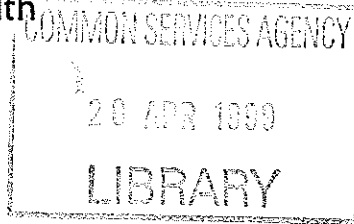




THE SCOTTISH OFFICE

Department of Health



NHS
MEL(1999)40

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

19th April 1999

Dear Colleague

THE NEW DEAL FOR JUNIOR DOCTORS

Continuing Action to Meet New Deal Standards:

- rest periods and working arrangements
- improving accommodation catering and security for juniors

Summary

1. This circular provides guidance for Trusts and other signatories to the New Deal for Junior Doctors on the consistent interpretation of the guidelines for achieving compliance with the contracted and actual hours of work targets and the 3 non-hours standards – accommodation, catering and security.

Background

2. Trusts and Health Boards should note that the guidelines, which were agreed by the Ministerial Group on Junior Doctors' Hours in 1990, are contained in the booklet "Junior Doctors – the New Deal" issued to all Trusts in 1991.

Action

3. Trusts and Health Boards should apply the guidance set out in the Annex and Appendices to this letter as they work towards full compliance with all New Deal targets and standards.

Yours sincerely

pp. Stuart Robert

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Assistant Director of Human Resources (Policy)

Addressees

- For action:**
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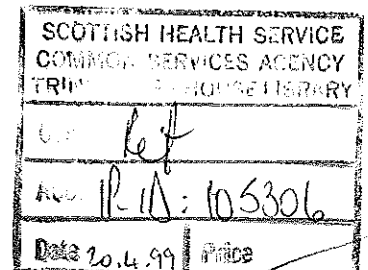
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INVESTOR IN PEOPLE

1. Details of the requirements of the contracted and actual hours targets are set out at Appendix A.

Details of agreed national guidance are provided as follows:

- rest requirements within New Deal working arrangements (Appendix B);
- 24-hour duty periods within partial shift working arrangements (Appendix C); and
- this circular also sets out, for the first time, guidance on the operation of *hybrid working arrangements*, where junior doctors' working patterns contain significant elements of more than one standard working arrangement (Appendix D).

2. The aim is to encourage a consistent approach in the interpretation of the guidelines as Trusts implement and maintain the New Deal targets and standards.

Background

3. Since the launch of the New Deal for Junior Doctors in 1991, there have been major improvements in junior doctors' and dentists' working hours. However, it would be wrong to suggest that all the problems of long hours and high work intensity have been solved. There also remains a need for continuing effort by Trusts to ensure that juniors are provided with acceptable living and working conditions, including decent standards for overnight accommodation and out-of-hours catering. Action on both hours and non-hours issues must go hand in hand to ensure that the *quality* of rest as well as its quantity is conducive to the training needs of junior doctors and to patient care.

Ministerial Commitment and Trust Responsibility

4. Ministers recognise that despite the hard work of NHS staff at all levels there is still a hard core of problem posts. In asking Trusts to review their local working arrangements, Ministers signalled that action on long hours would continue as a priority. This is particularly true in the case of PRHOs, where work intensity often remains unacceptably high and where full compliance with the hours targets is especially important during this first training year.

5. On 22 December 1998, Mr Galbraith wrote to all Chairmen of Trusts and DMUs asking them to take personal responsibility for ensuring compliance with the hours targets and the non-hours standards and underlining his own personal commitment to seeing full implementation of the New Deal.

Current Position

6. It is accepted that some difficulties remain in achieving full New Deal compliance within the NHSiS. To help Trusts address and resolve the outstanding issues, the Management Executive established an Audit Group to undertake a thorough-going review of those 11 Trusts experiencing the greatest difficulties in implementing the New Deal. The

Group's report is in preparation and it is likely to conclude that, in some instances, Trusts would benefit from access to a pool of expertise on New Deal implementation. The ME and the BMA Scottish Junior Doctors' Committee are discussing how best to provide access to such support and further information will be issued shortly.

Accommodation, Catering and Security Questionnaire

7. Guidance is provided on accommodation and catering at Appendix E. Providing good living conditions alongside decent hours is a vital component of the New Deal but a complete and up-to-date picture of the facilities across the NHS in Scotland is needed. The Audit Group's visits and the statistical returns for 30 September 1998 provided some valuable information but the Accommodation, Catering and Security Questionnaire issued in February was designed to provide us with the latest information.

APPENDIX A

THE NEW DEAL: SUMMARY OF HOURS' CONTROLS

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 of 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 (24 hours for double shifts)	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: Information on how to calculate and monitor rest periods is contained at Appendix B and Appendix C of this circular.

* '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.

REST PERIODS AND WORKING ARRANGEMENTS

Key features

1. Regardless of working pattern:
 - 1.1 rest must be adequate to ensure safe working for the duration of the duty period;
 - 1.2 total average rest must be such that, if on duty for up to the maximum weekly contracted hours permissible (72/64/56), the average hours of actual work will be not more than 56 per week; and
 - 1.3 it is not acceptable for the sum of rest periods within duty periods to be made up of short periods of rest with frequent interruption. Trusts should work to ensure a reasonable period of continuous rest, as set out in this Appendix.
2. In all cases, junior doctors working less than full-time hours (flexible trainees) will have their hours' limits adjusted pro rata. The guidelines given relate to full-time juniors only. It is important, however, that staff working less than full-time are not disadvantaged compared to their full-time colleagues either in terms of rest periods or work intensity.

On-Call Rotas

3. The New Deal states that for doctors in training working an on-call rota there should be "a reasonable expectation of eight hours rest during a period of 32 hours on duty.....this rest should be principally within the on-call period.....and where possible the greater part of this rest period should be continuous".
4. Rest requirements can best be illustrated through a series of questions and answers outlined below:

Rest Requirements for an On-Call Rota

- Q1. How much rest is there in total during a duty period?
- A1. If the duty period does not involve any out-of-hours duty, natural breaks only are required. Otherwise rest should be greater than or equal to a half of the out-of-hours duty period. It should particularly be noted that, at weekends, all duty periods are out-of-hours. So while one-half of 5pm to 9am Monday to Friday is eight hours, one-half of 9am to 9am Saturday to Sunday will be twelve hours.

- Q2. How much rest should occur in the out-of-hours period? (5pm to 9am Monday to Friday).
- A2. To meet the requirement that rest should be “principally within the on-call period”, at least six of the eight hours rest should occur during this time.
- Q3. How much rest must be continuous?
- A3. The “greater part” should be continuous. As a guide we would expect a minimum of five hours continuous rest within the recommended minimum 8 hours’ rest during a duty period.
- Q4. When should this continuous rest occur?
- A4. For the rest to give the maximum benefit to doctors and their patients it should be at a time which allows natural sleep. This is generally accepted to be between 10pm and 8am.

Reasonable Expectation

5. As a guide, it should be possible for Trusts to construct rotas in such a way that out-of-hours rest targets can be met during at least three-quarters of all rostered duty periods. This should be a minimum requirement and, if not met, the Trust should urgently review the working patterns or working practices in that unit or specialty.

Partial Shifts

6. The New Deal requires that doctors in training working partial shifts should have “a reasonable expectation of a period of 4 hours rest during a 16-hour duty period.”

7. Again the amount and distribution of rest required a partial shift duty period can be considered as a series of questions and answers:

Rest Requirements for a Partial Shift

- Q1. How much rest in total during a duty period?
- A1. If the duty period does not involve any out-of-hours duty, natural breaks are required. Otherwise rest should be greater than or equal to one-quarter of the out-of-hours duty period (ie 4 hours is one-quarter of 5pm to 9am) in addition to natural breaks during the normal working day. This is not necessarily the same as one-quarter of the duty period eg if a duty period was 9am to 9pm during a weekday, only 4 hours of this is during the out-of-hours period and so at least one hour of rest would be required. In the case of the twelve hours from 9am to 9pm on a weekend it is entirely out-of-hours duty and so at least three hours (one-quarter) rest would be expected.
- Q2. How much rest should occur in the out-of-hours period? (5pm to 9am Monday to Friday).

A2. The New Deal makes no stipulation that rest during partial shift duty periods should be during the out-of-hours period. Where the length of the duty period is within the single shift limit of 16 hours it is acceptable for the rest to occur at any time during the duty period, although frequent short periods would not be beneficial. See paragraph 9 below and Appendix C for guidance on “double shift” working.

Q3. When should this rest occur?

A3. During the duty period.

Reasonable Expectation

8. The same principles would apply as for on-call rotas (see above). The aim should again be for rest periods in partial shifts to be met during at least three-quarters of all duty periods. Otherwise, consider urgently changes to working patterns or working practices.

24-hour Partial Shifts

9. General guidance on 24-hour partial shifts is given at Appendix C.

10. Once again rest requirements for a 24-hour partial shift can be illustrated through a series of questions and answers:

Rest requirements for a 24-hour partial shift duty period

Q1. How much rest in total during a 24-hour duty period?

A1. As such a duty period is halfway between the maximum normally allowed for a partial shift and the weekday maximum for an on-call rota it is logical that the minimum rest required should be halfway between. Thus at least six hours rest during the duty period is required.

Q2. How much rest must be continuous?

A2. For the rest to be beneficial to doctors and their patients it should allow natural sleep. As a guide, at least four hours' rest should be continuous.

Q3. When should this continuous rest occur?

A3. As for on-call rotas, this rest should occur between 10pm and 8am.

Reasonable Expectation

11. The same principles would apply as for on-call rotas and partial shifts (see above). The aim should again be for rest periods in 24-hour partial shifts to be met during at least three-quarters of all duty periods. Otherwise consider urgently changes to working patterns or working practices.

Full Shifts

12. Within full shifts, natural breaks (see paragraph 4.A2 and paragraph 7.A1) will be needed away from clinical duty. It is reasonable to provide at least a 30-minute continuous break after approximately four hours' continuous duty. Trusts should devise working practices which allow proper cover for these absences. (These natural breaks must also, of course, be provided during the normal working day for doctors on on-call rotas or partial shifts and should not be considered part of their rest periods).

Contingency Plans

13. In cases where, despite the best efforts of the team, juniors' night-time rest periods are not adequately met, Trusts should have contingency plans ready so that they can provide adequate compensatory rest by way of time off work the following day, or as soon as practicable. This is evidently good clinical governance designed to protect patient care.

MEL(1998)40 – Pay for Intensive Working Patterns

14. As outlined above, all juniors, regardless of their working pattern, should have a reasonable expectation of rest within and between duty periods. However, under MEL(1998)40, which came into force from 1 April 1998, Trusts may now consider claims from junior doctors working on on-call rotas or partial shifts whose work intensity is at virtually full shift intensity. Where a claim is agreed payment of Additional Duty Hours (ADHs) should be made at the Class 1 (full shift) rate. In the event of a dispute, an appeals panel should be established in accordance with MEL(1997)71.

15. Similarly, where on-call rotas require intensive working at a level virtually the same as full shift, payments should be made at the Class 1 rate as stated in MEL(1998)40. This arrangement builds on the provisions previously introduced under MEL(1996)23.

16. Such extra payments should last until the work intensity has fallen to acceptable levels through the introduction of more appropriate working patterns or other organisational changes. Trusts should remember that posts in receipt of intensity payments breach the New Deal hours limits and should be recorded as such in the 6-monthly returns to the Management Executive.

SUMMARY OF REST PERIODS

Working Pattern	Natural breaks	Minimum rest during the whole of each duty period	Minimum continuous rest guide	Timing of continuous rest
Full shift	✓	Natural Breaks	At least a 30 minute continuous break after approximately 4 hours continuous duty	At least a 30 minute continuous break after approximately 4 hours continuous duty
Partial Shift	✓	Natural breaks if no out-of-hours duty. Otherwise one quarter of the out-of-hours duty period, eg. 5pm – 9am (Mon-Fri) = 4 hours 9am – 9pm (Sat/Sun) = 3 hours	Frequent short periods of rest are not acceptable	At any time during the duty period
24 hour partial shift*	✓	6 hours	4 hours	Between 10pm and 8am
On-call rota	✓	One half of the out-of-hours duty period, eg. 5pm – 9am (Mon-Fri) = 8 hours 9am – 9am (Sat/Sun) = 12 hours	Minimum 5 hours	Between 10pm and 8am

Reasonable expectation of rest: in each of these working patterns, rest targets must be met during at least three quarters of all rostered duty periods. Where this target is not met, urgent consideration will need to be given to changing the working patterns, or reviewing working practices within the existing working pattern, to reduce work intensity to acceptable limits.

*This working pattern should only be used where it is the most appropriate option.

NON-STANDARD WORKING ARRANGEMENTS: TWENTY FOUR-HOUR PARTIAL SHIFT DUTY PERIODS

1. Doctors in training must have adequate rest while on duty. It is accepted that some posts are more intensive than others, consequently the opportunities for rest may be limited. If, despite other measures to reduce intensity, rest remains inadequate for an on-call rota (with duty periods of up to 32 hours) continuous duty periods must be reduced.

2. For various reasons the adoption of standard partial shifts has not always been successful. However the New Deal provides that in a partial shift working arrangement, two shifts may be worked consecutively in order to facilitate the change from one shift to another, and states: "In such circumstances the total period of continuous duty shall not exceed 24 hours".

3. The existing New Deal guidance already provides for circumstances under which it is acceptable to work such a double shift. There is, however, a need for consistency over the way in which hours controls and rest periods are applied to such shift patterns.

Rest Requirements during a 24-hour Partial Shift duty period

4. These are set out in Appendix B. For patient safety it is important that 24-hour duty periods should not be permitted where rest is inadequate.

Length of Shifts

5. Where a doctor works a 24-hour partial shift the total continuous duty period *must not in any circumstances exceed* 24 hours. Shifts must be scheduled so as to include any time needed for handovers, ward rounds etc.

Time off duty between duty periods

6. The minimum time off after a duty period is eight hours for a partial shift. There should be a longer period off duty after a 24-hour shift. Doctors should not be on duty for more than four hours following the 16-hour period of out of hours duty. The next duty period should not start until at least the beginning of the next normal working day.

HYBRID WORKING ARRANGEMENTS

Definition

1. A hybrid working arrangement is a working pattern in which junior doctors' out-of-hours duty comprises work of substantially different levels of intensity due to different clinical responsibilities. As a result the post or placement comprises elements of two or more distinct working arrangements, usually combined within a time limit of one month or less.
2. Where a particular duty is in a clearly identified block of at least a month's duration before change to another duty of different intensity then this is not a hybrid but rather a change between two working patterns. Where the different duties alternate or are mixed within the same rota then this is a hybrid.

Where is a Hybrid not a Hybrid?

3. Some working arrangements may have been wrongly classed as hybrids by Trusts in an attempt to avoid implementing aspects of the New Deal. This is not acceptable.
4. A shift system in which the length of duty periods exceeds that permitted for the level of intensity (expected rest) is not a hybrid; it is a shift system which breaches the New Deal. An on-call rota with inadequate rest periods is not a hybrid; it is an on-call rota which breaches the New Deal.

Regulation of Hybrids

5. Each period of out of hours duty in a hybrid working arrangement should be clearly identified as belonging to an on-call rota, a partial shift or a full shift. This definition will be based solely on work intensity (expectation of rest) and the length of the period of duty should be decided accordingly.
6. The New Deal limits, including rest periods applicable to those differing levels of intensity, will apply:
 - a continuous period of duty should not exceed 14 hours for full shift intensity, 16 hours for partial shift intensity (24 for double shifts), 32 hours for on-call rota intensity (56 at weekends);
 - rest periods should be greater than or equal to one-half of the out of hours duty period for an on-call rota; greater than or equal to one-quarter of the out of hours duty period for a partial shift; and at least natural breaks for a full shift. The pattern and distribution of rest must be in accordance with the agreed guidelines as set out at Appendix B and Appendix C;
 - time off duty before the next duty period must be at least 8 hours after a full or partial shift period and at least 12 hours after an on-call duty period;

- in the case of a 24 hour partial shift, the next duty period should not start until at least the beginning of the next working day;
- actual hours of work should not exceed 56 per week on average regardless of the pattern of work.

Calculation of ADHs for hybrid contracts

7. For full-time staff only, standard pay rates apply to a total of 40 hours of duty regardless of when they occur, and ADHs apply to all hours beyond 40. It is not true to say that a particular hour of duty after 5pm must be an ADH – it could form part of the 40 standard hours (eg in a week of nights). It is relatively simple to determine the total number of duty hours for a hybrid working pattern – ADHs will be hours beyond 40. The challenge is to determine how many ADHs should be paid and at which percentage rate (Class I, II or III).

8. For the purposes of calculating pay it is simplest to divide up the rota as if blocks of time were spent exclusively on one working pattern. Contracts should simply state what working arrangements (full shift, partial shift or on-call rota) the doctor will work and for what proportion of the contract each will apply (eg partial shift for half the time and on-call for half the time). A hybrid working pattern can always be reduced to a combination of two (or more) distinct working patterns, each with a certain number of juniors nominally involved at any one time and allowing for prospective cover where appropriate.

9. As a working example, a hybrid between an on-call rota and a partial shift for 10 SHOs in O&G may have one SHO working on-call for Gynaecology and one SHO working a partial shift for Obstetrics at any one time each night and weekend day. While in practice all 10 SHOs alternate between shift and on-call work, this can be considered as equivalent to 5 SHOs working on-call and 5 SHOs working a partial shift. Thus if a 5 person on-call rota was paid 32 Class III ADHs and a five person partial shift was paid 24 Class II ADHs, it is apparent that a hybrid between the two would be paid 16 Class III and 12 Class II ADHs.

10. It is important that all of the out of hours duty periods are allocated to one of the working patterns and that an appropriate number of juniors are allocated to each of the hypothetically separate working arrangements.

11. An example of a 12-person hybrid full shift/on-call rota with a worked example is on the following page:

EXAMPLE OF A 12-PERSON HYBRID FULL SHIFT/ON-CALL ROTA

Week	Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1	70	day	on-call	day	day	day	-	09-23
2	64	day	day	day	day	day	on-call	-
3	62	09-23	day	day	day	on-call	-	-
4	46	day	day	day	09-23	day	-	-
5	56	day	day	on-call	day	day	-	-
6	63.5	day	day	day	day	night	night	night
7	42	night	night	night	night	-	-	-
8	70	day	09-23	day	day	day	-	on-call
9	54	day	day	day	day	day	09-23	-
10	62	on-call	day	day	day	09-23	-	-
11	56	day	day	day	on-call	day	-	-
12	46	day	day	09-23	day	day	-	-

Notes:

1. This example sets out the principles involved, using a hybrid which is the equivalent of six SHOs working a 1 in 6 on-call rota combined with six SHOs working a 1 in 6 full shift. For example, merging obstetrics and gynaecology rotas might typically produce a 10-12 person rota. But the underlying principles can be applied to larger or smaller groups.
2. Normal working day (shown as "day") is from 9.00 – 17.00.
3. 09-23 shift hands over to night shift between 22.30 and 23.00 then goes off-duty.
4. Night is from 22.30 to 09.00 the following morning.
5. On-call SHO is available for emergencies.

6. In the above example the separate components can be calculated as follows:

On-call rota component:

Total hours in week = $7 \times 24 = 168$

Normal working day = $8 \text{ hours} \times 5 = 40$

Out-of-hours to be covered = $168 \text{ less } 40 = 128$

Out-of-hours share per doctor on 1:6 rota = $128 \text{ divided by } 6 = 21.3$

Total hours per doctor to be worked = $40 \text{ standard plus } 21.3 = 61.3$

ADHs due = $62 \text{ (rounded figure) less } 40 \text{ standard} = 22 \text{ Class 3 ADHs}$

Full shift component:

There are six doctors working the full shift component. Over a seven-day period they will work between them the following shifts:

7 shifts 0900 – 2300 = $7 \times 14 \text{ hours} = 98 \text{ hours}$

7 shifts 2300 – 0900 = $7 \times 10.5 \text{ hours} = 73.5 \text{ hours}$

19 shifts * 0900 – 1700 = $19 \times 8 \text{ hours} = 152 \text{ hours}$

(*Of the six doctors in the shift, one is working the long day shift and one is on nights. The remaining four work a normal day during the week except on Friday, when only three work a normal day and the fourth is resting before nights, and the doctor who was on nights is off. This produced $4+4+4+4+3 = 19$ shifts).

Total doctor hours a week = 323.5

1 in 6 share is $323.5 \text{ divided by six} = 53.9$

ADHs due = $54 \text{ (rounded figure) } - 40 = 14 \text{ Class 1 ADHs}$

Remuneration:

As this rota is a half-and-half hybrid between an on-call rota paying 22 Class 3 ADHs and a full shift paying 14 Class 1 ADHs, the correct remuneration should be 40 standard hours plus 11 Class 3 ADHs and 7 Class 1 ADHs. If prospective cover applies additional ADHs will be payable. This should be calculated on each component of the rota in the usual way.

7. **Contracted duty hours:** as half the out-of-hours work is shift working and half is on-call rota (as reflected in the ADHs above) the maximum weekly contracted duty hours must not exceed 64 per week, ie. halfway between 56 (full shift) and 72 (on-call rota).

IMPROVING CATERING AND ACCOMMODATION FOR JUNIOR DOCTORS

Introduction

1. As well as limiting junior doctors' hours, the 1991 New Deal introduced agreed guidelines for living and working conditions to improve the overall well-being of juniors. This concentrated on accommodation standards, the need for decent standards of and access to catering, including out of hours, security for staff, recreational facilities, and provision of library areas. In the effort to bring down hours, and at a time when Trusts' running costs came under every-closer scrutiny, it was sometimes hard to remember that maintaining decent living conditions was vital to the recruitment, retention and motivation of doctors in training.

Current position

2. The Government is determined that adequate accommodation and catering in NHS Trusts should be highlighted as key features of the developing human resources strategy. We can simply no longer accept that tired junior doctors working long hours are being provided with inadequate conditions. And patients also have the right to expect no less for the staff who care for them.

3. This message has been underlined through:

MEL(1997)71 which asked Trusts to ensure that priority be given to achieving the accommodation, catering and security standards;

the Human Resources Strategy, published in April 1998, which identified conditions of work as a key issue along with the hours targets;

Mr Galbraith's letters of 22 December 1998 to Trust Chairmen asking them to take personal responsibility for ensuring full compliance with the non-hours standards;

The BMA's Hospital Accommodation Charter which provided guidance on best practice in the provision of accommodation for on-call staff;

the accommodation questionnaire MEL(1999)17 will give the Management Executive, and Trusts themselves, an up-to-date position of compliance with the standards and will identify areas where improvements need to be made.

4. **Adequate accommodation**, including accommodation while on call, should, therefore, be high on the agenda for all Trusts. Cleanliness, privacy, heating, ventilation, security and proximity to wards are key considerations in planning new accommodation or improving existing provision. Those Trusts who have already made significant strides in this area are commended, but it is recognised that more can and needs to be done.

5. As regards **catering**, the vital aim is to ensure that juniors should be able to get a meal or snack break in privacy away from the demands of the wards, patients or their relatives. Hot meals and snacks should be available out of hours when hard-pressed junior doctors might often most need them.