide training and disseminate examples of best practice on issues related to monitoring compliance with Working Time Regulations hours of work targets.
· Produce an Annual Report and recommendations to Ministers in March of each year.
5. RECOMMENDATIONS ACCEPTED – MARCH 2001

The Implementation Support Group (ISG) made a total of 13 recommendations to the Minister for Health and Community Care in its report dated March 2001. These were all accepted in full.

The recommendations were made to ensure that NHSS Trusts efforts continued to remain focused in meeting New Deal requirements on hours of work, rest, accommodation, catering and security.

The ISG has continued to work with Trusts across Scotland to ensure implementation of all recommendations where these have been appropriate. The following is an update on the progress that has been made:

5.1 Management Information

Recommendation 2001

SEHD to determine future policy on Trust validation of New Deal compliance data.

Progress achieved

The SEHD consulted widely with both ISG and NHS Scotland to establish what improvements were felt necessary to the existing systems used to collect New Deal compliance data on hours of work and rest. Trusts have in the past voiced concerns over the volume of detail required which had made the exercise both time consuming and cumbersome at stages of the operational year where medical staffing resources were already stretched to the full.

A new system introduced for the February 2002 round of data collection now involves SEHD sending to Trusts compliance data on a rota by rota basis held from the August 2001 set of Trust returns. This information details known resources by number and grade; the nature of the working pattern, the pay band worked; pay
band paid; a projected pay band, where known changes to working patterns are planned but are yet to come on stream; the number of actual hours worked; and finally details of when the rota was last monitored.

On return to SEHD, information is recorded on a central database and a full Trust Position Statement (TPS) produced for authorisation by the following representatives at NHSS Trust level:-

- Chief Executive
- Trust Executive Director with responsibility for New Deal compliance
- Junior Doctor representative
- Post Graduate representative

This ensures that senior representatives within NHSS Trusts continue to be tied into the compliance process and are aware of the areas that require greatest focus from a compliance perspective within their Trust. Furthermore information is also shared with ISG who, through their own local networks of Trust personnel and doctors in training, are able to provide an additional validatory perspective to the information provided.

This process ensures that SEHD, BMA and the NHSS continue to share confidence in the accuracy of compliance across Scotland, which can now be broken down not merely by Trust, but also by grade, specialty and hospital site where necessary.
Recommendation 2001

SEHD to develop a system for obtaining actual hours worked information that meets future requirements of the European Working Time Directive (EWTD).

Progress Achieved

Whilst the focus has, rightly, remained on compliance with the New Deal, attentions are turning to the wider EWTD agenda, which is the subject of a separate section within the body of the report (c.f. section 9).

The March 2001 recommendation has been incorporated into the revised TPS data gathering format wherein NHSS Trusts are now asked to detail the number of actual hours worked on a rota by rota basis.

5.2. Trust Infrastructure

Recommendation – 2001

The SEHD to issue guidelines on the membership, remit and frequency of Trust Implementation Groups. The operational effectiveness of these groups to feature in the New Deal accreditation assessment process.

Progress Achieved

Guidelines were issued to all Trusts in August 2001 outlining the recommended membership, remit, frequency and objectives for Trust Implementation Groups (TIG) (see Appendix 1). ISG is pleased to report that in most NHSS Trusts TIGs are now in operation and are proving to be an invaluable forum for addressing Trust-wide issues which impact on the achievement of New Deal compliance.
5.3 Monitoring Systems

5.3.1 Rota Design

Recommendation - 2001

ISG to submit proposals, by end August 2001, on the strategy for future devolvement of the rota-planning software to Trusts.

Progress

The focus for ISG has remained on developing a system that will meet the needs of Trusts within NHSS. The rota design software has been the subject of continued modification as ISG user knowledge has grown and limitations of the system have been more readily identified. Progress however has been difficult. This is particularly disappointing given the clear need for an IT support solution at Trust level. The software is now undergoing final evaluation and the Group anticipate a decision regarding the suitability and limits of this software in the near future.

5.3.2 Hours - Electronic Data Capture

Recommendation – 2001

ISG to pilot the electronic data collection system and propose an implementation strategy to SEHD by end August 2001.

Progress Achieved

It has long been recognised by ISG that an electronic data capture system is needed to support doctors in training in the recording of hours of work and rest; and that a system is also needed to efficiently support NHSS Trusts in the accurate analysis of New Deal compliance based on actual hours of work and rest.
The ISG has, over the past year, focused on the development of a software system that will facilitate the monitoring of hours worked that will work in conjunction with the rota design software. The aim has been to develop software which records actual hours of work and which then compares this information to the hours information detailed in the rota. Differences between theory and practice where they occur, for example in start and finish times or expected levels of rest, are presented for interpretation in graphical form. The result aimed for being that all parties concerned have a clear idea of why the rota has failed in compliance terms and where, in the working pattern, appropriate corrective action is required.

A pilot of the hours monitoring software was conducted in late 2001 and involved participation by Tayside University, North Glasgow, South Glasgow and Lothian University Hospital Trusts. The outcome from this exercise highlighted difficulties in navigation of the software that led to a high incidence of retrospective completion in the recording of actual hours of work and rest. On the positive side the software did highlight the potential for speed of compliance analysis and, despite the user difficulties identified in the pilot, all parties concerned felt the electronic system was preferred to any paper based methods currently in use.

5.3.3 Hours - Diary card Systems

Recommendation – 2001

Clerical diary card systems should continue to be used to provide the current New Deal compliance position within Trusts.

Progress Achieved

This system continues to be the most widely used method for recording doctors in training hours of work and rest. Problems continue to exist in relation to the numbers of returns completed by training grade doctors; flaws in the calculation of compliance by NHSS Trusts who continue to incorrectly interpret monitoring data; the time involved in collating monitoring data; and the chasing up of returns and repetition of
monitoring exercises where the level of completed returns fail to meet the 75% minimum requirement.

5.3.4 IT analysis of Diary Cards

Recommendation - 2001

The ISG to identify an IT solution which supports Trusts in the analysis of diary card monitoring returns.

Progress Achieved

Work in this area was put on hold by ISG in light of the electronic hours monitoring pilot. Whilst the need for software modification is acknowledged, the electronic data capture system is widely recognised as having the potential to provide the necessary basis of support to Trusts in the analysis of compliance. However, as a result of the intense effort in this area over the past year it is now recognised that no electronic capture system will replace diary card systems in every Trust in Scotland.

5.3.5 Responsibility for Monitoring

Recommendation - 2001

Trusts to ensure that responsibility for monitoring is devolved to clinical directorate level and those involved in the delivery of services are fully engaged in the compliance solution process.

Progress Achieved

The responsibility for monitoring largely remains the responsibility of medical staffing personnel across NHS Scotland- despite a recommendation that this task be devolved to clinical directorate teams featured in both the March 2000 and March 2001 ISG reports.
Furthermore the Minister for Health and Community Care, in commending the ISG March 2001 report to NHS Scotland, asked that each rota be allocated a lead clinician with responsibility for the management of New Deal compliance issues. His/her remit being to work with the ISG to assess where shortfalls in compliance exist and to identify what solutions could be introduced to resolve matters. As with the devolution of monitoring to clinical directorates, this has also largely not been adopted across NHSS.

5.4 New Deal accreditation

Recommendation - 2001

The ISG to develop a national approach for New Deal accreditation in Scotland by June 2001.

Progress Achieved

UK New Deal non-hour standards were issued to NHS Scotland in June 2001 under cover of HDL (2001) 50. This outlined the roles of ISG, NHSS Trusts, Postgraduate Deans and Doctors in Training in ensuring that standards are being met. It also required ISG to ensure that assessment of performance against standards was incorporated into the New Deal accreditation process.

ISG have undertaken New Deal accreditation visits to all hospital sites to inspect accommodation, catering and security facilities.

The HDL requires that the Group submit a report to the Trust, SEHD, postgraduate Deans, Royal Colleges and training grade doctor representatives within one month of the visit being made. The Trust is then given 6 weeks following receipt of the visit report to submit an action plan for improvements to SEHD where these are required. The content of action plans to be agreed with all interested parties (i.e. the Trust, the Dean, the ISG, and the Local Negotiating Committee).
At the time of writing no visit reports have been issued to NHSS in line with SEHD instruction. It is the understanding of ISG that a legal question has been raised by a number of NHSS Trusts over the range of accommodation covered by HDL (2001) 50.

Until this issue is resolved at a UK level SEHD have instructed ISG not to issue visit reports to NHSS Trusts.

5.5 Laboratory Systems

Recommendation - 2001

Trusts to ensure order-communication systems for laboratory and radiology services continue to feature prominently in the operational requirements of new IT investment.

Progress achieved

This continues to feature in Trust Capital Investment plans.

5.6 Phlebotomy Services

Recommendation - 2001

If any Trust considers that a 7-day phlebotomy service in acute specialties is not appropriate then a case for not introducing the recommended service must be made to SEHD.

Progress achieved

When surveyed by the SEHD most Trusts across NHS Scotland declared having either a 7-day phlebotomy service or funding approval to provide this level of service. Many Trusts however report difficulties in relation to the recruitment of staff to fill weekend vacancies and action continues to be taken at local level in an attempt to address this.
There are a number of exceptions where neither funding has been secured nor efforts made to ensure the provision of a 7-day service. Further, there is a discrepancy between the declared level of phlebotomy service across NHSS and the apparent delivery of this service at ward level.

5.7 Education & Training

Recommendation - 2001

Royal Colleges and Postgraduate Deans to be consulted on how delivery of training can be redesigned to fit with partial and full shift working.

Progress achieved

The implications for the training of doctors in a changing NHSS where reduced hours and a move away from on-call to full and partial shift type working patterns becomes more and more the norm is largely being taken forward by a UK group established to facilitate implementation of the European Working Time Directive (EWTD). Membership of this Group includes the BMA, the 4 UK Health Departments and representatives of the Royal Colleges and NHS. This Group will, as part of its work, assess the educational implications of hours reduction flowing from reduced training grade doctor exposure to service delivery. Where appropriate the Group will engage with the relevant educational bodies to ensure these same issues are addressed.

It is widely accepted that the findings of the SHO Modernisation Review Working Group chaired by Liam Donaldson CMO England will, when reported, form the basis of how the training of doctors will be delivered in future. This work will also feed into the UK EWTD Group.
5.8 Links with English and Welsh Task Forces

Recommendation - 2001

The ISG to maintain links with appropriate taskforces throughout the UK.

Progress Achieved

The ISG continue to network with UK colleagues on operational aspects of New Deal implementation. In the past year the Scottish Group has developed a strong working relationship with their ISG colleagues in Northern Ireland. This has involved the Scottish ISG attending the recent launch of the Northern Ireland ISG in Belfast; and colleagues from Northern Ireland participating in ISG group meetings held on a monthly basis to share experiences and to identify areas of common concern.

The ISG in Scotland has also further developed national policy guidance relating to both the New Contract and New Deal and many colleagues from across the UK now look to the Scottish Group for advice and guidance around areas of policy interpretation and application.

This is extremely encouraging particularly when considering the Group itself has only been in existence since September 1999.
6. FURTHER RECOMMENDATIONS – AUGUST 2002

6.1 Management Information

The ISG has, since its inception, continued to develop and improve the methods used for compliance data collection. This has led to increased confidence of the accuracy of Trust returns by both SEHD and the BMA.

The format for data collection has also necessarily evolved in recognition of the changing compliance environment. Progress towards August 2004 and stage 1 of EWTD implementation will require that information is collected on both hours of work and rest if the necessary evidential base is to be available to inform the planning process for full implementation of the Directive in 2009. Whilst recent improvements to the Trust Position Statement (TPS) now provide headline detail on actual hours worked, there is no available means as yet for gathering information on whether the EWTD 11 hour rest requirement in every 24 hour period is being met.

Recommendation:

1. SEHD to develop the New Deal compliance Trust Position Statement to incorporate details of rest achieved in line with EWTD requirements.

6.2 Trust infrastructure

Much progress has been made in this area over the past two years with a senior management structure in place across most of NHS Scotland to address New Deal compliance issues. Trust Implementation Groups have now been established in all Trusts throughout Scotland in line with SEHD guidance. Many Trusts have established well attended meetings which focus on New Deal objectives and are effective in gathering resources, expertise and information and co-ordinating strategies to achieve New Deal compliance. The benefit to these Trusts is clear. Others however suffer from poor attendance, inadequate composition and poor focus. Operational effectiveness of these groups is to feature in the New Deal accreditation process.
Recommendation

2. Trusts reassess the composition, attendance, objectives and progress of their Trust Implementation Groups to ensure they are fit for purpose.

New Deal ownership at clinician level varies throughout Scotland. The day to day management of training grade doctors is at best described as patchy across the service as a whole.

This is despite the Minister for Health and Community Care asking the NHSS, in her cover letter to the ISG March 2001 report, to appoint a lead clinician to every rota with responsibility for dealing with New Deal compliance issues. This remains largely undone. Where Trusts have appointed clinicians their engagement in the practical day to day issues impacting on New Deal compliance is generally very limited.

There is ambiguity within the NHSS community over SEHD expectation of the "lead clinician" role and currently no central guidance is available in this area.

Recommendation

3. SEHD to issue guidelines, by Autumn 2002, outlining the level of involvement required from lead clinicians at individual rota level in taking forward issues of New Deal non-compliance; and to consider further how this standard should feature in the New Deal accreditation process.

While significant progress in Trust infrastructure development has been made, in many cases practical New Deal expertise often resides with one member of the Human resources Directorate. This renders the system vulnerable to staff turnover or sickness.

Awareness and knowledge of the New Deal has increased over the past 18 months within NHSS. However, lack of knowledge at Trust, senior and junior doctor levels is
hindering efforts to secure New Deal compliance across the service as a whole. There is a need for systems to ensure that staff charged with implementing change and monitoring in line with the New Deal are appropriately trained (c.f. section 6.8) and that doctors in training are educated about New Deal compliant working patterns, their entitlements and responsibilities.

**Recommendations**

4. SEHD to issue guidance to Trusts regarding the appointment of individual(s) to take the lead in implementing the New Deal, and that they are of an appropriate grade, have appropriate experience and training; and that these factors feature in the New Deal accreditation process.

5. Trusts ensure that doctors in training are educated about hours of work legislation that exists to protect their health and safety and that of their patients.

While accepting that reducing doctors hours of work necessarily impacts on training and service delivery, the remit of ISG remains to assist Trusts in implementation of the New Deal. Several Trusts have therefore established groups to address training and service delivery in light of the New Deal, the European Working Time Directive, the Future Practice report and the SHO modernisation review. While the work of these groups is ongoing it is difficult to whole-heartedly recommend that all Trusts establish similar groups but it is clear they will be well placed to develop Trust-specific solutions in the context of a national framework.

**6.3 Software Support**

The potential for IT systems to facilitate New Deal implementation is clear. Over the past two years the ISG has been working closely with a commercial software development company to develop such tools. Efforts have focused on two areas; firstly development of rota design software, which would assist the design of New Deal compliant working patterns, and secondly an electronic data capture system as
a potential alternative to paper based monitoring. Progress has been slower than was first anticipated.

Considerable effort has been spent by ISG members in developing and evaluating the rota design software. Given the length of time taken to develop a product and the need to shift focus to the European Working Time Directive in the near future, a reassessment of the short, medium and long-term objectives of any software solution is needed. There is a clear need for software to assist in design of New Deal compliant work patterns in the immediate future.

Recommendation

6. ISG declare, by end August 2002, whether the rota design software currently being evaluated is fit for purpose. If not, that ISG undertake to evaluate other products currently available.

As August 2004 and thus phase I of EWTD implementation approaches any software provider must have plans to incorporate the limits of the EWTD.

Recommendation

7. ISG evaluate the capacity of all available products to incorporate both New Deal and EWTD limits and make a recommendation of a software solution that will address these needs, by Spring 2003.

It must be stressed that no software package will negate the need for an understanding of the New Deal. Whilst any future roll-out of the rota planning and hours monitoring systems may largely address the difficulties encountered in the complex area of compliance assessment, there still clearly remains a training need for staff on the concepts of rota design and the principles behind assessment of compliance that must be grasped if the software is to be used in any meaningful way.
Recommendations

8. ISG to consider the best approach to support software design company to deliver workshops aimed at promoting rota design and hours monitoring software products deemed fit for purpose by ISG. The SEHD outline the cost and resource implications as well as the level of available training support in their use and application.

9. The option of central negotiation by SEHD of any licences, which would be purchased by NHSS Trusts.

Once the Group gives final approval operational issues will need to be addressed if the product is to be adopted across NHS Scotland as a whole.

6.4 Hours Monitoring

6.4.1 Diary Card Systems

Currently paper based monitoring is the only practical system available for use across NHS Scotland. In addition, it is unlikely that any IT solution will eliminate the use of diary cards in Scotland.

ISG, in discussions with Trusts, have established that monitoring exercises using the diary card method have had variable success in terms of the number of individual returns completed by doctors in training and the degree of detail recorded on each return. Having discussed the issue in detail with both doctors and medical staffing personnel, it would appear that poor response to monitoring exercises may be due in part to the methodology used by Trusts. Throughout Scotland, Trusts have developed standard template monitoring forms. The design and efficiency is variable and in some cases interpretation of collected data may be rendered difficult due to poor form design.
Recommendation


6.4.2 Electronic Data Capture

The outcome of the pilot exercise in November 2001 resulted in further discussions between ISG and the software development company concerned. The group will be shortly undertaking further trials of the upgraded software and it is anticipated, as with the rota design software, that a decision on whether this solution is fit for purpose will be reached soon. It will then be for SEHD to consider whether, and how best, to promote this product to the wider NHSS community.

The rota design and hours monitoring systems have been developed jointly to ensure one is compatible with the other and, as detailed earlier in the report, that actual hours data captured using one system can be compared with the theoretical working patterns recorded on the other. It is the view of ISG therefore that any eventual promotion of these products to NHS Scotland be done jointly.

Recommendation

11. ISG to ensure that a decision on fit for purpose hours monitoring systems be made by Autumn 2002.

Given the difficulties and delays in developing an electronic data capture system, the need for paper based monitoring for the foreseeable future and the arduous nature of monitoring analysis, ISG should refocus efforts to identify an IT solution to support analysis of diary cards systems.
12. ISG to identify an IT solution that will support Trusts in their analysis of diary card monitoring systems.

6.4.3 Failure to Implement Monitoring Arrangements

The contract implementation guidance contained within HDL (2000) 17 states that from 1 December 2000 it is a contractual obligation for employers to monitor training grade doctor hours of work; and for doctors to co-operate with these same monitoring arrangements. Hours are to be recorded and checked twice yearly as a minimum and the monitoring period should be of two week and completed six weeks before the change of house. Failure on the part of NHSS Trusts to undertake hours monitoring will result in an improvement notice being served. If Trusts subsequently fail to implement appropriate monitoring arrangements within six months of the improvement notice being served, training grade doctors occupying posts not monitored will be paid as if they were in New Deal non-compliant posts.

Recommendation

13. Using information from the February 2002 TPS returns, SEHD to serve, by September 2002, improvement notices to all NHSS Trusts for rotas that have not been monitored since August 2001. The affected posts to attract Band 3 rates if improvement notices are not actioned within 6 months of being served.

6.4.4 Failure to Participate with Monitoring Arrangements

The HDL (2000) 17 also states that where an individual or group of training grade doctors in a rota fail, without good reason, to meet their contractual responsibility to supply monitoring data, they shall receive a written notice of their contractual obligation to cooperate and be required to participate in a further round of monitoring. Persistent failure to comply with monitoring arrangements will represent a breach of contract and may result in disciplinary procedures. In these circumstances the Trust is required to determine what it regards as the correct pay band on the basis of the available information.
ISG have, in discussions with Trusts, established that many are unclear over how "persistent failure to comply with monitoring arrangements" should be interpreted; what robust systems should exist in terms of "written notice" issue and read across to "disciplinary procedures"; and a lack of understanding over what "available information" should be used, in the absence of sufficient numbers of completed monitoring returns, to determine the "correct pay band."

It is the view of ISG that issues of approach to monitoring exercises and dealing with training grade doctors failing to comply will remain relevant, irrespective of any eventual system that is used across NHSS as a whole.

**Recommendation**

14. SEHD, after discussion with the ISG project board including SJDC, to issue to NHSS Trusts by end September 2002 an interpretation of current guidance as it applies to training grade doctors failing to participate in monitoring exercises.

6.4.5 **Responsibility for Monitoring**

This continues to be perceived as the remit of medical staffing personnel and serves only to perpetuate the lack of hands on day to day management responsibility for New Deal compliance issues at clinical directorate level.

**Recommendations**

15. SEHD to consider how best the devolvement of monitoring responsibility to clinical directorates should be facilitated and to consider the issue of separate instruction to Trusts on this matter. To cross-refer to best practice guidelines on monitoring as recommended earlier in the report and to incorporate these same standards into the future assessment of New Deal accreditation.
16. Any Trust that considers devolvement of monitoring responsibility to clinical directorate teams to be inappropriate will be required to submit a case to the SEHD outlining their rationale.

6.5 New Deal Accreditation

HDL (2001) 50 issued in June 2001 outlines the New Deal non-hours accreditation standards. HDL (2000) 17 issued in October 2000 details the standards as they apply to hours compliance, including guidance to be followed/applied on both the revision to pay bands as well as implementation of monitoring procedures necessary to maintain understanding of the hours worked position.

This report has also referenced additions to the accreditation framework in the form of best practice guidelines on approaches to monitoring exercises; devolvement of responsibility for undertaking monitoring exercises; and the appointment of lead clinicians on a rota by rota basis with practical hands on involvement in the day to day management of New Deal compliance issues.

Recommendation

17. SEHD to produce a single New Deal accreditation framework document by end 2002 which collates all existing standards against which Trusts are to be assessed for New Deal accreditation.

6.6 Laboratory Systems

The requesting of routine lab investigations is a task that is often time-consuming for doctors in training and frequently has little educational value. Further, systems to facilitate prompt return of test results are often inadequate and may result in doctors remaining at work and thus exceeding scheduled shift times. These factors can lead to failure to attain New Deal limits on several levels thereby rendering the work pattern non-compliant.
Recommendation

18. The SEHD survey, with appropriate validation, the current state of laboratory communication systems within Trusts in NHSS by end 2002.

6.7 Phlebotomy services

The SEHD has undertaken a survey of all acute specialties across NHSS to establish the level of phlebotomy cover. ISG were instructed by the SEHD to validate each of these returns at Trust level. Three Trusts have been identified from this survey as failing to meet the requirement. These are to be the subject of correspondence from SEHD who will be seeking to establish why a case for not introducing the recommended level of service has been received.

The ISG have identified a clear discrepancy between the Trust reported delivery of 7-day phlebotomy cover and that experienced by doctors at ward level. Validation of the phlebotomy survey returns must incorporate ward level delivery in addition to the appropriate systems in place, while being cognisant of the workload of ISG. This is likely to be on a sample basis.

It is likely that this validation exercise will demonstrate that provision of 7-day phlebotomy is far less wide spread than has been reported to date. The provision of robust phlebotomy services has significant impact on the attainment and maintenance of complaint working patterns, particularly at PRHO level. Phlebotomy services are facing difficulties at many centres in Scotland, while at others novel strategies have been implemented to ensure the establishment of a robust service 7 days per week.
Recommendations

19. SEHD to
- address the difficulties in phlebotomy recruitment and retention through the Scottish Personnel Group.
- undertake a bi-annual assessment exercise, with appropriate validation by SEHD, to monitor the extent of 7-day phlebotomy across NHSS.

20. ISG to
- Develop a system to allow sample validation of the extent to which phlebotomy is delivered at ward level.
- Validate SEHD survey by Autumn 2002 and validate all subsequent phlebotomy surveys at ward level.
- Disseminate examples of novel provision and best practice in relation to phlebotomy services.

6.8 Education & Training of Trust staff

While awareness of the New Deal has increased over the past year, there still remains a general lack of understanding across the NHSS as a whole over what constitutes a New Deal compliant working pattern; the processes which must be followed in relation to pay protection; and the procedures which must be followed where changes to pay bands are being proposed.

This is despite delivery of ISG training events following launch of the New Contract guidance and ongoing educational work at local level through regional ISG networks. There is recognition that, as Trusts develop an appropriate New Deal infrastructure, their effectiveness is hindered by a lack of education. ISG is best placed to deliver regular, high quality education sessions.

ISG is currently finalising an update to the New Deal Education & Training Guide issued in October 2000 as Appendix E to HDL (2000) 17. Once completed the document should be launched through a series of regional workshops during which the concepts and principles of New Deal compliance can be re-emphasised.
Recommendations


22. ISG to facilitate the delivery of on-going and regular education workshops using the revised Education and Training Guide as the basis for promoting the concepts and principles of rota design and assessment of New Deal compliance. ISG to publish detail of events in terms of dates and location by autumn 2002.

23. The ISG to utilise the web site to disseminate news and best practice cases to Trusts.

ISG is facing an ever increasing workload as the group continues to support Trusts in their efforts to secure New Deal compliance. It is recognised that many Trust personnel charged with New Deal issues are facing similar difficulties. The interaction between ISG and these Trust personnel may be streamlined in order to increase the efficiency with which concerns are addressed.

Recommendation

24. The SEHD to establish a New Deal Network in conjunction with ISG, the membership of which are drawn from representatives of Primary Care and Acute NHSS Trusts, to meet at an appropriate frequency to discuss New Deal issues; share best practice; and to discuss issues of general concern. These Trust representatives to work in support of ISG by providing a front-line New Deal advice service within the "home" Trust.
6.9 Future ISG Focus

6.9.1 Local Work

Until September 2001, the effort of all parties working towards New Deal compliance focused primarily on PRHO posts. These efforts ensured that, by 15\textsuperscript{th} September 2001, 95% of the most junior of doctors in Scotland were working safer New Deal complaint patterns. Since this time, attention has shifted to achieving compliance for all grades of doctors in training. This resulted in a massive expansion of workload for all charged with New Deal implementation and a resultant loss of the intense focus on PRHO posts. These circumstances may explain, in part, the disappointing drop in reported PRHO compliance figures to 77% in February 2002, and further decreases since then.

Recommendation

25. ISG review all PRHO rotas by November 2002

The ability to work and train flexibly will be a key feature of workforce recruitment and retention\textsuperscript{1}. Under the New Contract flexible trainees (also known as Less Than Full Time Trainees) attained parity of remuneration with their full time colleagues. However, staging of the banding multipliers for full time doctor in training resulted in a minor discrepancy of parity and resulted in a perceived difficulty in some Trusts to appoint to these posts. December 2002 sees the final stage of the New Contract banding multipliers and thus parity between flexible and full time trainees will be restored. Many flexible trainees work on non-compliant work patterns. The financial impact of this on Trusts is being addressed and in many cases flexible work patterns can attain compliance with minor changes.

Recommendation

26. ISG review all flexible trainee rotas by November 2002.

\textsuperscript{1} Future Practice: A Review of the Scottish Medical Workforce (2002)
Progressing New Deal implementation in Primary Care Trusts has been hindered by many of the same difficulties faced by Acute Trusts. However, the progress in terms of knowledge and infrastructure has been much less dramatic than in the acute setting. The resultant position is that many primary care rotas are at a high risk of slipping into non-compliance from a baseline of relatively low banding. It is the ISG opinion that many of these events may be averted by minimal intervention.

**Recommendation**

27. ISG review all Primary Care rotas by Feb 2003

6.9.2 National Issues

Strategic work to address the education implications of hours reduction and subsequent read across to service exposure is being taken forward by the UK EWTD Group.

**Recommendation**

28. ISG feed in to Scottish level discussions regarding hours of work and rest requirements and read across to training and service delivery.

There has been no significant progress in achieving New Deal compliant work patterns for SHOs and SpRs over the past year. At a national level, the recommendations of the SHO modernisation report are awaited, and the recommendations of the Temple report will impact on the structure of the workforce at this level in the medium term.

However, ISG in partnership with Trusts must develop a robust strategy to ensure all effort is made to achieve New Deal compliance for these grades of doctors, while being cognisant of national and UK level recommendations and the EWTD.
Recommendation

29. SEHD and BMA support Trusts in developing a strategy to achieve compliance for all doctors in training by August 2003, and that the SEHD, after consultation with the ISG Project Board, develop a mechanism to target areas where this has not been achieved.

ISG has gained wide experience of New Deal implementation throughout Scotland. There is considerable scope to improve the efficiency with which ISG interacts with Trusts personnel. This will be addressed in part by the establishment of a New Deal Network offering regular meetings.

In the past year the ISG web site has been established. This can be developed as a forum to inform Trusts of developments within ISG, scheduled training events, novel strategies to address common problems and to disseminate possible IT solutions (c.f. 6.3.2). This should be in conjunction with a new paper-based distribution network.

Recommendation

30. The ISG investigates the use of a paper-based solution to improve ISG communication with Trusts.

ISG has maintained links with taskforces in England and developed ties with the Northern Ireland ISG. The latter has proved to be mutually beneficial.

Recommendation

31. The ISG to maintain links with appropriate taskforces throughout the UK.
7. COMPLIANCE

The New Deal compliance figure for Scotland as at February 2002 is 48%. Broken down by grade this appears as follows:

PRHO: 77%\(^2\)  
SHO: 38%  
SpR: 42%

7.1 PRHO compliance

7.1.1. Current position

The starting point for PRHO compliance was 13% reported in the ISG March 2001 report.

The New Contract introduced a timescale of August 2001 for all PRHO posts to comply with New Deal limits on hours of work and rest. As at September 2001 95% of all PRHO posts complied with the New Deal. Again formal recognition must be given to Trust Management, consultants, nursing staff and medical staffing personnel and junior doctors for their efforts in broadly achieving the target date set. ISG provided necessary support and guidance on the available options and considerations available to NHSS around work pattern redesign to facilitate change. This largely involved a move from on call to both partial and full shift type working. There now exists only one on-call PRHO rota across NHS Scotland.

The decrease in the proportion of PRHO posts meeting New Deal limits by February 2002 is clearly disappointing. The shift of focus since September 2001 from achieving compliance for this single grade of doctor to all grades has contributed to the decline. In general, of the 87% non-compliant PRHO posts in March 2001, most failed to meet several New Deal parameters. Having achieved 95% compliance by September 2001, only a proportion were robustly within New Deal limits. The

\(^2\) This figure is based on known levels of compliance provided by ISG following validation of trust monitoring returns
following months saw posts drift into non-compliance by exceeding one or two New Deal limits.

Thus, while the failure to maintain PRHO compliance at 95% must be addressed, many of these PRHO posts can be brought within New Deal limits with relative ease when compared to March 2001. However, this will only be achieved by a co-ordinated focused effort of all involved. In the meantime, the PRHO compliance figures remain fragile and it is likely that Trust Position Statements from August 2002 will demonstrate further worsening of the current position.

7.1.2 Improving compliance

The ISG will undertake to review all PRHO rotas in Scotland by November 2002, in line with recommendation 29, and continue to undertake spot checks of PRHO rotas to ensure compliance levels are maintained in line with SEHD instructions. Where necessary the Group will also continue to keep NHSS Trusts, the SEHD, postgraduate Deans and BMA informed of posts that are subject to strike action as and when appropriate.

7.1.3 Maintaining compliance

The SEHD has devised a framework for dealing with PRHO posts that fail to comply with the New Deal. This is attached as Annex 3 to the report. In broad terms a three strikes policy has been introduced.

- This means that where PRHO posts monitor non-compliant for the first time, ISG will write formally to the Trust referring to the guidelines issued by SEHD on the process to be applied for ensuring compliance with the New Deal for this grade of training doctor.

- Where the rota is declared non-compliant on a second occasion, the SEHD Chief Executive will write formally to the NHSS Trust concerned confirming that one further breach of compliance will result in training posts being permanently withdrawn.
• On the third occasion where PRHO posts are found to be non-compliant following the 1 August 2001 deadline, SEHD will write to the postgraduate Dean concerned requesting permanent withdrawal from the process used to allocate medical students to their hospital placements.

At the time of writing the following rotas have reached either strike 1 or 2 in the process (c.f. Appendix 4)

7.2 SHO/SpR Compliance

SHO: 38%  
SpR: 42%

The New Contract for Doctors in Training requires that all Senior House Officers (SHO) and Specialist Registrar (SpR) posts comply with New Deal limits on hours of work and rest by August 2003.

The measures needed to secure compliance for these grades of staff present many additional challenges to those faced for PRHOs. Firstly, the proportion of work carried out by these grades that could be performed by a non-medical practitioner is much more limited. Secondly, the conflict between education, hours and service requirements is more apparent and may require more radical solutions than simple rota redesign. Work and guidance at a UK level on the SHO Modernisation Report, and at a national level with Future Practice- A Review of the Scottish Medical Workforce- will largely inform the direction both the NHSS and ISG take in terms of approach in this area. However, ISG remit remains hours only and therefore solutions requiring redesign or reconfiguration require action and ownership outwith ISG. In the meantime, work continues by ISG in providing redesign work of existing working patterns and theoretical paper modelling of proposals for service redesign and reconfiguration put forward by NHS Scotland.

The ISG Project Board comprising SEHD and the Scottish Junior Doctors Committee (SJDC) of the BMA are considering what action is needed in support of NHS Trusts
where the compliance deadline of August 2003 is not met for these grades of training doctor.

7.3 Compliance by Specialty

There follows a description of the problems being encountered in 7 major specialties of Accident & Emergency, Psychiatry, Anaesthetics, General Medicine, General Surgery, Obstetrics & Gynaecology, and Paediatrics.

7.3.1. Accident & Emergency

Compliance SHO: 51%
SpR: 28%

Full shift work patterns account for over 90% rotas in Accident & Emergency. The most significant factor contributing to non-compliance in these rotas is that work intensity leads to the inability to achieve rest Natural Break requirements of 30 minutes in every 4 hours work. Awareness of natural breaks has increased over the past year, and many A&E departments have introduced rostered breaks to assist juniors in achieving their rest.

7.3.2. Anaesthetics

Compliance SHO: 13%
SpR: 9%

Compliance figures in this speciality are disappointing. Anaesthetic trainees may face unpredictable workloads out of hours, making attainment of on call rest requirements difficult. Many however either remain working on call shifts or have moved to 24-hour partial shifts with the inherent problems associated with these. Many directorates have viewed 24-hour partial shifts as a transition to true partial shift working, which in some cases is more appropriate to achieve compliance.

Trainees in anaesthetics face specific problems, such as the inability of new SHOs to participate in out of hours cover for an initial period. Like surgical trainees, their normal working day is largely dictated by theatre list times, pre- and post-operative
periods which frequently requires a normal working day longer than 8 hours and therefore impact on the ability to achieve the Natural Break requirements. In addition, amalgamating tiers is largely inappropriate given the nature of training.

7.3.3 General Medicine*

Compliance SHO: 40%
SpR: 55%

While many medical middle graders remain on a pattern of work that is incompatible with their work intensity, progress has been made over the past year. The recognition that many, but by no means all, rotas will require a move to shift working is becoming more widespread. Trusts and juniors are highlighting the conflict between education, hours and service and some are identifying novel solutions through focus groups. Similar discussions have taken place at the Royal College of Physicians in Edinburgh.

Following Trust and ISG efforts, many medical middle grader posts have moved to compliant working patterns and are currently monitoring hours of work and rest. The group therefore expect improvement of these compliance figures in the next year. At this level, many solutions have required reconsideration of historical rota boundaries, amalgamation of rotas and novel cross-cover arrangements.

As with many specialties, there will be a subset of rotas where compliance cannot be achieved by simple rota redesign or intra-hospital reconfiguration. In such cases, cognisance must be taken of the recommendations of the Future Practice report and the need for service redesign at a broader level.

* including Paediatrics
7.3.4 General Surgery

Compliance SHO: 27%
SpR: 23%

Historically, general surgery has been staffed by training grade doctors working on call patterns and the provision of surgical services has developed around this. In many cases, the intensity of work in this speciality is not compatible with on call working and requires a move to shift patterns. Such a move is generally resisted by consultants and juniors alike, with both expressing concerns about continuity of care and training requirements. These concerns are not supported by robust evidence but have resulted in part to the lack of progress in this area.

General surgery faces specific problems when working towards New Deal compliance. The trainees normal working day is largely dictated by theatre lists and therefore many work in excess of 8 hours. This, along with the need to be in theatre, can impact on the doctors ability to achieve Natural Breaks.

When faced with a potential change in working pattern, surgical trainees frequently express concern regarding their exposure to theatre time. While important, this cannot be an absolute obstacle to achieving a safe New Deal compliant work pattern. Peer reviewed studies demonstrate that detailed consideration of training and service needs while undertaking rota redesign can result in a favourable outcome [Reference]. Further there is no evidence from abroad to support the view that shift working results in poorly trained surgeons. However, it is clear that attainment of New Deal compliant work patterns and educational requirements are difficult to achieve in the current framework of surgical service delivery. It is crucial that Royal Colleges and Postgraduate Deans examine the mechanisms by which training and service can be delivered within the limits of the New Deal and eventually the EWTD.
7.3.5 Obstetrics & Gynaecology
Compliance SHO: 46%
SpR: 30%

A substantial proportion of Obstetrics and Gynaecology trainees now work shift patterns. In some centres this is even reflected at consultant level. The intensity and nature of the speciality largely dictate such a work pattern.

Exceeding maximum duty hours and the inability to attain rest requirements are the major problems facing those in non-compliant posts.

In some areas, the discrepancy between staffing and workload cannot be resolved without considering additional staff, amalgamation of rotas, or service reconfiguration.

7.3.6 Paediatrics
Compliance SHO: 58.2%
SpR: 48.2%

Progress has been made in this speciality, but further efforts are needed. New Deal non-compliance lies generally in the volume and intensity of work. Further, the scope to transfer tasks, many of which are more specialised than in general adult medicine, to non-medically trained personnel is more limited. This issue of multiple-site cover poses further problems which require more detailed solutions.

7.3.7 Psychiatry
Compliance SHO: 51%
SpR: 68%

Compliance in Psychiatry is more favourable than in other specialties. Out of hours intensity dictates that many doctors may remain working compliant on call rota patterns. In general, however, progress in Primary Care has lagged behind that in Acute Trusts.
The ISG has identified a number of potential problems in Primary Care. Firstly, a number of rotas have been poorly designed or maintain historical structures, for example failing to account for juniors attending out of hours psychotherapy sessions or only attaining the minimum time off between shifts. Such rotas are often compatible with Band 2 or 1 in terms of intensity, but are at a high risk of drifting into non-compliance. For this reason ISG will review all primary care rotas in line with recommendation 26. Secondly, some juniors are working compliant patterns, but the Trust have not completed the rebanding procedure and thus the juniors remain in the non-compliant band. This situation reflects a lack of awareness of the New Deal and the generally poorer ownership in Primary Care Trusts. ISG will be addressing this in the next year.
8. FUTURE STRUCTURE AND DIRECTION OF THE ISG

In the past year the ISG has continued to operate on the basis of a regional team network complemented by a central ISG team, as envisaged in the March 2000 ISG report.

8.1 ISG Resource and Structure

8.1.1 The Central Team

The central team currently comprises:

Chairman
Scottish Executive Health Department Representative
Training Grade Project Doctor
ISG Manager

Given the inherent association of doctors in training, hours of work and education, the Group has benefited over the past year from the knowledge and guidance of the chairman, Professor Stuart MacPherson, Postgraduate Dean for South- East Scotland.

The Central ISG team structure has, in principal, worked well but has seen a significant turnover in staff and, for the majority of the past year, been under-resourced. This has impacted on the work of the central team in terms of policy making and guiding the future focus of the ISG, and on the support available to the regional team structure. However, the Central team is now fully staffed following recent appointments and has seen some restructuring. It is envisaged that the new ISG Manager, will assume a ‘hands on’ approach to day to day management of the regional teams. The new SEHD representatives will take a wider view of workforce issues. It is envisaged that this may allow ISG knowledge and experience to feed into more global workforce discussions, whilst protecting the ‘hours only’ remit of ISG.
For the past year, the Project Doctor on the Central ISG team has continued to maintain a regional role. While this has many benefits, the Central workload is such that the ability to maintain regional commitments is impaired. Further discussions are required in this area, however there exists an opportunity to appoint a dedicated training grade doctor to the central team in addition to the regional team staffing.

8.1.2 The Regional Teams

Prior to August 2001, each of the four regional teams comprised two training grade doctors. Since then, the teams have consisted of a training grade doctor and a non-medical with health care experience, as envisaged in the March 2001 report. This has been a productive development and the ISG has benefited from the additional depth and breadth of knowledge of the New Deal and NHS in general afforded by these appointments. It is expected that this team structure will continue.

The teams have delivered over the past year in the face of an ever-increasing workload as moves to implement the New Deal for all grades of juniors progress. It is envisaged that, in the short term, suboptimal staffing may impact on the capacity of the regional teams. Medium-term solutions have been agreed but more immediate systems to deal with the increasing ISG workload are required.

Since its inception, ISG has often become involved in more practical aspects of New Deal implementation, including rota design and analysis of monitoring data. This is out with the ISG remit, which is “to support the work of NHS Trusts in meeting hours of work targets”. Over the next year ISG should see a shift to a more supportive role in line with the Group remit. This transition will need to be in conjunction with efforts to increase skills and knowledge within Trusts. In line with this move, there exists an opportunity to provide dedicated ISG office space and appropriate resources and support.

During the next year, the ISG should develop more robust performance management system allowing appraisal and progress monitoring of team members. Furthermore, mechanisms to broaden training opportunities for ISG staff should be investigated.
During the next year objectives include:

**8.2 New Deal Compliance**

The next year will see full implementation of the pay banding in December 2002, and the deadline for implementation of the New deal for all grades of junior doctor in August 2003. This will place increased pressure on Trusts and ISG. ISG will assist Trusts in consolidating progress already achieved and in their continued efforts secure compliance across the board in line with recommendations made in section 6.9 of this report.

**8.3 Education and Training**

There exists a lack of awareness at Trust level, which is impacting on the considerable efforts of both Trust and ISG. Therefore ISG will, during the next year, focus efforts on developing knowledge and skills within the Trust New Deal infrastructure as detailed in section 6.8. This will assist in a realignment of ISG to become a more supportive body- in line with the Groups remit.

**8.4 Software Support and Monitoring**

The Group will focus efforts on endorsing suitable rota design software and assessing electronic data capture tools to assist monitoring exercises. The need for IT solutions to facilitate diary card monitoring will also be assessed.

**8.5 Accommodation, catering and security**

While the discussions continue at the UK level, progress in this area is difficult to predict. ISG will continue to advise Trusts regarding the current guidance and subsequently in the light of any future developments.

**8.6 European Working Time Directive**
August 2004 will see the first implementation phase of the EWTD for doctors in training. The timetable is detailed in section 9 of this report. ISG will continue to feed into national discussions regarding the EWTD and related workforce issues. The ISG Project Board will further discuss the timing and nature of the expansion of ISG remit and efforts to incorporate the EWTD.

8.7 Liaison with other taskforces

The coming year should see increased liaison with other UK taskforces, and the Northern Ireland ISG in particular. In the past year, this group has faced and overcome many challenges. Increased contact between these two groups will facilitate development of knowledge and expertise in both nations and assist efforts to secure New Deal compliance.
9. EUROPEAN WORKING TIME DIRECTIVE

9.1 Overview of the European Working Time Directive

The European Working Time Directive (EWTD) is European Law that seeks to “lay down minimum safety and health requirements for the organisation of working time” \(^3\) for workers in the European Union. This directive was incorporated into UK law by The Working Time Regulations 1998 (WTR). Doctors in training were specifically excluded from both items of original legislation \(^4\). However, a timetable for inclusion of junior doctors was agreed in 2000 between the European Parliament and the Council of Ministers and was detailed in an amending European directive \(^5\). This will be incorporated into UK law in the near future.

The EWTD seeks to protect the Health and Safety of workers in the European Union. It limits the maximum working week to 48 hours and details minimum rest requirements.

9.2 EWTD Rest Requirements

| Article 3: Minimum daily rest period of 11 consecutive hours per 24-hour period |
| Article 4: Minimum rest break when the working day exceeds 6 hours |
| Article 5: Minimum uninterrupted rest period of 24 hours in any 7 day period |
| Article 7: Minimum 4 weeks paid annual leave |
| Article 8: Maximum average 8 hours work in any 24 hours for night workers |

9.3 Implementation Timetable for Doctors in Training

The timetable agreed between the European Parliament and the Council of Ministers is outlined below.

- **August 2004**: 58-hour maximum working week. Rest requirements enforceable
- **August 2007**: 56 hour maximum working week
- **August 2009**: 48 hour maximum working week
- **August 2012**: Deadline for 48 hour working week may exceptionally be extended to 2012, in which case an interim 52 hours maximum working week will apply from 2009.

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\(^3\) European Council Directive 93/104/EC  
\(^4\) EWTD Article 1 and WTR Section 18  
Introduction of the 48 hour maximum working week will be phased in over 5 or 8 years from August 2004. The rest requirements will be introduced in August 2004.

This timetable only applies to doctors in training. All other non-training grades, including staff grades, associate specialists and consultants, are covered by the original legislation.

9.4 The EWTD and the New Deal

Doctors in training are currently, and will continue to be, covered by the limits of the New Deal. The New Deal limits doctors in training to 56 hours of actual work per week. Therefore, the EWTD will only supersede the hours of work limits in the New Deal in August 2009.

Introduction of the EWTD rest requirements in August 2004 may have a profound impact on the way doctors work. While the New Deal requirements are similar to the EWTD in some areas, such as Articles 4, 5 and 7, Article 3 and 8 may pose the greatest challenges. The need to attain 11 consecutive hours rest in any 24 hour period coupled with a possible 8 hour maximum shift length at night will necessitate a radical reconsideration of workforce structure, training and healthcare delivery.

9.5 The SiMAP Ruling

The New Deal maintains the concepts of ‘duty hours’ and ‘actual hours’ of work. A doctor working an on-call or partial shift may be ‘on duty’ but not actually working unless waiting to perform a clinical task or until called upon to perform a duty for his/her employer 6.

A group of Spanish primary care physicians, Sindicato de Médicos de Asistencia Pública (SiMAP), brought a case to the European Court claiming that all hours spent resident at their place of work should be considered actual work. In response, the

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6 HDL (2000) 17 Appendix B
European Court issued a judgement in October 2000 defining all resident hours as work under the EWTD.

This is of huge significance for doctors in training. It effectively prohibits resident on-call or partial shift working patterns and thus requires all resident doctors to work full shifts.

It is likely that this ruling will also apply to junior doctors in the UK.

9.6 The Future

Many groups are currently working to assess the implications of the EWTD on the medical workforce both at a UK and a Scottish level (c.f. Section 5.7). The EWTD is European Law that has been incorporated into UK Law. It is not an agreement between the Government and the medical profession. While the hours limits are non-negotiable, the EWTD allows the possibility of derogations on aspects of the rest requirements. This may introduce an element of flexibility in attaining rest requirements in exchange for compensatory rest. Discussions regarding this are ongoing at a UK level.

It is clear that introduction of the EWTD will introduce limits that are incompatible with the current working patterns of junior doctors within the NHS. Several areas of the EWTD require further clarification, including the potential for derogations and the application of the SiMAP ruling, before the full impact on the medical workforce can be assessed.

With the recent reviews of doctors training and medical workforce planning in Scotland, and new legislation driving change, the next decade will see a dramatic shift in the way the medical profession works, trains and delivers health care for the future.
Dear Colleague

NEW DEAL FOR DOCTORS IN TRAINING - TRUST IMPLEMENTATION GROUPS

In the March 2001 New Deal Implementation Support Group report endorsed by Susan Deacon, Minister for Health and Community Care, it was recommended that the Scottish Executive Health Department (SEHD) should issue guidelines on the membership, remit and frequency of New Deal Trust Implementation Groups (TIG). This same report stated that the operational effectiveness of these groups should also feature in the New Deal accreditation assessment process.

It is proposed that following completion of returns on accommodation, catering and security included in HDL (2001) 62 assessment of trusts for accreditation purposes will be timetabled early in the new calendar year.
I enclose a document outlining what SEHD consider to be the minimum standards for TIGs and ask that you ensure this is copied to those members of staff who it recommends should be actively involved in the New Deal compliance process. These same standards should be operating within your trust as soon as is practically possible and certainly in advance of the accreditation timetable as outlined.

Should you have any queries on the content or intent of this note please do not hesitate to contact either Kevin Hanlon on 0131 244 3572 or Janis Millar 0131 244 1846.

Yours sincerely

KEVIN HANLON
TRUST IMPLEMENTATION GROUPS

Membership

- Executive Director with lead responsibility for New Deal (often as Chair)
  - Senior Clinical staff
- Medical Director
- Lead Clinicians with responsibility for compliance in their area
- Post Graduate Tutors
  - Doctors in Training
- Any site BMA representatives
- Trust representatives
  - Senior Nursing staff
- Representatives of the nursing staff within the hospital
  - Human Resources
- Director of Human Resources – helps to emphasise importance of issues and aids organisation of HR support.
- Lead within Human Resources responsible for compliance with New Deal
  - Trust Management
- Depends on the organisation within the trust. Ops/Departmental/Divisional Managers, i.e. those responsible for day to day departmental management.
- Facilities manager - for discussions on accommodation, catering and security.
- Finance representative to assess cost implications.
  - ISG
- Regional ISG team.
  - Others
- There are others who will undoubtedly make a useful contribution to TIG meetings. However, there is a risk these discussions become too large and unmanageable. Invitations should be extended to others when it is considered relevant to the agenda.
Frequency

• Will vary according to the levels of non-compliance within trusts. However should be held quarterly as a minimum.

Remit

• The remit of the Trust Implementation Group to be:

  To ensure that [TRUST] becomes and remains compliant with the provisions of the New Deal for Doctors in Training including hours of work, rest criteria and accommodation, catering and security standards.

Objectives

• Maintain information base on levels of non-compliance across trust on rota by rota basis and actions in progress towards securing compliance with New Deal standards.

• Monitor progress towards compliance and ensure actions undertaken within timescales agreed on each non compliant rota.

• Co-ordinate trust wide activities in support of the compliance agenda.

• Assess accommodation, catering and security provisions in line with nationally agreed standards and monitor progress of remedial work to be undertaken to improve standards where appropriate.

• Follow up of action points generated from previous TIG meetings.
Appendix 2 - Membership of the Implementation Support Group

Central ISG

Chairman - Professor Stuart Macpherson
SEHD representative - Kevin Hanlon
Project Doctor - Dr Chris McCullough (Feb- Aug 2002)
                     Dr Jane Burnett (Aug 2001 - Feb 2002)

Regional Teams

North - Dr Andrew Thomson
         Mr Scott Strachan
East - Dr Chris McCullough
          Ms Caroline Woolley
West (1) - Dr Karen Crozier
            Ms Anne MacCrimmon
West (2) - Dr Gayle Campbell
           Mrs Jane McMeekin
Dear Colleague,

PRHO COMPLIANCE

I am writing to congratulate you on the successful efforts which have been made by your Trust in ensuring that compliance with New Deal targets on hours of work and rest for PRHO posts has in the main been secured. From a Scottish total of 761 posts, only 41 posts were found to be non-compliant and have now had training approval withdrawn.

The New Deal Implementation Support Group (ISG) was established in partnership with the Scottish BMA Junior Doctors Committee (SJDC), to provide support to trusts on New Deal compliance issues. This has taken the form of advice on appropriate support services and/or redesign of working patterns that meet New Deal compliance parameters. Disappointingly the Group continues to identify instances where working patterns have been designed and introduced by trusts which have failed to meet New Deal requirements. Against this backdrop I feel it necessary to ask you and your senior management team personally ensure all within your trust are aware of the need for ISG to be sighted on any proposed changes to current working patterns or on any newly designed working patterns, prior to their introduction. This will ensure that a quality assurance process and consistency of standard across NHS Scotland is in place. More importantly it will avoid unnecessary work at clinical directorate level both in terms of introducing changes to working practices which in themselves are non-compliant, and recording and analysing monitoring information which merely serves to confirm the non-compliance of a flawed working pattern.

The New Deal is a necessary first step towards implementation of the European Working Time Directive (EWTD). There is work currently underway to address SHO and SpR hours of work and provide a basis for the Health Department and NHS Boards to work together to respond to EWTD implementation. This in my view provides the platform for all to be able, with confidence, to sign off the PRHO compliance position. We do not want to find ourselves retracing steps on an issue which all considered to be resolved.

1 November 2001
I have asked ISG to ensure that further monitoring exercises of PRHO posts are undertaken by trusts at a time determined by the Group, to ensure necessary protections introduced on PRHO hours limits by trusts are being sustained. Where steps introduced to secure PRHO compliance are found to have been withdrawn, I will have no hesitation in sanctioning once more the removal of training approval where recommended by postgraduate Deans. Similarly where PRHO posts are found to drift from compliance parameters on an ongoing basis, the ISG will be asked to maintain records and postgraduate Deans will be required to take action to ensure offending posts are permanently withdrawn from the process used to allocate medical students to their hospital placements. Ongoing steps to be taken in relation to specific operational circumstances are outlined in the attached Annex for information.

The Minister for Health and Community Care has stated her determination to see this task through, not just for training grade doctors, but also for patients and for the reputation of NHS Scotland. This issue should and will remain a priority for us all. We have taken an important first step. It has been a difficult one but one about which we should be proud. We must now continue to work in partnership to build on this encouraging progress.

Yours sincerely

Trevor Jones
Head of Department and Chief Executive, NHS Scotland
posts deemed non-compliant by the 15 September deadline and subsequently withdrawn from the process used to allocate medical students to their hospital placements from August 2002. Trusts to institute necessary changes to working practices and to re-monitor over a two-week period to confirm that compliance has now been secured. Prior to the end of the rotational period of the post the Health Department to instruct ISG to obtain a further two-week period of monitoring evidence to ensure standards are being maintained. Trust to then submit evidence to the appropriate postgraduate Dean for consideration of training approval reinstatement.

where a further round of monitoring is undertaken in November 2001 (as outlined in the recent press release) and the trust is shown to have altered the environment within which posts were monitored as compliant prior to the 15 September deadline. This may have involved the provision of phlebotomy services for the monitoring period only; or consultants no longer ensuring that PRHO staff are leaving wards at their rostered finishing time. In these instances it is proposed posts found to be non-compliant will be immediately withdrawn from the process used to allocate medical students to their hospital placements in August 2002. No second chance to secure compliance in these instances is proposed. It then follows that the postgraduate Dean and the affected trust(s) are left to agree where training posts should be reallocated to, in light of trust service and PRHO training needs, within a period not exceeding 18 months following the date that non-compliance is established. This allows sufficient time for any potential disruption to service delivery to be managed effectively.

posts which continually drift in and out of compliance parameters. Trusts to institute necessary changes to working practices and to re-monitor over a two-week period to confirm that compliance has now been secured. However this should only be done on a maximum of three occasions. In other words where rotas are found to have drifted into non-compliance on three occasions (no time limit to be applied) they should be permanently withdrawn from the process used to allocate medical students to their hospital placements. The management of the withdrawal process should be as outlined in (ii).

posts which fail the extended 17 October deadline to secure compliance. Trusts to institute necessary changes to working practices and to re-monitor over a two-week period to confirm that compliance has now been secured. However if monitoring at a future date reveals that compliance parameters for these rotas fail once more, then the maximum three breaches will have occurred as outlined in (iii) above and these posts will be permanently withdrawn from the process used to allocate medical students to their hospital placements.
## Appendix 4 - PRHO Posts Reaching Strike 1 or 2

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