GUIDANCE ON JUNIOR DOCTORS’ HOURS

March 2006
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1. INTRODUCTION

This guidance summarises Department of Health instructions from a variety of sources, in an attempt to gather together all the current guidance in a form which is comprehensive and easy to understand. Where possible guidance is quoted and referenced, so that if it is necessary to refer to the original source, it is easy to do so. The guidance applies to all junior doctors employed under the national terms and conditions of service (Advance Letter (MD) 1/01: ‘Pay and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service’ 7th February 2001, paragraphs 1 and 2).

The Hampshire and Isle of Wight Guidance on Junior Doctors’ Hours was last reviewed in August 2004 and needed to be updated to reflect the fact that, inevitably, since then some guidance had changed or developed. It was equally clear that there were several areas where local organisations had interpreted and applied guidance differently, such as compensatory rest and the re-banding procedure. The aim of the guidance is to ensure that all Trusts within Hampshire and the Isle of Wight adopt a consistent approach and the same procedures when tackling junior doctors’ hours issues.

In order to review and update the existing guidance, the SHA Dean Team of the Hampshire & Isle of Wight (HIoW) Strategic Health Authority (SHA) Workforce Development Directorate (WDD) established a small working group comprising experienced representatives drawn from Trusts in HIoW to provide comments and feedback. Its work has proved to be invaluable and we are grateful for the comments and contributions of those involved. This small group has, in turn, reported back to the WTD Project Leads Forum, which, chaired by Martyn Dell, Medical Workforce Development Manager, meets regularly and draws its membership from each NHS Trust and Primary Care Trust which employs junior doctors.

The review process also included discussions with:

- the wider network of strategic health authorities, partially via the ‘Improving Doctors’ Working Lives’ web forum (http://www.idwl.info);
- NHS Employers;
- the Severn and Wessex Deanery;
- the British Medical Association (BMA).

This part of the process has also benefited from the independent review of two junior doctors.

Wherever possible, this document is drawn from official guidance and the sources clearly stated. Where the Hampshire and Isle of Wight WDD has interpreted the guidance, the advice given is the best available, but we cannot offer assurance on these areas. Guidance may need to be changed as a result of testing in courts or tribunals, or if new national recommendations are issued.

Following the departure of the Junior Doctors' Hours Advisor, Medical Workforce Officer and the Facilities Accreditation Officer, and in the light of Commissioning a Patient Led NHS (CPLNHS), it is considered highly unlikely that many of the responsibilities of these posts will form part of a future Workforce Development Directorate’s remit, which will instead be devolved to Trusts to manage at a local level.

Finally, I should like to acknowledge the contributions made by members of the SHA Dean Team - Lisa Unsworth, Medical Workforce Officer, and Jodie Lawford, Junior Doctors’ Hours Advisor, who have led this important piece of work.

Dr Judy Curson
Hampshire and Isle of Wight SHA Dean, March 2006
2. BACKGROUND

Junior doctors’ hours were negotiated under the New Deal arrangements (*HSC 1998/ 240: ‘Reducing Junior Doctors’ Hours’) and modified by agreement. From 1 December 2000 the Additional Duty Hours were replaced by ‘banding supplements’ (*HSC 2000/031: ‘Modernising Pay and Contracts for Hospital Doctors and Dentists in Training’ 12 October 2000), which were determined by the doctor in post completing a banding questionnaire.

The new system was designed to offer the highest rewards to those in the highest intensity posts, working the most unsocial hours, and provide incentives to employers to reduce hours and intensity in line with the New Deal and (European) Working Time Directive (WTD). Under the new contract for doctors in training, from August 2003 the overall average weekly actual working hours for all doctors in training should not exceed 56, and from August 2004 all doctors in training should be fully compliant with both the New Deal and the rest requirements of the WTD.

2.1 Workforce Development Directorate Role

Prior to 31st March 2006, the WDD has had specific responsibility for:

2.2 Performance management of compliance with the WTD and implementation in HloW

WTD is an ongoing priority for strategic health authorities. The HloW WDD was responsible for performance management of Trust plans to maintain 2004 WTD compliance and to work towards achieving the 2009 targets, including:

- critical assessment of Trust WTD 2009 action plans;
- supporting Trust workshops and meetings;
- keeping a strategic understanding of the changing profile of WTD in the local health economy, for example, Modernising Medical Careers (MMC);
- utilising access to expert advice and solutions to help Trusts work towards compliant working practices;

These will remain the responsibility of the WDD as far as possible within existing resources. The Severn and Wessex Deanery will continue provide advice and support with regard to training and educational matters, and will facilitate the implementation of the additional national training numbers (NTNs) allocated to this region.

2.3 Ministerial Returns

Strategic health authorities have responsibility for the collection and forwarding to NHS Employers of the monitoring returns of junior doctors’ hours which form the basis of the six-monthly report to the Department of Health. Data is required from all employers of doctors in training to reflect doctors’ working arrangements in terms of New Deal compliance and pay banding.

The WDD has coordinated recent ministerial returns prior to and including the 30th Ministerial Return (March 2006) on behalf of the Hampshire & Isle of Wight SHA. This specifically involves:

- collecting individual monitoring returns from every Trust in HloW which employs doctors in training;
- aggregating the data and completing the monitoring return annexes to be submitted to NHS Employers;
• presenting the results back to NHS Trusts;
• providing support for Trust planning to improve compliance.

The expectation is that the WDD will continue retain full responsibility for coordinating the ministerial return process and acting as contact point nationally and maintaining the network of New Deal/ WTD leads within HIoW. This will be confirmed prior to the 31st Ministerial Return (September 2006).

The ministerial return process is described in greater detail in section 12.

2.4 Re-banding
Responsibility for the re-banding of junior doctors' posts was part of the now-disbanded Regional Action Team's remit; however this responsibility was passed onto various successor bodies such as strategic health authorities and workforce development confederations.

In HIoW, the WDD has been specifically responsible for the administration of the approval process for provisional and formal re-banding cases. In recent years, Trusts have generally built up their own local teams (often with the aid of bespoke WDD funding) and are now far better positioned to maintain up-to-date knowledge and expertise. With effect from 1st April 2006 re-banding will become entirely the responsibility of Trusts themselves, and Trusts will therefore need to establish a robust, internal approval and scrutiny process. This includes ‘ownership’ of the DRS software which, it is envisaged, will be agreed with one of the Trusts.

Trusts are strongly encouraged to engage their junior doctors in developing solutions and deal with disagreements in the first instance and for the Trusts to then liaise with the local BMA office to work together to resolve issues that may arise.

Where agreements cannot be reached, the nationally agreed banding appeals procedure as set out in the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002 (Version 6, 1 June 2005) should be implemented. The residual WDD responsibility will be to establish and maintain a list of suitably qualified Trust representatives who would be available for such appeals.

2.5 Facilities Accreditation
Responsibility for the facilities accreditation was part of the now-disbanded Regional Action Team's remit; however this responsibility was passed onto various successor bodies such as strategic health authorities and workforce development confederations.

In HIoW, the WDD also had responsibility for inspection of junior doctors’ accommodation, including:

• administration of the facilities accreditation process;
• site visits as required;
• site reports completed at least twice annually for each Trust; including:
  - comments on the current status of facilities;
  - details of any anticipated improvements;
- recommendations for improvements to be compliant with legislation (HSC2000/036);
  - agreement of action plans with details of necessary improvements to be made in order to be compliant with HSC2000/036 and timescales;
  - monitoring of the expenditure of the capital allocation fund for each Trust.

Most Trusts in HIoW now have (or have firm plans to develop) good quality accommodation, and with effect from 1st April 2006, the responsibility for monitoring the facilities and ensuring continued compliance with the standards will be formally devolved to Trusts as employers of the doctors in line with arrangements elsewhere.

In addition, the responsibility for overview will transfer to the Wessex Institute (part of Severn and Wessex Deanery) who will include this within their quality monitoring arrangements with regard to doctors in training. Professor Clair du Boulay, Institute Dean, will be developing appropriate arrangements.

If Trusts have any queries regarding the standards required for facilities and accommodation, they should in the first instance refer to HSC 2000/036 ‘Living and Working Conditions for Hospital Doctors in Training’ (Department of Health 13 December 2000)
3. DEFINITION OF TERMS

3.1 Doctors in training
According to Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’ the scope of doctors in training include the following:

Pre-Registration House Officers
Senior House Officers
Registrars
Senior Registrars
Specialist Registrars, and
Locums employed in the NHS in those grades

3.2 Day

3.3 Night time
According to Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’, night time in relation to a worker, means a period:

(a) the duration of which is not less than seven hours, and
(b) which includes the period between midnight and 5 am,

which is determined for the purposes of the Working Time Regulations by a relevant agreement, or, in default of such a determination, the period between 11 pm and 6 am;

3.4 Week

3.5 Weekend
According to the Appendix to the HSC 2000/031 ‘Part B: Definitions’, a weekend worked is one which involves the doctors being on duty at any time during the period from 7pm Friday to 7am Monday.

3.6 Rest period
According to Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’, a rest period in relation to a worker, means a period which is not working time, other than a rest break or leave to which the worker is entitled under these Regulations;

3.7 Shift work
According to Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’, shift work means any method of organising work in shifts whereby workers succeed each other at the same workstations according to a certain pattern, including a rotating pattern, and which
may be continuous or discontinuous, entailing the need for workers to work at different times over a given period of days or weeks;

3.8 Working time

According to Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’ working time, in relation to a worker, means-

(a) any period during which he is working, at his employer's disposal and carrying out his activity or duties,

(b) any period during which he is receiving relevant training, and

(c) any additional period which is to be treated as working time for the purpose of the Regulations under a relevant agreement;

The implication of SIMAP and Jaeger for the NHS is that time spent resident on call for clinical purposes will count as “working time” in its entirety, even if the doctor in training is resting (or even sleeping) for the whole of the on call period (see relevant sections below for more information).

3.9 Average Working Time

According to Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’ the average weekly working time is calculated by dividing the total number of hours worked during the reference period by the number of weeks in the reference period.

The calculation of average weekly working time should not to be affected by periods where a worker is absent due to annual leave entitlement, sick leave and maternity leave. If any of this leave occurs within a reference period, then an equivalent number of days to the period of leave should be added from the next reference period.

3.10 Reference period


The average weekly working time of doctors in training is averaged over a 26-week reference period. Days when the doctor is absent on leave should be excluded from the calculation.

Where a doctor in training has worked for his/her employer for less than 26 weeks, the reference period applicable is the period that has elapsed since s/he started work for the employer.

3.11 On–Call


The NHS Executive considers that time when a worker is "on call" but otherwise free to pursue their own activities, is not working time.

"Working Time" is defined as when a worker is "working, at his employer's disposal and carrying out his/her activity or duties".
For the time to be “working time” all three elements must be satisfied. This means that although a worker who is "on call" can be contractually paid for being "on call", for the purposes of the Regulations "working time" will not start until they receive a call to go to work. Once the worker receives the call or the employer has contacted them by some other means, "working time" will commence from then on.

This also includes for example doctors who may be called to give advice over the telephone. The period they are on the telephone giving such advice can be counted as "working time".

A distinction should be made between those workers who need to respond immediately and those who are warned in advance (e.g. theatre nurses who may be advised that they will be needed in a couple of hours). In the latter case working time should not start until the worker has left his/her residence.

WDD note regarding on-call:

If it is a requirement of the post by the health centre to be resident whilst on call then this will be a contradiction of the SiMAP and Jaeger judgements.

However many Trusts have a clause written within local terms and conditions that state a doctor must be within half an hour’s travel of the health centre whilst on call. For a trainee on a rotation this may present a problem, as on face value it requires them to move closer to the health centre if outside the half an hour boundary. In reality this may be totally impractical.

The health centre can, however, provide accommodation for trainees to use either close to or on hospital grounds whilst on call. This can be voluntarily used by the trainee at their discretion, if this suits their personal circumstances.

It should be noted that the trainee will still be classed as non resident, as they have voluntarily chosen to use the accommodation whilst on call. They are also free to conduct any of the activities usually permitted whilst non resident on call (e.g. can go shopping etc).

As the health centre has not explicitly stated that the post is resident, the trainee has voluntarily used the accommodation provided, and is free to conduct normal activities whilst on call, they are not in breach of the SiMAP or Jaeger ruling and are not classed as resident on call.

3.12 Prospective cover

According to the Appendix to the HSC 2000/031 ‘Part B: Definitions’, prospective cover is when the doctor is contracted to provide internal cover for colleagues when they are on annual and/or study leave, i.e. if no locums are provided. Prospective cover is also in operation when on-calls are required to be swapped when taking leave or when leave is fixed in advance. When a doctor not on the rota acts as a “floater”, (i.e. covering any doctors on the rota who are away on holiday), prospective cover is not in operation.

3.13 Reasonable expectation of rest

According to the Appendix to the Health Service Circular 2000/031 ‘Part C: Guidance on hours of work and rest requirements’, reasonable expectation of rest in each of the working patterns, rest targets must be met during at least 75% of all rostered duty periods.

Example 1: 5pm to 9am Mon to Fri = 4 hours; 8am to midnight Sat or Sun = 4 hours
Example 2: 5pm to 9am Monday to Friday = 8 hours
According to the *Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002*, 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 75% 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.
4. CONTRACTED HOURS

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, full-time doctors and dentists in training are contracted for 40 hours per week, plus further contracted hours as agreed with the employing authority, (subject to controls set out in the Terms and Conditions of Service paragraph 20) and exceptionally, duty cover in occasional emergencies or unforeseen circumstances (see Terms & Conditions of Service paragraph 110).

The contracted hours may be in the form of an on-call rota, partial shift, 24 hour partial shift, full shift or hybrid working arrangement. Employing authorities shall keep the working and contractual arrangements under review to ensure they meet the controls and remain in line with the demands of the post.Trusts may wish to advise junior doctors of who to contact if they have concerns about the rota. Hours of duty include periods of formal and organised study (other than study leave), training, all rest while on duty, and prospective cover where applicable.

4.1 On-call rotas

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, practitioners on on-call rotas usually work a set working day on weekdays, from Monday to Friday. The out-of-hours duty period is covered by practitioners working “on call” in rotation. Practitioners are rostered for duty periods of more than 24 hours. The frequency of on-call depends on the number of practitioners providing cover and is normally expressed as 1 in 4, 1 in 5, etc. Practitioners working on on-call rotas shall have adequate rest during a period of duty.

According to the Appendix to the HSC 2000/031 ‘Part B: Definitions’, examples include:

Example 1: If six doctors share a rota equally between them, but locums are employed for leave, this is a 1 in 6 rota without prospective cover. This means each doctor will, for the whole duration of their contract or placement, work less than one-sixth of all on-call duty periods, unless they do not take any leave. If, for example, six doctors share a rota equally between them and cover each other’s leave, this is a 1 in 6 with prospective cover. The contribution of non-training grades and flexible trainees in the frequency of on-call rotas should be taken into consideration.

Example 2: If eight doctors share a rota equally between them, but locums are employed for leave, this is a 1 in 8 rota without prospective cover. This means each doctor will, for the whole duration of their contract or placement, work less than one-eighth of all on-call duty periods, unless they do not take any leave. If, for example, eight doctors share a rota equally between them and cover each other’s leave, this is a 1 in 8 with prospective cover. The contribution of non-training grades and flexible trainees in the frequency of on-call rotas should be taken into consideration.

4.2 Partial shifts

According to the Appendix to the HSC 2000/031 ‘Part B: Definitions’ on most weekdays doctors on partial shifts work a normal day. But, at intervals, one or more doctors will work a different duty for a fixed period of time, e.g. evening or night shifts. Doctors can expect to work for a substantial proportion of the out-of-hours duty period, during which time they will expect to achieve some rest in addition to natural breaks. Juniors will be rostered for duty periods of not more than 16 hours.
4.3 24 hour partial shifts

According to the Appendix to the HSC 2000/031 ‘Part B: Definitions’ weekdays are usually worked as normal days. In rotation, a duty period is rostered, not exceeding 24 hours including handovers, for the weekend and out-of-hours cover. Juniors will be rostered for duty periods of more than 16 hours, but less than or equal to 24 hours.

4.4 Full shifts

According to the Appendix to the HSC 2000/031 ‘Part B: Definitions’ a full shift will divide the total working week into definitive time blocks with doctors rotating around the shift pattern. Doctors can expect to be working for the whole duty period, except for natural breaks. Juniors will be rostered for duty periods which do not exceed 14 hours.

4.5 Hybrids

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, hybrids are working arrangements of two or more distinct working arrangements described above. The different working arrangements must be worked either concurrently in the same rota or alternately within a time limit of up to one month. Practitioners working on hybrids shall have adequate rest during a period of duty.


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.

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.

When is a Hybrid not a Hybrid?

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.

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.
5. NEW DEAL CONTROLS ON HOURS

It should be emphasised that since August 2004, WTD must be taken as applying to doctors in training in parallel with the New Deal – for each parameter where there are differences the more stringent of the requirements will apply. For completeness, we have provided an outline of both, followed by a table comparing the hours of work and rest requirements of the New Deal with those of the WTD.

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, paragraph 20:

The following controls on hours of duty shall apply to full time doctors and dentists in training working on-call rotas, partial shifts, 24 hour partial shifts, full shifts or hybrids (except in circumstances where they are acting up as a consultant):

According to HSC 1998/240: 'Reducing Junior Doctors’ Hours’, Annex B: Rest Periods and Working Arrangements:

Regardless of working pattern:

- rest must be adequate to ensure safe working for the duration of the duty period;
- 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.
- 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. The regional task force should work with trusts to ensure a reasonable period of continuous rest, as set out in this annex.

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.
5.1 New Deal Controls on On-call rotas

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, paragraph 20:

- Employing authorities shall ensure that the maximum average contracted hours of duty for practitioners working on on-call rotas do not exceed 72 per week, including handovers at the start and finish of duty periods.
- Employing authorities shall ensure that no period of continuous duty for practitioners working on on-call rotas is longer than 32 hours during the week and 56 hours at the weekend.
- Employing authorities shall ensure that practitioners working on on-call rotas have a minimum period of 12 hours off duty between periods of duty and one minimum continuous period off duty of 62 hours and one minimum continuous period off duty of 48 hours in every period of 21 days.


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".

Rest requirements can best be illustrated through a series of questions and answers outlined below:

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 or 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" this rest should, as a guide, be of at least six hours’ duration.

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 of 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.
5.1.1 Revision of weekend rest requirements for on-call rotas

The Appendix to HSC 2000/031 ‘Part C: Guidance on hours of work and rest requirements’, amends and replaces the definition contained in HSC 1998/240:

If the agreed total rest expectation of 50% of the out-of-hours duty period within the duty period is achieved, this is acceptable and no further action is needed. For a weekend duty period of 9am Saturday to 5pm Monday, this would mean a total of 24 hours rest during that period.

or

At weekends, if the rest requirement equivalent to that for a weekday is achieved (8 hours for 24 hour period, 5 continuous between 10pm and 8am, on at least 75% of duty periods), but the total rest does not meet the requirement for the weekend (at least 50% of the out of hours duty period on 75% of occasions), the requirements of the New Deal will still be met if:

(i) “equivalent paid rest” is built into the rota for each weekend worked, in the form of working days or half days (to count as a day or half day on duty for total hours purposes). This rest should be taken by the end of the Monday of the following week (ie within 8 days). However, in exceptional circumstances, the period of equivalent paid rest built into the rota may be taken at another time in the rota cycle. This must be with the agreement of the individual trainee and apply to no more than 25% of weekends worked.

and

(i) the trust clearly demonstrates that the post is fully compliant with all the other hours limits and rest requirements of the New Deal, including the limit of an average 56 hours a week of actual work.

Equivalent paid rest will be awarded for each weekend worked where the total rest requirement is not met, on the following basis:

<table>
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<th>Total rest achieved per 48 hours weekend</th>
<th>Equivalent paid rest</th>
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<td>Greater than 20 hours, less than 24</td>
<td>Half day (4 hours)</td>
</tr>
<tr>
<td>Less than/equal to 20 hours</td>
<td>Full day (8 hours)</td>
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If less than 16 hours rest is attained, the post is New Deal non-compliant and changes must be made to the working pattern. In the meantime, full day equivalent paid rest will be awarded on such occasions.

If the conditions at (1) and (2) cannot be met, other actions will be necessary in order to meet the New Deal requirements governing weekend rest.
5.2 New Deal Controls on Partial Shifts and 24 Hour Partial Shifts

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, paragraph 20:

Employing authorities shall ensure that:

- The maximum average contracted hours of duty for practitioners working a partial shift or 24 hour partial shift do not exceed 64 per week, including handovers at the start and finish of shifts.

It should be emphasised that partial shifts are by their very nature resident, and that no resident shift pattern should now exceed 58 hours as a result of the SiMAP and Jaeger judgements (including resident on-call). Please refer to the relevant section for further information regarding the implication of the SiMap and Jaeger judgements.

- No period of continuous duty for practitioners working partial shifts is longer than 16 hours, including the time required for handovers.

- No period of continuous duty for practitioners working 24 hour partial shifts is longer than 24 hours, including the time required for handovers.

- Practitioners working partial shifts and 24 hour partial shifts have a minimum period of 8 hours off-duty time between shifts; do not work more than 13 days without a minimum period of 48 hours of continuous off-duty time; and have one minimum continuous period off-duty of 62 hours and one minimum continuous period off-duty of 48 hours in every period of 28 days.
5.2.1 New Deal Controls on Partial Shifts

According to HSC 1998/240: 'Reducing Junior Doctors' Hours', Annex B: Rest Periods and Working Arrangements:

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."

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

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 (i.e. 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 e.g. 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.

Q3. When should this rest occur?

A3. During the duty period.

5.2.1.1 Reasonable Expectation

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.
5.2.2 New Deal Controls on 24 Hour partial Shifts


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.

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".

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.

5.2.2.1 Length of Shifts

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.

5.2.2.2 Time off duty between duty periods

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.


5.2.2.3 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 weekly 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.
5.2.2.4 Reasonable Expectation

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 \textit{at least three-quarters} of all duty periods, the majority of which should be in the overnight period. Otherwise consider urgently changes to working patterns or working practices.
5.3 New Deal Controls on Full Shifts

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, paragraph 20:

Employing authorities shall ensure that:

i. The maximum average contracted hours of duty for practitioners working a full shift do not exceed 56 per week including handovers at the start and finish of shifts.

ii. No period of continuous duty for practitioners working full shifts is longer than 14 hours, including the time required for handovers.

iii. Practitioners working full shifts have a minimum period of 8 hours off duty between shifts; do not work more than 13 days without a minimum period of 48 hours of continuous off-duty time; and have one minimum continuous period off duty of 62 hours and one minimum continuous period off duty of 48 hours in every period of 28 days.


Within full shifts, natural breaks 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).

5.3.1 Contingency plans

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.
5.4 New Deal Controls on Hybrids

According to the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002, paragraph 20:

Employing authorities shall ensure that the maximum average contracted hours of duty for practitioners working an hybrid arrangement do not exceed a point, calculated as a proportion of the part that each arrangement makes to the hybrid, between the average maximum contracted hours of duty for each of the working arrangements which comprise the hybrid arrangement.

WDD note: The BMA has pointed out that each working pattern within the hybrid should be assessed according to the rules for that working pattern, and not on an average basis.


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.

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 Annex B and Annex C; (WDD note: i.e. Annex B and Annex C of HSC 1998/240: ‘Reducing Junior Doctors’ Hours’);

- 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.
### THE NEW DEAL: SUMMARY OF HOURS’ CONTROLS

<table>
<thead>
<tr>
<th>Working pattern</th>
<th>Maximum average contracted and actual duty hours per week (see Notes 1, 2)</th>
<th>Minimum rest during duty periods (hours) (see Note 3)</th>
<th>Maximum continuous duty period (hours)</th>
<th>Minimum period off duty between duty periods (hours)</th>
<th>Maximum consecutive duty (days)</th>
<th>Minimum continuous period off duty (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full shift</td>
<td>56</td>
<td>Natural breaks</td>
<td>14</td>
<td>8</td>
<td>13</td>
<td>48 + 62 in 28 days</td>
</tr>
<tr>
<td>Partial shift</td>
<td>64</td>
<td>4</td>
<td>16 (24 hours for double shifts)</td>
<td>8</td>
<td>13</td>
<td>48 + 62 in 28 days</td>
</tr>
<tr>
<td>On-call rota</td>
<td>72*</td>
<td>8</td>
<td>32 (56 at weekends)</td>
<td>12</td>
<td>13</td>
<td>48 + 62 in 21 days</td>
</tr>
</tbody>
</table>

**Note 1:** Contracted hours should take into account routine early starts, late finishes, time off during the working day (e.g. 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 Annex B and Annex 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.
## SUMMARY OF REST PERIODS

<table>
<thead>
<tr>
<th>Working Pattern</th>
<th>Natural breaks</th>
<th>Minimum rest during the whole of each duty period</th>
<th>Minimum continuous rest guide</th>
<th>Timing of continuous rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Shift</td>
<td>_</td>
<td>Natural Breaks</td>
<td>At least a 30 minute continuous break after approximately 4 hours continuous duty</td>
<td>At least a 30 minute continuous break after approximately 4 hours continuous duty</td>
</tr>
<tr>
<td>Partial Shift</td>
<td>_</td>
<td>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</td>
<td>Frequent short periods of rest are not acceptable</td>
<td>At any time during the duty period</td>
</tr>
<tr>
<td>24 hour partial shift *</td>
<td>_</td>
<td>6 hours</td>
<td>4 hours</td>
<td>Between 10pm and 8am</td>
</tr>
<tr>
<td>On-call rota</td>
<td>_</td>
<td>One half of the out-of-hours duty period, eg: 5pm - 9am (Mon-Fri) = 8 hours 9am - 9pm (Sat/Sun) = 12 hours</td>
<td>Minimum 5 hours</td>
<td>Between 10pm and 8am</td>
</tr>
</tbody>
</table>

**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 pattern, 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.
6. WORKING TIME DIRECTIVE CONTROLS ON HOURS

The European Working Time Directive (Council Directive No. 93/104/EC of 23 November 1993 concerning certain aspects of the organisation of working time, hereto referred to as ‘EWTD’) was translated into UK law by way of the Working Time Regulations 1998 (hereto referred to as ‘WTR’).

According to the Working Time Regulations 1998 (Statutory Instrument 1998 No.1833, 1 October 1998 PART III Exceptions, Paragraph 18 Excluded sectors, section b), the Working Time Regulations do not apply “to the activities of doctors in training”.

6.1 Background on the European Working Time Directive

This section is based on Guidance on Working Patterns for Junior Doctors: A document produced jointly by the Department of Health, the National Assembly for Wales, the NHS Confederation & the British Medical Association, November 2002:

The European Working Time Directive (EWTD) initially excluded junior doctors across Europe. However, after a process of negotiation, a timetable of staged implementation was agreed by Member States in May 2000 (European Directive 2000/34/EC May 2000) – on the back of a clear intention that the hours limits in the Directive should apply equally to junior doctors. This is to be welcomed as an important measure aimed at improving the quality of patient care and safeguarding the health and safety of both doctors and patients. The staged implementation means that the full ‘48 hour week’ does not have to be introduced before August 2009; but that an interim position of a 58 hour week, with significant changes in rest requirements, will come into force from August 2004. Junior doctors should in any case be working no longer than 56 hours a week after August 2003 under the new contract, but until 2004 may continue to provide on-call cover for up to 72 hours provided that their actual working hours do not exceed 56.

6.2 Timetable of implementation

<table>
<thead>
<tr>
<th>DATE</th>
<th>DEADLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2000</td>
<td>Timetable set</td>
</tr>
<tr>
<td>August 2004</td>
<td>Interim 58 hour week</td>
</tr>
<tr>
<td>August 2007</td>
<td>Interim 56 hour week</td>
</tr>
<tr>
<td>August 2009</td>
<td>48 hour week</td>
</tr>
</tbody>
</table>

In addition to the overall hours limit, the EWTD requires the following rest and break entitlements:

- 11 hours continuous rest in every 24 hour period;
- minimum 20 minute break when working time exceeds 6 hours;
- minimum 24 hour rest in every 7 days; or
- minimum 48 hour rest in every 14 days;
- minimum 4 weeks annual leave;
- average of no more than 8 hours work in 24 hours for night workers (if applicable).
6.3 The “SiMAP” Case

Sindicato de Médicos de Asistencia Pública (Simap) v Conselleria de Sanidad y Consumo de la Generalidad Valenciana C-303/98 EC

This section is based on Guidance on Working Patterns for Junior Doctors: A document produced jointly by the Department of Health, the National Assembly for Wales, the NHS Confederation & the British Medical Association, November 2002:

Under the New Deal there is a distinction made between hours of duty and hours of work. The New Deal allows junior doctors working resident on-call to be on duty for periods of up to 72 hours a week, so long as they do not carry out actual work for more than 56 hours. However, in October 2000 the European Court ruled on a case brought by Spanish doctors against their employers. This has become known as the SiMAP case.

The Court's ruling clarified the meaning of working time within European Law for medical practitioners and essentially means that, under the terms of the Directive, all hours that are spent resident on-call will be considered as work and will count towards the weekly average, even if under the New Deal they would have been considered as rest.

The hours limits of the EWTD will therefore become limits, not on the hours of actual work for resident junior doctors (currently standing at 56 per week under the New Deal), but on hours of actual duty. This will be a major reduction from the current limits of 72 hours per week for on call rotas, 64 hours per week for partial shifts and 56 hours per week for full shifts. From August 2004, non-resident doctors may fall under the definition that ‘work begins when a doctor is disturbed from rest and ends when rest is resumed’. However, doctors resident on-call will have all hours counted as working hours.

6.3.1 Effects of SiMAP on On-call Rotas

The extension of the EWTD to cover doctors in training, taken together with the SiMAP judgement, means that the hours limits under the New Deal will be sharply curtailed for resident doctors. As indicated in the implementation table in the introduction, from August 2004 the maximum resident duty will be 58 hours, falling to 48 from 2009. These hours will be able to be averaged over an agreed reference period.

Non resident doctors who have actual hours of work of 48 or less will be able to remain on on-call rotas up to New Deal limits – as their EWTD limit will apply only to those hours spent at their place of work.

As a consequence, for resident doctors the number of doctors required to run an on-call rota will increase from August 2004 to 8 if a 40 hour basic working week is maintained and if fundamental changes are not made to the way in which services are organized and/or the skill mix of the staff who provide them. However where creative solutions are adopted, e.g. rethinking both consultant and junior working patterns and extending the roles of non-medical practitioners, it is possible to construct EWTD compliant middle grade rotas with as few as 6 or even 5 middle grade doctors. These types of solutions will require non-medical practitioners prepared to assume a level of responsibility similar to that of junior doctors and working to clear agreed protocols.

If the rest criteria are strictly applied it is difficult to achieve on-call rotas that are compliant with the EWTD. As indicated above it is possible to derogate from the rest and break provisions of the EWTD (but not from the hours limits themselves). However, if rest requirements are derogated from, they must wherever possible be replaced with an equivalent period of compensatory rest. Compensatory
rest is rest which replaces time worked, so that the total hours worked remain within the 56 or 48 hour limit. Derogating from these provisions would allow greater flexibility in designing compliant rotas while ensuring that doctors in training were not disadvantaged in terms of rest entitlements.

If the concept of compensatory rest is widely accepted and implemented, then lower intensity non-resident on-call rotas may well remain acceptable working patterns for the future. That being said, it is important to note that achieving this will depend on adequate numbers of doctors or others being available to maintain a compliant rota.

In areas where:

a) there are already a minimum of 7-8 juniors on a rota, or other satisfactory staffing arrangements involving consultants and/or nonmedical practitioners; or

b) geography or clinical overlap allow merging of units and rotas; and

c) levels of intensity of out of hours work are limited it may be possible to run on-call rotas that satisfy the requirements of the EWTD, at least until August 2009.

This will be made easier by increased use of cross-cover. Clinically, it has been traditional to maintain clear divisions between subspecialty groups when on call – even for the most junior doctors. This may no longer be practical as hours limits reduce. Furthermore many of the tasks performed by the most junior doctors in the out of hours period are generic – as is indicated by most intensity surveys having broadly similar boxes to tick for ‘what you do when on call’ – which suggests there is scope for making more effective and flexible use of junior doctors on call.

It is possible to develop systems where resident juniors provide cross-cover for, for example, broad medical or broad surgical rotas when on call, as long as they are appropriately supervised by a Higher Specialist Trainee and/or Consultant for each subspecialty that they cover. This ‘generic cover’ system is used to great effect in many medical systems, for example Australia, Canada and New Zealand – where the doctors at PRHO or SHO level are expected to be less sub-specialist when on call.

This system is not incompatible with remaining attached to a sub-specialist team for the working week, enabling the development of a training and mentoring relationship to be preserved. It is important to ensure that proper supervision and handover regimes are in place.

6.3.2 Effects of SiMAP on Shift Working

It is inevitable, at least in the shorter term, that increases in shift working will be necessary to implement the EWTD.

It should be remembered that the term ‘shift working’ can cover a multitude of different working patterns: a split weekend; a week, or half-week, of nights; 24 hours on, 24 hours off. In considering the introduction of shifts it is important to keep the following principles in mind:

Compliance with the EWTD is not optional.

It is possible to deliver training effectively in shorter working hours and with different types of working pattern.

It is unhelpful to focus on the type of working pattern per se (eg shift, on call) rather than on whether or not it is a good working pattern which delivers training, meets service needs and WTD hours and rest requirements whilst allowing junior doctors a satisfactory quality of life.
6.4 The “Jaeger” Case

Landeshauptstadt Kiel v Dr Med Norbert Jaeger, Case C-151/02

The European Court of Justice judgment on 9 September 2003 in the “Jaeger” case confirmed the SiMAP judgment.

6.5 Enforcement of the Working Time Regulations

According to HSC 1998/204 ‘Working Time Regulations: Implementation in the NHS’, the limits (e.g. the weekly working time and night work limits), other night work provisions and record keeping requirements in the Regulations will be enforced by the health and safety enforcing authorities, i.e., the Health and Safety Executive and Local Authorities. The entitlements (e.g. the daily and weekly rest periods, daily rest breaks and the paid annual leave) will be enforced by Employment Tribunals. Further information about Employment Tribunals is available from the Employment Tribunal Service.

6.6 Opting-out of the Working Time Regulations

According to Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’, an individual worker can, if they wish, agree with their employer to work over the maximum weekly limit in normal circumstances. If they do so, the agreement must be in writing. The worker can bring the agreement to an end at any time provided that adequate notice (not less than 7 days) is given in writing.

In normal circumstances workers should not be expected to work over an average of 48 hours per week (the maximum weekly limit) on a regular basis. However, there may be circumstances where a worker might agree to work more than the maximum weekly limit averaged over 17 weeks. In these circumstances, the worker has to agree in writing that the maximum weekly limit does not apply to him/her.

The written agreement should:

• identify the worker;
• set out the terms of the agreement - which may apply indefinitely or relate to a specified period;
• specify a period of notice (not less than 7 days and not more than 3 months) under which the worker may terminate the agreement.

To end the agreement, a worker must give written notice to their employer.


• It is not possible to derogate from the average weekly working time limit, only from the rest requirements.

• Doctors in training are already restricted to no more than 56 hours’ actual work on average per week from 1 August 2003, as part of their contract.

• An individual junior doctor can sign a waiver and ‘opt out’ of the 58-hour WTD ceiling after 1st August 2004, but contractually can do no more than an average of 56 hours actual work a week. The waiver is voluntary and workers cannot be required to sign it.

• Workers cannot ‘opt out’ of the rest requirements.
According to *Meeting the Requirements of the Working Time Regulations - Information for NHS and Social Care Employers following Recent Judgment in the ECJ (Gateway reference 2544) DH 23 January 2004*:

Where a member of staff chooses to work in excess of the average weekly hours limit under the WTR, they are required to sign a waiver. If an employee chooses to work for more than one employer the hours worked in all employments are aggregated and if over the weekly limit a waiver should be signed. The employee can opt in again at any time, subject to the notice period agreed.

### 6.7 Locums and workers with more than one employer


Some workers have more than one employer. They may have a permanent contract and work separately on the bank for their own or another employer. In these cases both employers will have to ensure that these workers do not work over the maximum weekly limit.

In cases where workers have more than one employer, all that is required of the employer is to take reasonable steps to ensure that workers are not working beyond the statutory limit. This can be easily done by, including a special box in a time sheet asking whether or not the person has another employer. Provided this question has been asked, the employer has carried out their legal obligations, irrespective of whether or not the worker is willing to answer that question.

If a worker is working over the maximum weekly limit between the two employers, it is recommended that both employers obtain agreement in writing from the worker agreeing to disapply the maximum weekly limit.

Each employer would be responsible for ensuring that they provide adequate rest breaks according to the hours worked for them. Therefore if a worker is entitled to compensatory rest from working with employer A, then employer A should ensure it is given. Employer B should not be penalised.

NHS employers will have to take adequate steps to ensure that patient care is not affected as a result of workers working over the maximum weekly limit.

### 6.8 Record Keeping

The following information is taken from the *Supporting Guidance to HSC 1998/204: ‘Working Time Regulations: Implementation in the NHS’, paragraphs 3.2 and 9.1 – 9.13:*

#### 6.8.1 Working time limits:

An employer will need to keep records that are adequate to show they have complied with the weekly working time limits. It is for the employer to determine what records need to be kept. The employer may be able to use existing records, or need to make new arrangements according to individual circumstances.

It will be fairly apparent in the majority of cases whether a worker is close to working in excess of the maximum weekly limit. It may be sufficient for those workers who keep regular hours to be asked to notify the employer should the hours worked change. The employer could monitor the hours worked by such workers more closely, or adjust the work they are asked to do, to ensure compliance.
An employer is not required to keep a running calculation of workers average weekly working time, though in some cases an employer may wish to monitor an individual worker's hours more closely.

In the case of hourly paid workers, NHS employers may find keeping a worker's pay records would adequately demonstrate their working hours.

The Regulations state that the records must be kept for 2 years from the date on which they were made.

Where a worker has agreed to work over the average 48 hour weekly working limit, an employer is required to keep records of the number of hours that the worker has worked.

6.8.2 Night work limits:

An employer will need to keep records that are adequate to show they have complied with the weekly working time limit. It is for the employer to determine what records need to be kept. The employer may be able to use existing records or need to make new arrangements according to individual circumstance.

The records must be kept for 2 years.

6.8.3 Health assessments for night workers and other night work provisions:

Employers need to keep records that are adequate to show they have complied with all the night work provisions.

The records must be kept for 2 years from the date on which they were made.

6.8.4 Rest periods:

There is no requirement under the Regulations to keep records regarding rest periods, unless there is compensatory rest to be accounted for. In such instances it would be necessary to keep adequate records to show that the Regulations have been complied with.

6.8.5 Annual leave:

There is no requirement to keep records of annual leave for the purposes of the Regulations. However, employers may wish to set up a mechanism in order to be satisfied that statutory requirements have been adhered to.

6.8.6 Records required for individual workers who have opted out

For every individual who agrees to work more than the maximum weekly limit, the employer is obliged to keep records which:

(a) identify the worker,
(b) set out the terms of the agreement which may apply indefinitely or relate to a specified period,
(c) specify the number of hours worked for the employer during each reference period since the agreement came into effect. (This excludes any period, which ended more than 2 years before the beginning of the applicable reference period.)

These records must be available for inspection by the Health and Safety Executive Officer or any other authority, which is responsible for enforcement.
6.8.7 The availability of records

Records kept in accordance with the Regulations should be made available to the appropriate enforcing authorities and also in the interests of good industrial relations, to staff side representatives.
HOURS OF WORK AND REST REQUIREMENTS – A COMPARISON

The following Table 1 compares the requirements of the New Deal with those of the Working Time Regulations, as they will apply to doctors in training from August 2004. The Working Time Regulations must be taken as applying in parallel with the New Deal – for each parameter where there are differences the more stringent of the requirements will apply.

<table>
<thead>
<tr>
<th>New Deal Requirements</th>
<th>Working Time Regulations Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum contracted hours for each working pattern</td>
<td>Maximum contracted hours for each working pattern</td>
</tr>
<tr>
<td>On-call rotas: 72 hours per week</td>
<td>On-call rotas (resident)</td>
</tr>
<tr>
<td>Partial shifts and 24 hour partial shifts: 64 hours per week</td>
<td>Partial shifts and 24 hour partial shifts (resident)</td>
</tr>
<tr>
<td>Full shifts: 56 hours per week</td>
<td>Full shifts:</td>
</tr>
</tbody>
</table>

| Maximum number of actual hours | Irrespective of the contracted hours, the number of actual work hours should be: | 58 | 56 | 48 |

**Controls on duty periods**

<table>
<thead>
<tr>
<th>Working pattern</th>
<th>Maximum continuous duty</th>
<th>Minimum period off duty between duty periods</th>
<th>Minimum continuous period off duty</th>
<th>Working pattern</th>
<th>Maximum continuous duty</th>
<th>Minimum period off duty between duty periods</th>
<th>Minimum continuous period off duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full shift</td>
<td>14 hours</td>
<td>8 hours</td>
<td>48 hours + 62 hours in 28 days</td>
<td>Full shift</td>
<td>13 hours</td>
<td>11 hours</td>
<td>one of 24 hours in each 7 day period or,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>two of 24 hours in each 14 day period, or,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>one of 48 hours in each 14 day period.</td>
</tr>
<tr>
<td>Partial shift</td>
<td>16 hours (except 24 hour partial shifts)</td>
<td>8 hours</td>
<td>48 hours + 62 hours in 28 days</td>
<td>Partial shift</td>
<td>13 hours</td>
<td>11 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-call rota</td>
<td>32 hours (56 hours at weekend)</td>
<td>12 hours</td>
<td>48 hours + 62 hours in 21 days</td>
<td>On-call rota (res) (non-res)</td>
<td>13 hours</td>
<td>11 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Silent*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Maximum number of continuous duty days for all working patterns is 13 days, followed by a minimum of 48 hours off duty.
- Duty hours: all hours working or on-call (including rest while on duty).
- Actual hours: all hours on duty carrying out tasks for the employer, including periods of formal study leave or teaching.

* Where Working Time Regulations are silent on aspects of the above, New Deal limits will apply.

## Rest requirements

<table>
<thead>
<tr>
<th>Working pattern</th>
<th>Natural breaks</th>
<th>Minimum rest during the whole of each duty period</th>
<th>Minimum continuous rest guide</th>
<th>Timing of continuous rest</th>
<th>Working pattern</th>
<th>Natural breaks</th>
<th>Minimum rest during the whole of each duty period</th>
<th>Minimum continuous rest guide</th>
<th>Timing of continuous rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full shift</td>
<td>Yes</td>
<td>Natural breaks</td>
<td>At least a 30 minute continuous break after approximately 4 hours continuous duty</td>
<td>At least a 30 minute continuous break after approximately 4 hours continuous duty</td>
<td>Full shift</td>
<td>Silent*</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>Silent*</td>
</tr>
<tr>
<td>Partial shift</td>
<td>Yes</td>
<td>Natural breaks if no out of hours duty. Otherwise one quarter of the out of hours duty period *</td>
<td>Frequent short periods of rest are not acceptable</td>
<td>At any time during the duty period</td>
<td>Partial shift</td>
<td>Silent*</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>Silent*</td>
</tr>
<tr>
<td>24 hour partial shift</td>
<td>Yes</td>
<td>6 hours</td>
<td>4 hours</td>
<td>Between 10pm and 8am</td>
<td>24 hour partial shift</td>
<td>Silent*</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>Silent*</td>
</tr>
<tr>
<td>On-call rotas</td>
<td>Yes</td>
<td>Mon-Fri: one half of the out of hours duty period **. Weekends: see revision note below</td>
<td>Minimum 5 hours</td>
<td>Between 10pm and 8am</td>
<td>On-call rotas</td>
<td>Silent*</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours</td>
<td>Silent*</td>
</tr>
</tbody>
</table>

Reasonable expectation of rest: in each of the working patterns, rest targets must be met during at least 75% of all rostered duty periods.

* Where Working Time Regulations are silent on aspects of the above, New Deal limits will apply.

Limits shown shaded in the above tables are subject to derogation and compensatory rest.

Weekend Rest requirements

Revision of weekend rest requirements for on-call rotas

1. If the agreed total rest expectation of 50% of the out-of-hours duty period within the duty period is achieved, this is acceptable and no further action is needed. For a weekend duty period of 9am Saturday to 5pm Monday, this would mean a total of 24 hours rest during that period.

OR

2. At weekends, if the rest requirement equivalent to that for a weekday is achieved (8 hours for 24 hour period, 5 continuous between 10pm and 8am, on at least 75% of duty periods), but the total rest does not meet the requirement for the weekend (at least 50% of the out of hours duty period on 75% of occasions), the requirements of the New Deal will still be met if:

   (i) "equivalent paid rest" is built into the rota for each weekend worked, in the form of working days or half days (to count as a day or half day on duty for total hours purposes). This rest should be taken by the end of the Monday of the following week (i.e. within 8 days).

   However, in exceptional circumstances, the period of equivalent paid rest built into the rota may be taken at another time in the rota cycle. This must be with the agreement of the individual trainee and apply to no more than 25% of weekends worked.

AND

(ii) the trust clearly demonstrates that the post is fully compliant with all the other hours limits and rest requirements of the New Deal, including the limit of an average 56 hours a week of actual work.

Equivalent paid rest will be awarded for each weekend worked where the total rest requirement is not met, on the following basis:

<table>
<thead>
<tr>
<th>Total rest achieved per 48 hours weekend</th>
<th>Equivalent paid rest</th>
<th>Total rest achieved per 48 hours weekend</th>
<th>Equivalent paid rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 20 hours, less than 24</td>
<td>Half day (4 hours)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than/equal to 20 hours</td>
<td>Full day (8 hours)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No distinction is made between weekend and weekday working.*

* Where Working Time Regulations are silent on aspects of the above, New Deal limits will apply.

### Table 2

<table>
<thead>
<tr>
<th>Maximum contracted hours for each working pattern</th>
<th>2004</th>
<th>2007</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call rota (resident)</td>
<td>58</td>
<td>56</td>
<td>48</td>
</tr>
<tr>
<td>(non-resident)</td>
<td>72</td>
<td>72</td>
<td>72</td>
</tr>
<tr>
<td>Partial shifts and 24 hour partial shifts (resident)</td>
<td>58</td>
<td>56</td>
<td>48</td>
</tr>
<tr>
<td>Full shifts</td>
<td>56</td>
<td>56</td>
<td>48</td>
</tr>
</tbody>
</table>

**Maximum number of actual hours**

Irrespective of the contracted hours, the hours on duty and the working pattern, the maximum number of hours of actual work of a junior doctor in a week should be:

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2007</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>56</td>
<td>56</td>
<td>48</td>
</tr>
</tbody>
</table>

### Controls on duty periods

<table>
<thead>
<tr>
<th>Working pattern</th>
<th>Maximum continuous duty</th>
<th>Minimum period off duty between duty periods</th>
<th>Minimum continuous period off duty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full shift</td>
<td>13 hours</td>
<td>11 hours</td>
<td>48 hours + 62 hours in 28 days</td>
</tr>
<tr>
<td>Partial shift</td>
<td>13 hours</td>
<td>11 hours</td>
<td>48 hours + 62 hours in 28 days</td>
</tr>
<tr>
<td>On-call rota</td>
<td>13 hours</td>
<td>11 hours</td>
<td>48 hours + 62 hours in 21 days</td>
</tr>
</tbody>
</table>

- Maximum number of continuous duty days for all working patterns is 12 days, followed by a minimum of 48 hours off duty.
- Duty hours: all hours working or on-call (including rest while on duty).
- Working hours: all hours on duty at the place of work, including periods of formal study leave or teaching.

### Rest requirements

<table>
<thead>
<tr>
<th>Working pattern</th>
<th>Natural breaks</th>
<th>Minimum rest during the whole of each duty period</th>
<th>Minimum continuous rest guide</th>
<th>Timing of continuous rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full shift</td>
<td>Yes</td>
<td>At least a 30 minute continuous break after approximately 4 hours continuous duty</td>
<td>At least a 30 minute continuous break after approximately 4 hours continuous duty</td>
<td>At least a 30 minute continuous break after approximately 4 hours continuous duty</td>
</tr>
<tr>
<td>Partial shift</td>
<td>Yes</td>
<td>One quarter of the out of hours duty period*, or at least a 20 minute continuous break during shifts longer than 6 hours if this is greater</td>
<td>At least a 20 minute continuous break during shifts longer than 6 hours Frequent short periods of rest are not acceptable</td>
<td>At any time during the duty period</td>
</tr>
<tr>
<td>24 hour partial shift</td>
<td>Yes</td>
<td>6 hours</td>
<td>4 hours</td>
<td>Between 10pm and 8am</td>
</tr>
<tr>
<td>On-call rotas</td>
<td>Yes</td>
<td>Mon-Fri: one half of the out of hours duty period **.</td>
<td>Minimum 5 hours</td>
<td>Between 10pm and 8am</td>
</tr>
<tr>
<td>Weekends: see revision note below</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** NHS Employers, Department of Health website: [http://www.dh.gov.uk/assetRoot/04/07/55/53/04075553.pdf](http://www.dh.gov.uk/assetRoot/04/07/55/53/04075553.pdf)

**Note:** TCS make reference to ‘a 30 minute break after approximately 4 hours continuous duty’ only in respect of full shifts. Hampshire and Isle of Wight Workforce Development Directorate – Guidance on Junior Doctors’ Hours – March 2006
WTR requires those working any shift longer than 6 hours to receive a continuous break of at least 20 minutes during the working period – this has been incorporated into the above table where necessary. Limits shown shaded above are subject to derogation and compensatory rest.

**Reasonable expectation of rest:** in each of the working patterns, rest targets must be met during at least 75% of all rostered duty periods.

* e.g.: 5pm to 9am Mon to Fri = 4 hours; 8am to midnight Sat or Sun = 4 hours

** e.g.: 5pm to 9am Monday to Friday = 8 hours

### Weekend Rest requirements

#### New Deal with Working Time Regulations

<table>
<thead>
<tr>
<th>Revision of weekend rest requirements for on-call rotas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If the agreed total rest expectation of 50% of the out-of-hours duty period within the duty period is achieved, this is acceptable and no further action is needed. For a weekend duty period of 9am Saturday to 5pm Monday, this would mean a total of 24 hours rest during that period.</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>2. At weekends, if the rest requirement equivalent to that for a weekday is achieved (8 hours for 24 hour period, 5 continuous between 10pm and 8am, on at least 75% of duty periods), but the total rest does not meet the requirement for the weekend (at least 50% of the out of hours duty period on 75% of occasions), the requirements of the New Deal will still be met if:</td>
</tr>
<tr>
<td>(i) &quot;equivalent paid rest&quot; is built into the rota for each weekend worked, in the form of working days or half days (to count as a day or half day on duty for total hours purposes). This rest should be taken by the end of the Monday of the following week (i.e. within 8 days).</td>
</tr>
<tr>
<td>However, in exceptional circumstances, the period of equivalent paid rest built into the rota may be taken at another time in the rota cycle. This must be with the agreement of the individual trainee and apply to no more than 25% of weekends worked.</td>
</tr>
<tr>
<td>and</td>
</tr>
<tr>
<td>(ii) the trust clearly demonstrates that the post is fully compliant with all the other hours limits and rest requirements of the New Deal, including the limit of an average 56 hours a week of actual work.</td>
</tr>
<tr>
<td>Equivalent paid rest will be awarded for each weekend worked where the total rest requirement is not met, on the following basis:</td>
</tr>
<tr>
<td>Total rest achieved per 48 hours weekend</td>
</tr>
<tr>
<td>Greater than 20 hours, less than 24</td>
</tr>
<tr>
<td>Less than/equal to 20 hours</td>
</tr>
</tbody>
</table>

Limits shown shaded in the above tables are subject to derogation and compensatory rest.

*Source: NHS Employers, Department of Health website: http://www.dh.gov.uk/assetRoot/04/07/55/53/04075553.pdf*
7. NATURAL BREAKS

7.1 Natural break requirement according to the Working Time Directive


When daily working time is more than 6 hours a worker is entitled to a minimum uninterrupted break of 20 minutes, away from their work station. It should be a break in working time and should not be taken either at the start, or at the end, of a working day and should not overlap with a worker's daily rest. This means where a worker who starts at 8am and has a lunch break at 1pm he/she will not be entitled to an additional 20 minute rest break as he/she has already had a break.

The Regulations do not provide for in work rest breaks to be paid.

Where the worker is required to work during any time which is supposed to be rest time (e.g. during in-work rest breaks) then they are entitled to receive compensatory rest.

7.2 Natural break requirement according to the New Deal


Within full shifts, natural breaks 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).

7.3 WDD comments on natural breaks

The natural break requirements under the New Deal are more stringent than those provided by the WTD. The period of undisturbed rest of at least thirty minutes duration taken after approximately four hours of continuous duty is a chance for the junior doctor to have something to eat or have some rest, and is in effect a paid lunch break.

When work patterns are designed they must ensure adequate cover is available to allow natural breaks to be achieved routinely. If junior doctors frequently appear to be working for longer than four hours without a break, the working arrangements need to be reviewed.

Trusts should investigate the reasons for non-achievement of natural breaks, particularly:

- if breaks are being taken, but they are of less than thirty minutes duration;
- to ensure that junior doctors understand the definition and importance of natural breaks.

It should be noted that natural breaks do not count as rest and are in addition to the rest requirements under the New Deal.

For full shift patterns, any time taken over the thirty minutes natural break should be calculated as additional rest for the purposes of monitoring analysis, as it may reduce the intensity of work and the banding supplement attributed to the monitoring exercise.
7.4 Are natural breaks ‘resident’ or ‘non-resident’?

All junior doctors are entitled to at least thirty minutes rest after approximately four hours’ continuous duty. This time can be spent in any way the junior doctor chooses. Ideally the juniors will find a quiet room to rest. If they choose to leave the department they can do so, however they must be back ready to work within thirty minutes and inform colleagues they have left the department in case of emergencies. They are unlikely to go home due to the brief length of the rest break.

7.5 WDD clarification of voluntary residency/ compulsory residency and natural breaks

- Voluntary residency

  When working a non-resident on-call rota junior doctors are not expected to be on site for the entire shift. However if the junior doctor lives further than thirty minutes drive away and/ or chooses to use the accommodation block rather than travelling home it must be recognised that this is the individual’s choice and that time spent in the accommodation is not classed as work, thus their work pattern remains non resident.

- Compulsory residency

  When working a full shift junior doctors are required to be on site and available regardless of the time (day or night). They cannot leave the site for non work activities until the shift has finished. This shift must include natural breaks.

7.6 Is a junior doctor entitled to a natural break when on study leave?

When a junior doctor takes study leave they are entitled to natural breaks in the same way as if they were working. After approximately four hours the junior doctors must achieve at least thirty minutes of undisturbed rest. If the junior doctor does not achieve this they must give an explanation why, as failure is likely to only occur in a very unusual circumstance. This includes study leave at home and on-site courses.
8. COMPENSATORY REST

8.1 NHS guidance on compensatory rest


Where the worker is required to work during any time which is supposed to be rest time (e.g. daily or weekly rest periods) then the worker must:

a. be permitted to take "equivalent periods (the same number of hours lost) of compensatory rest": or

b. in exceptional cases, where providing equivalent compensatory rest is not possible, be granted rest in order to protect a worker's health and safety.

In practice, exceptional circumstances will be rare, but will also be self-evident.

The following guidance is taken from Meeting the Requirements of the Working Time Regulations - Information for NHS and Social Care Employers following Recent Judgment in the ECJ (Gateway reference 2544) DH 23 January 2004, paragraphs 6 - 12:

The Regulations provide that compensatory rest must be given when the daily/weekly rest requirements cannot be met. Compensatory rest will most likely be necessary when staff are either:

- working a shift pattern and the shift extends beyond thirteen hours due to an unforeseen situation or emergency; or
- working on-call from home and are called upon to work during the period of duty; or
- whenever staff are rostered to be resident on call for more than 13 hours continuously.

In each situation the rest provided should make up for the rest missed; and, under the provisions of the Jaeger judgment, should be taken as quickly as possible after the end of the working period. The implications of the Jaeger judgment are that it will not be sufficient to aggregate the rest available to an individual over a period and assume that the minimum requirements have thus been met.

The arrangements for taking compensatory rest will need to be determined locally in the light of circumstances.

It is recognised in the regulations that services such as the NHS and Social Care will have instances where a continuous emergency service must be maintained. Exceptionally, where it is not possible for objective reasons to grant a period of compensatory rest, an employer should afford the worker such protection as may be appropriate to safeguard the worker's health and safety.

Employers must make sure that staff can take their rest so as not to compromise health and safety.

8.2 WDD comments on compensatory rest

Compensatory rest is a period of rest the same length as the period of rest, or part of a period of rest, that the worker has missed. The purpose of the WTD derogation is to ensure that where necessary this rest can be taken at times that fit in around patient services.
Where possible, however, it is probably simpler for NHS employers to plan staffing patterns so that doctors in training receive their full rest entitlement under the regulations and the need for compensatory rest is minimised.

The WDD contacted NHS Employers for clarification, since the Department of Health document ‘Meeting the requirements of the Working Time Regulations. Information for NHS and Social Care Employers following Recent Judgement in the ECJ (gateway reference 2544)’ seems to suggest that it could be possible to have a rota in which doctors worked shifts over thirteen hours in length as long as compensatory rest is built in.

Following discussions, the WDD and NHS Employers concluded that if such a rota was implemented it may not breach WTD, but the Trust could potentially be at risk should there be an adverse event, as a consequence of which there could be a strong legal case made against the employer which claimed that doctors were consistently being asked to work hours which exceeded the legal maximum length and were therefore unsafe to practise.

The WDD therefore advises against the use of a work patterns that do not adhere to the WTD requirement of eleven hours rest in every 24-hour period. The WDD feel that compensatory rest should only be used on an occasional basis and should not be built into rotas. If a Trust decides to implement this kind of arrangement they could be open to challenge if an error occurred, as it could be argued that the doctors had not had sufficient rest and were not fit for work. The WDD therefore recommends that Trusts avoid building compensatory rest into work patterns.
9. PAY BANDING

The following information applies to doctors and dentists, including flexible trainees, in the training grades, (i.e. PRHOs, HOs, SHOs, Registrars, Specialist Registrars and Senior Registrars), and is based on the Appendix to the HSC 2000/031 published by the Department of Health on 12 October 2000:

From 1st December 2000, the Additional Duty Hours (ADH) pay system was replaced with the pay banding system. The bands reflect whether the post is New Deal non-compliant, whether the doctor works, up to 40, 48 or to 56 hours a week; the type of working pattern, the intensity of work and the unsocial nature of the working arrangements.

Under the pay banding system, junior doctors receive a basic salary and, unless they are working a maximum of 40 hours a week entirely within the hours of 8am to 7pm Monday to Friday, they receive an out-of-hours supplement. This supplement will be a single sum of money, calculated as a proportion of the basic salary (see table below) and added to the monthly salary to remunerate overall time on duty and reflecting the working pattern, intensity of work and the anti-social nature of the post. There are different levels of supplement depending on the nature of the post.

If a flexible trainee works in a post which does not comply with the New Deal, they will meet the criteria for Band 3 and will receive the full pay for that band with no pro rata reductions (i.e. from 62% supplement rising to 100%). If a flexible trainee does 40 hours of actual work per week or more they will be treated exactly the same as a full time trainee. This means that they will be allocated to a band using the same criteria as full timers and will receive the full pay for that band with no pro rata reduction.

There are three bands:

**Band 3** includes all juniors whose posts are non-compliant with the hours limits and/or the rest requirements of the New Deal, as stipulated in HSC1998/240, modified by agreement on weekend rest periods.

**Band 2** includes all juniors whose posts are compliant with the New Deal and who work over 48 hours and up to and including 56 hours of actual work per week.

**Band 1** includes all juniors whose posts are compliant with the New Deal and who work up to and including 48 hours of actual work per week.

Band 2 is split into Bands 2A and 2B, and Band 1 is split into Bands 1A, 1B and 1C:

Bands 2A and 1A will include all juniors who, within their respective hours' limits, work at high intensity and at the most unsocial times, as defined by the banding criteria.

Bands 2B and 1B will include all juniors who, within their respective hours' limit, work at less intensity at less unsocial times

Band 1C will include all juniors working on a low frequency on-call rota from home.

The total salary of junior doctors will comprise a basic salary to which a supplement, calculated as a proportion of the basic salary, will be added according to the band to which the doctor is allocated, as set out below. Figures in brackets show total salary expressed as a multiple of basic salary:
<table>
<thead>
<tr>
<th>Band</th>
<th>Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 3</td>
<td>100% (2.0)</td>
</tr>
<tr>
<td>Band 2A</td>
<td>80% (1.8)</td>
</tr>
<tr>
<td>Band 2B</td>
<td>50% (1.5)</td>
</tr>
<tr>
<td>Band 1A</td>
<td>50% (1.5)</td>
</tr>
<tr>
<td>Band 1B</td>
<td>40% (1.4)</td>
</tr>
<tr>
<td>Band 1C</td>
<td>20% (1.2)</td>
</tr>
</tbody>
</table>

Full-time doctors whose entire working week consists of 40 hours or less between 8am and 7pm, Monday to Friday, will receive no additional supplement and their post will therefore not be allocated to one of the above bands.

The current junior doctors’ contract was implemented in December 2000 with junior doctors completing a banding questionnaire or flowchart (similar to that shown on the next page). Junior doctors sharing the same work pattern were assessed together and assigned the same banding, and those junior doctors who do not have identical duties and responsibilities as the others on the rota or shift system were assessed separately.
Which Band Will I Be In?
(Adapted from Appendix A of Junior Doctors Contract Part A: A general guide to the new pay system, DoH 2000)

(This chart excludes Flexible Trainees)

Doctors doing out of hours work

Do you comply with New Deal hours & rest limits?

Yes

No

Do you work more than 48 hours actual work?

Yes

Do you work an on-call rota?

Yes

Criteria R
Are you resident and carrying out any work after 7pm or non resident and doing 4 hours work after 7pm on 50% or more occasions?

No

Do you do a 1 in 6 (inc PC) or more frequently or work 1 weekend in 3 or more frequently?

Yes

No

Do you do a 1 in 8 (inc PC) or more frequently or work 1 weekend in 4 or more frequently?

Yes

No

Salary Multiplier (SM)
Juniors are paid a supplement on top of basic salary priced as a proportion of base salary according to their out-of-hours work

Band 3
SM 100%

Band 2A
SM 80%

Band 2B
SM 50%

Band 1A
SM 50%

Band 1B
SM 40%

Band 1C
SM 20%

No

Do more than 1/3 of your duty hours fall outside 7am to 7pm Mon to Fri or do you work 1 weekend in 3 or more frequently?

Yes

No

Do you do a 1 in 8 without PC or less frequently?

Yes

No

Are you resident for clinical or contractual reasons?

PC = prospective cover
Weekend = Friday 7pm-Monday 7am
10. FLEXIBLE TRAINEES

10.1 Original pay banding arrangements for flexible trainees

The original pay banding arrangements for flexible trainees were published in the \textit{Appendix to the Health Service Circular 2000/031} and described how Band F was created to accommodate flexible training within the banded system. Band F is for flexible trainees who do less than 40 hours of actual work per week, and was split into Band FA, FB and FC, according to hours and patterns of work criteria. For bands FA and FB the supplement was paid in full, and not adjusted in any way according to a proportion of full time salary. Flexible trainees who perform \textit{all} their duty between 8am and 7pm Monday to Friday, were paid on a simple pro rata equivalent of their full time colleagues (Band FC).

10.2 New pay banding arrangements for flexible trainees

The original arrangements were superceded by new pay banding arrangements which were agreed by the BMA, the four Departments of Health, Conference of Postgraduate Medical Deans (COPMeD) and NHS Employers and took effect from 1 June 2005.

The following section has been taken from \textit{‘Equitable Pay For Flexible Medical Training’ JNC (J) 2005-01 (3) Final 070405} published by NHS Employers:

Pay for doctors in training has been an issue for all concerned for some time. We are optimistic that the system proposed in this paper and the mechanism for implementation will address the concerns of doctors, deaneries/NES and employers and in doing so facilitate the movement into flexible training of those that need to do so.

The system proposed is one where the basic salary is determined by the actual hours of work, as derived initially from the rota and confirmed by monitoring.

A division into 4-hour bands based on hours of actual work enables some averaging to take place, and the pay for each band is based on the lower hours limit.

Thus:

- F5 is 20 or more and less than 24 hours of actual work a week and attracts 0.5 of the full time basic salary.
- F6 is 24 or more and less than 28 hours of actual work a week and attracts 0.6
- F7 is 28 or more and less than 32 hours of actual work a week and attracts 0.7
- F8 is 32 or more and less than 36 hours of actual work a week and attracts 0.8
- F9 is 36 or more and less than 40 hours of actual work a week and attracts 0.9

Added to this is a supplement, paid as a proportion of the basic salary identified above, to reflect the intensity of the duties.

This system has the advantage of proportionality, and loses the image of ‘a full basic salary plus a supplement’ for part-time work that the service finds so difficult to accept. It also benefits from being based on hours of actual work, and is thus demonstrably equitable.

\[
\text{Total salary} = \text{salary}^* + \left[ \begin{array}{c} \text{salary}^* \times 0.4 \\ 0.5 \end{array} \right] + \left[ \begin{array}{c} \text{salary}^* \times 0.2 \\ 0.5 \end{array} \right]
\]

\*salary = F5 to F9 calculated as above.

The supplements will be applied on the basis as set out below using the flowchart attached.
- **Band FA** – trainees working at high intensity and at the most unsocial times.
- **Band FB** – trainees working at less intensity at less unsocial times.
- **Band FC** – all other trainees with duties outside the period 8am to 7pm Monday to Friday.

<table>
<thead>
<tr>
<th>Band</th>
<th>Supplement payable as a proportion of the calculated basic salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>FA</td>
<td>50%</td>
</tr>
<tr>
<td>FB</td>
<td>40%</td>
</tr>
<tr>
<td>FC</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Banding Flowchart (Flexible Trainees)**

1. **Start**
   - **Do you comply with New Deal hours and rest limits?**
     - **No** → Band 03 (1.0)
     - **Yes** → **Do you do any work outside 8am to 7pm Mon-Fri?**
       - **No** → **No supplement**
       - **Yes** → **Do you work an on-call role?**
         - **No** → Band FA (0.5)
         - **Yes** → **Do you do a 1 in 10 (inc. PC) or more frequently?**
           - **Yes** → **Do you do a 1 in 13.5 (inc. PC) or more frequently OR work 1 weekend in 6.5 or more frequently?**
             - **Yes** → Band FB (0.4)
             - **No** → Band FA (0.5)
           - **No** → Band FA (0.5)

**Criteria R** – Are you resident and carrying out any work after 7pm, or non-resident and doing 4 hours work after 7pm on 50% or more occasions?

Hampshire and Isle of Wight Workforce Development Directorate – Guidance on Junior Doctors’ Hours – March 2006
The parameters are used in the same way and on the same matrix as used for full-time trainees in Band 1, with the exception that the frequency of on-call and weekend working have been adjusted to take account of the lower frequencies expected of flexible trainees. The values chosen are those applicable to a trainee contracted for 60% of full time. This value was chosen because most flexible trainees currently contract for this proportion of full time. Should it become apparent that the majority of trainees are not contracted for this proportion of full time hours, the criteria will be adjusted accordingly.

Implementation

The duties of those working flexibly comprise both educational and service elements, in common with other doctors in training. It is essential that responsibility for each component is properly allocated, with those responsible for payment having appropriate control over their own costs. This has formed a major obstacle to the employment of flexible trainees in the recent past.

Basic principles

- The Deanery/SHA funds the basic hours of the trainee contracted for educational purposes.
- The trust, or equivalent body, funds the intensity supplement, and any additional hours worked over and above the level contracted for educational purposes.
11. JUNIOR DOCTORS’ HOURS MONITORING

11.1 Mutual obligation to monitor hours

Since 1st December 2000 there has been a contractual obligation on employers to monitor junior doctors’ New Deal compliance and the application of the banding system, through robust local monitoring arrangements supported by national guidance, and on individual junior doctors to cooperate with those monitoring arrangements.

According to the ‘Junior Doctors Hours’ – Monitoring Guidance, Part A’ published by the Department of Health in October 2000, these arrangements are described as being subject to:

- review by regional improving junior doctors working lives action team (or equivalent); and
- for employers, the performance management systems.

In practice, if either the employer or the employee is not fulfilling their obligations, this could affect the means of determining pay banding and lead to financial and contractual uncertainty.

Trusts need to ensure they collect and analyse data sufficient for reassessing hours’ compliance and/or resolving pay or contractual disputes. At the employers reasonable request, junior doctors, in turn, will be responsible for recording data on hours worked, and forwarding that data, in accordance with the guidance ‘Junior Doctors hours monitoring: principles and guidance’ which accompanies HSC 2000/031.

Junior doctors and their employers are expected work together to identify appropriate working arrangements or other organisational changes in working practice which move non-compliant posts to compliant and to comply with reasonable changes following such discussion.

The objective of the contract is, over time, to reduce the hours worked by junior doctors. The changes in contractual terms must not be used as a justification to increase hours worked in any post. On and following implementation, any substantive change to the working pattern of any existing post which may lead to an increase in the hours worked can only be introduced with the assent of the postholder and the approval of the regional improving junior doctors working lives action team (or equivalent). The nature of the approval system is contained in the implementation guidance “A general guide to the new pay system” which accompanies HSC 2000/031.

11.2 Key principles for junior doctors’ hours monitoring

According to ‘Junior Doctors’ Hours – Monitoring Guidance, Part B: Key principles for a national monitoring framework’ Department of Health October 2000, the eight key principles are:

- agreed national set of standards and guidance;
- simple to use and easy to understand;
- targeted and comprehensive: a framework which covers juniors’ posts to the extent necessary to provide sufficient information to determine New Deal compliance and pay banding allocations;
- accurate and transparent: a framework which is accurate and reliable, open to scrutiny, and which commands the confidence of key parties at all levels;
- clear performance management lines of accountability within trusts and externally;
- audit trail: full data records must be kept locally for a minimum of 6 years and available on reasonable request to inform decisions and allow for review or appeal where appropriate;
- properly resourced locally, with the ultimate contractual responsibility for providing and overseeing monitoring processes resting with NHS Trusts as the employers of junior doctors;
monitoring systems must be capable of adaptation to take into account any future changes in contractual or legal requirements and the extent of the data required, on an ongoing basis, at local level to reassess hours' compliance and/or to resolve disputes.

11.3 What data should be collected?

According to ‘Junior Doctors’ Hours – Monitoring Guidance, Part C: Operating guidance for introducing a national monitoring framework’ Department of Health October 2000:

Trust medical data systems must record:

- grade and specialty;
- contracted working arrangement (shift, on-call rota, etc);
- contracted duty hours;
- information on the frequency and pattern of on-call or shift working, including the number of posts in the rota/shift and prospective cover arrangements;
- information on work intensity (the work/rest ratio)

For measuring compliance against New Deal targets the following controls or limits must be assessed:

- contracted hours;
- hours of duty, and when those hours occur;
- hours of actual work, and when those hours occur;
- total and continuous rest periods;
- maximum continuous duty;
- gaps between shifts;
- number of consecutive days worked;
- gaps between periods of time off duty;
- natural breaks;
- leave and cover arrangements.

In addition, for pay banding purposes, information will be required as outlined in the banding criteria on:

- residency status when on-call;
- frequency of weekend working;
- rest attained.

11.4 Who should be monitored?

Data should be collected by the trust from all PRHOs, Dental HOs, SHOs, and SpR/Reg/SRs - including flexible trainees and locum doctors in training employed by the trust during the whole monitoring period. Career grade doctors and other non-training grade medical staff will be covered by their own pay, hours and WTD contractual arrangements, so should not be monitored under this guidance.

Doctors who have identical duties and responsibilities when working on a shift or an out-of-hours portion of an on-call rota should be assessed as working on the same rota or shift. Where this is not the case, those with different duties and responsibilities should be assessed separately. This will enable trusts to ensure that banding decisions can be made which accord with the core principle that all doctors working on the same rota or shift are allocated to the same pay band.
Each duty period must be assessed individually to determine whether the New Deal requirements have been met on the required proportion of occasions as defined in HSC/1998/240 (as amended for assessing weekend rest in pay banding guidance).

11.5 When should the data be collected?

For pay banding purposes to take effect from 1st December 2000, all doctors in training must have completed a banding questionnaire.

Re-monitoring at the request of either party must be undertaken within a reasonable period of time. This may arise where, for example, an individual doctor can produce well founded reasons why their hours of work or work intensity are not adequately reflected in the results of the monitoring, or where the results vary substantially from the anticipated outcome, or following a major organisational change, or in cases of contractual dispute. Re-monitoring should usually involve the same set of doctors.

For ongoing monitoring, i.e. for both pay and New Deal purposes, hours should normally be recorded and checked at a minimum of twice a year. Non-typical periods should be avoided: e.g. change of house, bank holidays, examination periods. A monitoring period of two weeks is recommended. Twelve-monthly monitoring may be considered in cases where all parties including the regional task force (or equivalent) agree:

- that posts have clearly been shown to be compliant with the New Deal; and
- which pay band the post should be in; and
- that the pay banding is unlikely to change within the next twelve months.

Alternatively, monitoring may be agreed more frequently

- where posts are substantially non-compliant;
- in cases of contractual dispute;
- where there is a demonstrable and substantial change in working pattern or working practices in the post(s) during the training period; or
- following an agreed change in working pattern or practice.

11.6 Sanctions in the event of non-monitoring

11.6.1 If the Trust fails to monitor

If the Trust does not implement monitoring after 1 December 2000 which meets the key principles (set out in Junior Doctors’ Hours – Monitoring Guidance Part B: Key Principles for a national monitoring framework), the Regional Office will serve an improvement notice. If the trust subsequently fails to implement an appropriate monitoring system within six months, it must pay the junior doctors concerned as if they were in New Deal non-compliant posts (in terms of hours controls) i.e. at Band 3 pay rates. These rates will apply until such time as the Regional Office confirms that the Trust now meets its contractual requirement to monitor.

11.6.2 If junior doctors fail to monitor

Where an individual junior or group of junior doctors in a rota or rotational placement fails, 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 such circumstances, the Trust will determine what it regards as the correct pay band, on the basis of the available information.
Hours’ information must use agreed local recording methods, (eg diary cards, Yorkshire Monitor optical mark readers, barcode readers) which accord with the national framework principles (listed in Junior Doctors’ Hours – Monitoring Guidance Part B: Key Principles for a national monitoring framework). Hours should be recorded during the agreed monitoring period, preferably during or at the end of the duty period worked, rather than through potentially less reliable retrospective questionnaires or telephone surveys. This process is particularly recommended in the busier acute specialties.

11.7 What needs to be done locally?

Junior doctors and relevant working colleagues (e.g. medical and other clinical staff, medical staffing officers etc) must be notified adequately in advance of the agreed monitoring period. Those being monitored must have received at their induction or soon thereafter local guidance and instructions on the purposes of monitoring and what is entailed. Job descriptions, letters of appointment and individual contracts should remind all juniors of their contractual obligation to monitor hours on request. In turn, every effort should be made by Trusts to assist and encourage full participation in the exercise. Juniors should know where to send the information recorded, adequate collection points on-site shall be established, and they should know how to get feedback on the outcome of their participation.

11.8 How should the data be collected?

Much of the data needed for assessing banding criteria or New Deal compliance as listed above will already be available in trusts’ Medical Staffing sections, e.g. contracts of employment, contracted duty periods, calculations for prospective cover within the team, weekly shift/rota timetables. This data will need to be supplemented by accurately recorded data; e.g. actual length of working week, including early starts/late finishes, rest achieved during the day and overnight, natural breaks, actual working times as opposed to rostered duty periods. Monitoring may throw up situations where the working reality is very different from the expected working patterns, and could indicate the likely source of non-compliance.

Under this national framework a minimum return rate for monitoring data should be set at 75% of all doctors in training in each rota or shift (irrespective of grade) participating in the monitoring round, and at 75% of all duty periods worked over the monitoring period, provided this is deemed to be a representative figure in both cases. This threshold is important for making a valid and accurate assessment of hours worked and rest attained.

11.9 How should the hours data be processed and analysed?

There should be clear local arrangements for the designation of staff who will process, record and analyse data collected, together with robust performance management structures at all levels in the NHS to ensure that national framework guidance is observed in all trusts employing junior doctors.

The system selected for the processing of data should comply with the key principles at Part B. It should be consistent across trusts within the region, compatible with other data and capable of determining New Deal compliance and pay banding. Original data and summary documents should be kept by Trusts for a minimum of six years in case of future dispute. The requirements of the Data Protection Act regarding access to individual records and maintaining confidentiality must be followed at all stages.

The processing of data should take place immediately after the exercise, allowing adequate time to chase up ‘non-returns’ or follow up individual queries. The trust should then publish a summary report within 15 working days of receipt of an adequate sample of monitoring data. The report should be set
out in a simple, easy to understand format through which duty and working hours can be clearly assessed against New Deal requirements and pay banding criteria. The summary should serve as helpful feedback to individual juniors thereafter. In addition, results on the monitoring exercise should be published locally, broken down by grade and by specialty, and giving response rates in each case. Publication will provide information on problem areas and allow for subsequent discussion by trusts, juniors and others on action plans for the future. This will encourage greater joint ownership of problems raised in the drive for workable, sustainable solutions.

For pay banding purposes the mechanisms for agreeing whether monitoring results are valid are laid down in the accompanying guidance. For ongoing compliance purposes, results should be made available to the local New Deal implementation group and/or the BMA junior doctors representative(s) nominated as monitoring validation officer(s). The implementation group or nominated junior can then check to see if monitoring procedures were properly applied, and can test current data against previous monitoring outcomes and any subsequent known changes in working practices, working arrangements or workload pressures. The opportunity for re-monitoring should be given where formally requested either by the trust or junior(s):

- in cases of contractual dispute over the results;
- where there is a demonstrable and substantial change in working pattern or working practices in the post(s) during the training period; or
- in circumstances such as where an individual doctor can produce well founded reasons why their hours of work or work intensity are not adequately reflected in the results of the monitoring, or where the results vary substantially from the anticipated outcome, or following a major organisational change, or in cases of contractual dispute, and where reference to the regional task force (or future equivalent) for advice or independent arbitration is unlikely to result in early local resolution without further hours' information.

11.10 Who else needs monitoring information?

Hours' monitoring must become a familiar aspect of local and regional performance management requirements. Data publication should include:

- dissemination to the New Deal Implementation Group and local negotiating group (LNC);
- individual feedback to juniors participating in monitoring;
- a summary report sent to the regional task force (or its equivalent);
- information for other local/regional bodies e.g. postgraduate deans, workforce planning/development groups, commissioning health authorities, PCG/Ts;
- data may also be used as a quality indicator and made more openly available, e.g. for prospective juniors, patient groups.

Regional task forces (or their equivalent) will be responsible for checking the summary data provided to them for consistency and for their analysis of regional compliance trends. They will also be available to arbitrate on banding disputes, to assist appeals panels where appropriate and to provide advice and support where requested on working patterns, working practices and their impact on patient care.

Information may also be requested by appropriate bodies nationally for strategic purposes, e.g. for ministerial accountability, or to consider new systems of incentives and sanctions, repercussions for workforce planning, education and training, and particularly to check for consistent and comprehensive regional and local performance management arrangements and performance development plans or outcomes.
11.11 Recommendations on monitoring from the British Medical Association

Adapted from the recommendations set out in ‘Monitoring of Junior Doctors’ Hours - A case study perspective’ British Medical Association Health Policy and Economic Research Unit Report November 2003

- Transparency - The monitoring process needs to be transparent, so that any mistrust or misunderstanding of the process by doctors is reduced. The aims and objectives of the process must be made clear to all doctors. Feedback following the monitoring period is crucial if the resistance of doctors is to be minimised.

- Communication - Communication is critical to successful monitoring and must be fostered at all levels. Where possible, doctors should be involved in all aspects of the monitoring process, to ensure inclusiveness and hence co-operation of doctors. Good practice has shown that involving doctors in devising rotas is preferable and more effective than imposing rotas devised by Trust staff alone.

- Flexibility - The monitoring process needs to be made more flexible to take into account the circumstances of different specialties.

- Efficiency - The methods used to collect data need to be efficient and effective for both doctors and Trust staff, in order to reduce the need for retrospective, and hence inaccurate, monitoring and limit the time spent by Trust staff chasing returns

- Sharing – The sharing of good practice is essential to the development and modernisation of the monitoring process. Whilst it is not possible to advocate a method which suits all trusts, sharing of ideas, concerns and issues would further enhance the ability of individual trusts to implement methods that best suits their needs.

11.12 Key Features of Successful Monitoring

The following section has been adapted from the South East Action Team ‘Improving Junior Doctors Working Lives Information Sheets’ (May 2003).

- **Ownership**

It is essential that there is clear ownership of the monitoring system by the Trust as a whole. The Local Implementation Group, senior clinical and managerial staff and junior doctors should all be aware of the importance of monitoring and should support its implementation. It is evident that monitoring exercises that are supported by these groups have increased diary return rates and reduced re-monitoring rates. It should be stressed that this exercise is not done for the benefit of the Action Teams or their successors. There is a contractual obligation on both the junior doctors and trusts to comply with the monitoring protocol.

- **A proactive Local Implementation Group (LIG)**

This should bring together and co-ordinate all the key figures involved in monitoring and those involved in junior doctors’ hours generally.
• **Effective Management**

There needs to be a clearly identified and adequately resourced individual responsible for implementing the monitoring exercise. This individual should be afforded the time to plan, run and support the data collection. Where necessary this may involve the personal delivery of diary cards to individual junior doctors and chasing up collection, which can facilitate communication on the manner of completing the forms and data analysis at the time of distribution, which in turn improves the quality and quantity of the return. Regular and effective liaison with the junior doctors also helps. Some hospitals have employed Divisional Liaison Managers; one of their responsibilities is to liaise between the junior doctor and the senior managers to build up a good rapport with the doctors. This should hopefully improve the diary card return rate.

• **Appropriate monitoring methods**

- The method of monitoring selected should take into account the grade and specialty under review, as well as other non-trainees participating in the project. For example a two-week snapshot may not be appropriate for a very low frequency on call rota.

- It should also take into account the local circumstances of the Trust. Any Trust employing junior doctors has an obligation to monitor the hours and intensity of doctor’s work. However individual Trusts may have specific constraints in terms of the practicality of monitoring and the resources available to monitor and the method of monitoring should take this into account.

• **Communication and training**

Doctors need clear communication on what they are expected to do and why. Many doctors have fears that the results of monitoring exercises will be used to enforce difficult and unpopular rotas, and therefore communication should be used to address these anxieties. It should emphasise the need for monitoring, the methods chosen and training should be available to ensure honesty and consistency in the completion of returns.

• **Feedback**

The junior doctors need to be made aware of the outcome of any monitoring exercise. Feedback should be within fifteen working days of receiving adequate monitoring either through departmental meetings or personal letters. It is suggested that if the feedback is written this can also be used for the purposes of ‘formal notification’ of a change in banding as described in Terms and Conditions of Service paragraph 21Q.

• **Transparency & Accountability**

Monitoring works best when all parties are honest and open and individuals are accountable for the results of the monitoring exercise. Openness and honesty during the monitoring process can improve relations between departments and doctors provided they can see the results are analysed accurately and reported back to them and any problems identified are discussed at the department or directorate meeting acted upon promptly.
11.13 Hampshire and Isle of Wight WDD Monitoring Process Recommendations

Monitoring of junior doctors hours has been undertaken using a variety of methods although the most widely used is diary cards. Diary card monitoring aims to collect information on the number of hours and intensity worked, and should be undertaken at least twice per year, for a period of at least two weeks.

It is important that the results are representative of the month period as a whole, as the Trust or the doctor can request re-monitoring to take place if there is good reason to believe that the data is not representative. For a monitoring round to be considered valid, data on at least 75% of the duty periods worked during the monitoring period from at least 75% of the doctors should be received.

It is very important that accurate, reliable and comprehensive data is collected and analysed correctly, as inaccurate data may lead to the allocation of the wrong band.

Doctors should be given full details of the monitoring process at induction to increase compliance and accurate diary completion.

This should be backed up by a letter at the start of the monitoring round explaining

- the rationale behind monitoring
- stating that it is a contractual obligation to comply with monitoring
- stating that “failure to comply will result in re-monitoring all doctors in the group not just individuals”
- stating where to return the forms and to whom and when
- stating the name, extension number and email address of the person in charge of the monitoring exercise so doctors can contact them if necessary.

Trusts should aim to collect the diaries on at least a weekly basis so they can evaluate the success of the monitoring promptly (see the section on 're-monitoring' below).

Trusts should aim to inform doctors of the results of the monitoring as soon as they are available.

If the junior doctors have failed to return the minimum of 75% the whole group of doctors on that rota are required to re-monitor.

11.13.1 Re-monitoring

If, after the first week of monitoring, it is known that the results of the exercise will not be valid, either because it is not a typical week or the return rate is too low, then there is no need to wait for the second week. Re-monitoring should be instigated immediately among the same group of doctors after steps are taken to ensure validity will be improved.

As part of the re-monitoring process each doctor should receive a personal letter, which is also copied to the clinical tutor/medical director/ Head of Services, explaining:

- the need to re-monitor.
- stating that it is a contractual obligation to comply with monitoring.
- stating that “failure to comply with the exercise constitutes a breach of contract which will result in the Trust taking disciplinary action against individuals”.
- stating that if individuals fail to comply with the repeat monitoring the Trust will determine the correct Pay Band on the basis of “best evidence”.
- where and when to return the forms and to whom.
- clearly stating the name, extension number and email address of the person in charge of the re-monitoring process.
If, for example, a 75% diary card return is not received, the Trust must re-monitor as soon as possible and inform the junior doctors who are in breach of their contract that they are responsible for the re-monitoring exercise. The Trust must be able to show evidence of two failed attempts, before submitting whatever returns were received and asking for the rota to be re-banded on “best evidence”. It is suggested that the Trust should write to the juniors to inform them of the application for re-banding and reminding them that it is a contractual requirement of junior doctors to return diary cards.

11.13.2 Monitoring timescale

Diary card monitoring is a part of the junior doctors’ working life that they would much rather avoid. Unfortunately due to this, the monitoring process is often stretched over a much longer period than necessary and diary cards are often completed retrospectively. The coloured timelines below give the recommended week-by-week summary of the appropriate timescales for the monitoring process, where each block represents one week.

If the first monitoring attempt produces a valid outcome, the monitoring process should last a total of seven weeks.

If a second monitoring attempt is required the monitoring process may be extended to twelve weeks.

<table>
<thead>
<tr>
<th>Key</th>
<th>Stage in monitoring cycle</th>
<th>Minimum number of weeks</th>
<th>Extended number of weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Inform junior doctors that a monitoring exercise is imminent</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>Monitor for minimum of two weeks</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>Analyse the first monitoring attempt</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>D</td>
<td>Re-monitor if the first monitoring attempt is not valid (i.e. less than 75% return or unrepresentative)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>E</td>
<td>Analyse the second monitoring attempt</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>F</td>
<td>If the second monitoring attempt also fails the Trust should report the analysed band with a comment stating whether it regards the monitoring exercise to be representative. If the Trust considers the monitoring exercise to be unrepresentative it may wish to request that an alternative band is reported on the basis of ‘best evidence’ (i.e. recent valid monitoring or the theoretical work pattern)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>G</td>
<td>Feedback monitoring outcome(s) to junior doctors</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

12. MINISTERIAL RETURN PROCESS
Please note that this section is intended to be an aide memoire for the ministerial return process and does not provide comprehensive operational instructions. It was believed to be correct at time of writing in February 2006.

12.1 What information do Trusts have to provide and how is it submitted?

Prior to September 2005, Trusts in Hampshire and the Isle of Wight were required to submit the monitoring data to be reported in the ministerial return to the WDD via Excel spreadsheets. Since September 2005 Trusts have instead used the ministerial return function of DRS (Doctors Rostering Software). In order to submit the required data, Trusts first need to ensure that there is an agreed rota (or "work pattern") template defined for each group of doctors (or "work group"), and then that valid monitoring information (which is representative of the six month period up to the date of the ministerial return) is available on their local databases. Trusts publish this information by selecting the groups to be included in the return and uploading them on to the DRS web database. The WDD then co-ordinates the return by reviewing the data on the web database, agreeing the bands to be reported and collating all Trust data into three annexes which are returned to NHS Employers by a given deadline.

12.2 Who are NHS Employers?

NHS Employers is the employers' organisation for the NHS in England, was launched on 1 November 2004. Its work programme includes pay negotiations, health and safety, diversity, recruitment and retention, the NHS Pension Scheme review and whistle-blowing. NHS Employers is part of the NHS Confederation but has its own director, policy board and assembly.

12.3 Trusts have the opportunity to discuss monitoring results with junior doctors and the WDD and agree the bands to be reported in the return

The purpose of the process is to return a fair analysis of the intensity of work of doctors in training. The previous method of data submission (via Excel spreadsheets) allowed Trusts to decide the monitored bands to be reported prior to the data submission to the WDD. The new method of data submission requires the WDD to agree the banding to be returned based on the evidence published on the web database. This calls for better communication between Trusts and the WDD, and Trusts are therefore requested to provide more detailed commentary than in the past in order to facilitate this process. If a Trust wishes to report a different band to that monitored for a particular work group, they should make an explicit request to the WDD and provide reasons in the comments box within the group details.

12.4 Trusts should report monitored band not paid band

For the purposes of the ministerial return, NHS Employers collect data on the monitored band of the doctors in training; regardless of band the doctors are actually paid.

It is important that the results are representative of the six month period as a whole in order to facilitate a reasonable assessment of compliance for these work groups. If the monitoring exercise is deemed representative and shows a different band to the approved pay band, the Trust should report the monitored band for the purposes of the ministerial return (and if the monitored band is higher, the Trust should pay accordingly until a valid exercise confirms that the approved pay band is correct).

If the Trust considers a particular monitoring round to be unrepresentative and would like an alternative band to be returned (due to a failure to achieve a valid diary card return of 75% on two occasions, exceptional circumstances, or an insufficient time period monitored for work groups with very few doctors working infrequent out-of-hours, for example), it should explicitly request that a
compliance assessment be based on the “best evidence” available (i.e. valid monitoring data from the previous ministerial return, or if unavailable, the work pattern analysis).

For those work groups which were monitored at Band 3 in particular, it would be helpful if in addition to explaining why the breaches occurred, the Trust makes an explicit reference to the Trust’s formal opinion on whether it considers the monitoring to be representative in the comments box within the group information.

12.5 How to report junior doctors who work for two Trusts

The advice given by Corrin Shepherd at NHS Employers with regards to reporting junior doctors that are not employed by a Trust but work on an on-call rota that they monitor, is that:

- **If the doctor’s work is split between the two Trusts**, it is the employing Trust (i.e. the one which holds the doctors contract of employment) who should include the doctor in their return.

- **If the doctor works entirely at one Trust**, it is that Trust who should include the doctor in their return, even if they are not the employing Trust.

12.6 How to report when doctors employed by different Trusts work on the same rota

In previous ministerial returns the Trust who monitored the doctors simply gave the employing Trust the data to return to the WDD in their Excel spreadsheet. Using DRS for the ministerial return means that this is no longer possible, and this potentially creates additional work for employing Trusts who now need to obtain, data input and analyse diary cards for doctors they employ but do not manage.

Trusts are not however expected to re-input diary cards monitored in other Trusts, as diary card monitoring data can be transferred electronically.

In order for the data reported to be accurate and without duplication, where there is a combination of doctors employed by different Trusts on one rota, you should identify those doctors that you are reporting as their particular grades, (SHO, SpR for example) and those to be reported by other Trusts as “others” in the DRS work pattern and diary card screens.

If another Trust has monitored and analysed the rotas, they can email the monitoring data for you to include in your return as follows:

- **The Trust which monitored will need to save the relevant work group onto their C: drive or network drive:**

  a) From the File menu in DRS, select “Save as XML”
  b) Attach this XML file to an email and send to the other Trust

- **The Trust which receives the file:**

  a) Save the email attachment as an XML file on your C: drive or network drive.
  b) From the File menu in DRS, select “Open” and select the file you just saved.
  c) DRS will open the saved file in “Current file view”, which means that only this will be listed on the screen.
  d) From the Edit menu, select “Work Group details” (or alternatively use the “Group info” button).
  e) Make a note of the details, especially the monitoring start date and the doctors grades and names (if defined).
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>f)</td>
<td>From the Edit menu, select “Diary cards” (or alternatively use the “Diary cards” button)</td>
</tr>
<tr>
<td>g)</td>
<td>Select the first day of the monitoring exercise by clicking on the grey box immediately to the left of the date.</td>
</tr>
<tr>
<td>h)</td>
<td>Hold the shift key down, use the mouse to scroll down and select the last day of the monitoring exercise.</td>
</tr>
<tr>
<td>i)</td>
<td>Release the shift key and you should have all of the diary card information highlighted.</td>
</tr>
<tr>
<td>j)</td>
<td>Click the right mouse button, and select “Copy”.</td>
</tr>
<tr>
<td>k)</td>
<td>Close the diary card screen.</td>
</tr>
<tr>
<td>l)</td>
<td>From the View menu, select “Database”. This will take you back to your local database.</td>
</tr>
<tr>
<td>m)</td>
<td>Select the group you want to copy the diary card data to.</td>
</tr>
<tr>
<td>n)</td>
<td>From the Edit menu, select “Work Group details” (or alternatively use the “Group info” button)</td>
</tr>
<tr>
<td>o)</td>
<td>Click on “New Exercise New Doctors”</td>
</tr>
<tr>
<td>p)</td>
<td>Input the monitoring start date under “Current monitoring exercise”.</td>
</tr>
<tr>
<td>q)</td>
<td>Type in the word <em>doctor</em> under “Surname” in order to “bookmark” where you would like the diary card data to be placed.</td>
</tr>
<tr>
<td>r)</td>
<td>Save and exit.</td>
</tr>
<tr>
<td>s)</td>
<td>From the Edit menu, select “Diary cards” (or alternatively use the “Diary cards” button)</td>
</tr>
<tr>
<td>t)</td>
<td>Click the right mouse button, and select “Paste”.</td>
</tr>
<tr>
<td>u)</td>
<td>Check that the monitoring start date is correct (N.B. Do not tick the box which says “Change the dates”, as it may cause DRS to crash!)</td>
</tr>
<tr>
<td>v)</td>
<td>Use the drop-down menu to the right of where it says “New Doctor” to ensure that it says “Add doctor to study” for all doctors.</td>
</tr>
<tr>
<td>w)</td>
<td>Select “Paste”. The new diary cards should now be visible.</td>
</tr>
<tr>
<td>x)</td>
<td>Close the diary card window.</td>
</tr>
<tr>
<td>y)</td>
<td>From the Edit menu, select “Work Group details” (or alternatively use the “Group info” button).</td>
</tr>
<tr>
<td>z)</td>
<td>Select the new monitoring start date from the drop-down menu beneath “Existing Exercises”.</td>
</tr>
<tr>
<td>aa)</td>
<td>Select “Make this the current exercise”.</td>
</tr>
<tr>
<td>bb)</td>
<td>Ensure that the correct doctors’ names are listed beneath “Current monitoring exercise”, and delete the fictitious doctor which was input as a “bookmark”.</td>
</tr>
<tr>
<td>cc)</td>
<td>Beneath “Current monitoring exercise”, ensure that the doctors you wish to report are defined as the correct grade (i.e. F1, F2, PRHO, SHO or SpR), and that the doctors who are going to be reported by the other Trust are defined as “Other”. (This may mean reversing the grades of the doctors copied in with the monitoring data).</td>
</tr>
<tr>
<td>dd)</td>
<td>Ensure that the group is marked as “Live”.</td>
</tr>
<tr>
<td>ee)</td>
<td>Ensure that the group is ticked for return (i.e. return flag set ON).</td>
</tr>
</tbody>
</table>
12.7 How to report when doctors from different specialties work on the same rota

There may be situations where there are doctors from different specialties working on the same rota. These rotas would need to be duplicated and/or amended, in order for the diary cards to be analysed together (therefore representative monitoring), but reported separately according to their specialty.

If, for example, there are 6 Obs & Gynae and 4 Paediatric SHOs working on same rota, a second work group needs to be created and amended as follows:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Design the joint work pattern, input monitoring data and analyse as a group.</td>
</tr>
<tr>
<td>b)</td>
<td>Duplicate (i.e. copy and paste) work pattern into the database.</td>
</tr>
<tr>
<td>c)</td>
<td>Open the first of the work patterns, go into group info screen, set the specialty as Obs &amp; Gynae and label the 6 Obs &amp; Gynae doctors as “SHO” and the 4 Paed doctors as “Other”.</td>
</tr>
<tr>
<td>d)</td>
<td>Analyse the diary cards for the whole of the first group.</td>
</tr>
<tr>
<td>e)</td>
<td>Open the second work pattern, go into group info screen, set the specialty as Paediatrics and label the 4 Paed doctors as “SHO” and the 6 Obs &amp; Gynae doctors as “Other”.</td>
</tr>
<tr>
<td>f)</td>
<td>Analyse the diary cards for the whole of the second group.</td>
</tr>
</tbody>
</table>

12.8 Why having groups with the status “R Template” causes problems

Work patterns must show “R Return” in the approval column in order be included in the return (i.e. those listed as “R Templ” or “R Impl” will be automatically omitted). This is because the DRS software development team have written in a ‘gate’ which prevents groups being included in the return if they have not been at least provisionally approved by an SHA. This was designed in order to ensure that a new work group would have to be agreed properly by an SHA before it could be included in the return.

Our experience from the last ministerial return showed that this technical design decision can become problematic when Trusts try to step outside of the intended process. It is therefore critical that Trusts adhere to the intended process by gaining official WDD approval for new work groups prior to the ministerial return.

12.9 If the diary card monitoring shows a different band to the work pattern analysis

If the diary card monitoring analysis shows different band to work pattern analysis, the Trust should consider whether the diary card monitoring is representative. If deemed unrepresentative monitoring, the Trust must return in the normal way, but with the addition of comments requesting WDD agree alternative band be reported as the monitored band is deemed unrepresentative.

12.10 The ministerial return process using DRS

- **Ensure that you have the correct version of DRS installed (version 2.1.8)**

If you do not know which version of DRS you currently have installed on a particular machine, open DRS and from the Help menu select ‘About’.

DRS version 2.1.8 can be downloaded from: [www.drsusers.com/downloads/drs218/drs.msi](http://www.drsusers.com/downloads/drs218/drs.msi)

Documentation including installation & testing instructions, system requirements and a list of DRS lead contacts at each Trust, grouped by Health Authority can be downloaded from: [www.drsusers.com/downloads/drs218/drsdocs.zip](http://www.drsusers.com/downloads/drs218/drsdocs.zip)
• **Connect to the DRS web database**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>From the Supervisor menu, select “Configure link to web database”.</td>
</tr>
<tr>
<td>b)</td>
<td>Enter the server URL [<a href="http://www.drtrustservices.com">www.drtrustservices.com</a>]</td>
</tr>
<tr>
<td>c)</td>
<td>Enter your Trust user ID and password (you should have been given these at your training session)</td>
</tr>
<tr>
<td>d)</td>
<td>Select “Check link”. You should get a window that says “Link is OK”.</td>
</tr>
<tr>
<td>e)</td>
<td>Select “Save”.</td>
</tr>
</tbody>
</table>

N.B. This is usually a one-off procedure, which should not have to be repeated once the initial connection has been made.

• **Ensure that all the groups containing doctors in training who are currently working in the Trust and are marked as “live”**

Either:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Select multiple groups</td>
</tr>
<tr>
<td>b)</td>
<td>From the Edit menu, select “Change work group status”</td>
</tr>
<tr>
<td>c)</td>
<td>Select “Live”</td>
</tr>
<tr>
<td>d)</td>
<td>Select “Update”</td>
</tr>
</tbody>
</table>

Or:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Select individual groups</td>
</tr>
<tr>
<td>b)</td>
<td>Select the “Group info” button on the toolbar.</td>
</tr>
<tr>
<td>c)</td>
<td>Select “Live”</td>
</tr>
<tr>
<td>d)</td>
<td>Select “Save and exit”</td>
</tr>
</tbody>
</table>

Or:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Select individual groups</td>
</tr>
<tr>
<td>b)</td>
<td>From the Edit menu, select “Work group details”</td>
</tr>
<tr>
<td>c)</td>
<td>Select “live”</td>
</tr>
<tr>
<td>d)</td>
<td>Select “Save and exit”</td>
</tr>
</tbody>
</table>

• **Ensure that all the groups containing doctors in training who are currently working in the Trust are marked for inclusion in the return**

Either:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Select multiple groups</td>
</tr>
<tr>
<td>b)</td>
<td>From the Edit menu, select “Return flag set ON”</td>
</tr>
<tr>
<td>c)</td>
<td>When DRS asks for confirmation, select “OK”</td>
</tr>
</tbody>
</table>

Or:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Select individual groups</td>
</tr>
<tr>
<td>b)</td>
<td>Right mouse click and select “Toggle return flag”</td>
</tr>
</tbody>
</table>

• **Ensure that you have a theoretical work pattern for every group.**

Where Trusts do not have 100% diary card return for a particular exercise it is vital that there is a theoretical work pattern template entered so that DRS can produce a combined analysis in order to make an accurate return.
However, Trusts should remember that the theoretical work pattern is a representation of the work required by the service. It does not take account of the private arrangements made by doctors to swap shifts.

The Trust's main concerns when entering a theoretical work pattern are:

- The number of doctors sharing the pattern. Only doctors who share evenly the work of the group should be included. This means, for example, that two flexible trainees sharing a full-time post, (or “slot-share”), can be included in the group, but a single flexible trainee would need to have their own work pattern defined separately.
- The level of cover provided by the work pattern.
- The type and length of the duties; the expectation of rest (other than natural breaks), and whether the doctors are required to be resident.
- The frequency of out-of hours work.

- **Enter diary card monitoring data for each group (this must be from a monitoring exercise during the six-month period prior to the ministerial return).**

- **Check the data to be submitted.**

It is important that the band reported to NHS Employers for each group is agreed by the junior doctors, the Trust and the WDD. If the Trust wishes to report a band other than that provided by DRS analysis, it should raise this with the WDD.

The trust should check the return summary print to make sure the return matches their expectation:

| a) From the “Prints” menu, select “Return summary print”. This will display a summary of all the groups the Trust is returning, and their monitored band according to the DRS analysis. |

N.B. The agreed band will only appear on the return summary print once the data has been uploaded to the web database and the band to be reported has been agreed by the WDD.
- Once you are happy with the information to be reported, use the “ministerial return process” to upload your data. Please note that all this process is doing is synchronising the information held on your machine with the information held on the web database.

<table>
<thead>
<tr>
<th>a) From the Remote menu, select “Ministerial return process” and a pop-up box will appear.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>b) You have three options of what to include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Groups already on the database”</td>
</tr>
<tr>
<td>2. “Groups marked for inclusion on the return print”</td>
</tr>
<tr>
<td>3. “Groups marked with status ‘live’”</td>
</tr>
</tbody>
</table>

The WDD recommend that you select option 2: “Groups marked for inclusion on the return print”, however, having options 1 and 3 does allow some flexibility. Option 1 for example, allows you to upload the data if a further diary card is returned after you have already placed a group on the web database.

<table>
<thead>
<tr>
<th>c) You also have three options of how to submit this data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Report changes” (this informs you of what is different from what is currently on the web database, and what you are intending to upload)</td>
</tr>
<tr>
<td>2. “Update changes” (this synchronises what is on your local database and what is on the web database)</td>
</tr>
<tr>
<td>3. “Report changes and update” (this synchronises what is on your local database and what is on the web database and produces a report telling you what the changes have been)</td>
</tr>
</tbody>
</table>

The WDD recommend that you select option 3: “Report changes and update”

<table>
<thead>
<tr>
<th>d) Select “OK”</th>
</tr>
</thead>
</table>

Trusts may use this process as many times as necessary to modify the data, until the return is finally signed off.
13. RE-BANDING APPROVAL PROCESS

13.1 The original regional approval system

Responsibility for the re-banding of junior doctors’ posts was part of the now-disbanded Regional Action Team’s remit, before being was passed onto various successor bodies such as strategic health authorities and workforce development confederations.

The Appendix to the Health Service Circular 2000/ 031 published by the Department of Health on 12th October 2000 described an arrangement where Trusts are encouraged to discuss informally with the regional task force (or equivalent) any proposed change to existing posts which would lead to an increase in hours worked. To obtain approval for such a change, the Trust must:

- submit a clear written statement to the regional task force (or equivalent) explaining the valid reason behind the change;
- confirm with the regional task force (or equivalent) that the change will not lead to a breach of the New Deal;
- obtain confirmation from the postgraduate dean that the proposed change will not adversely affect the educational content of the post;
- satisfy the regional task force (or equivalent) that all affected postholders have been consulted on the proposed changes and have given written agreement.

Once this has been done, the regional task force (or equivalent) can then give written approval for the change. Failure to obtain such approval means that the trust cannot introduce the change. If it is envisaged that the change will be brought in at the change of postholder, agreement should be obtained from both outgoing and incoming doctors, and a clear indication of the proposed change should be detailed in the job advertisement and description.
13.2 Mechanism for rebanding

The re-banding process following the monitoring of junior doctors’ hours or changes in the working arrangements is outlined in the Advanced Letter (MD) 2001/01 ‘Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service’ (7th February 2001) as follows:

<table>
<thead>
<tr>
<th>Stage One</th>
<th>Institute change in working practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To institute a change in working practice, the employer must:</td>
</tr>
<tr>
<td></td>
<td>• Consult the postholders and obtain the agreement of the majority participating in the rota;</td>
</tr>
<tr>
<td></td>
<td>• Obtain agreement from the clinical tutor for education purposes;</td>
</tr>
<tr>
<td></td>
<td>• Submit details of the new rota to the regional action team (or equivalent) for information and invited comment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage Two</th>
<th>Monitoring of working pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Such monitoring must comply with the principles set out in HSC 2000/031 and be subject to validation by local junior doctor representatives and the regional action team (or equivalent).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage Three</th>
<th>Written notification of monitoring outcome</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Stage Four</th>
<th>Approval mechanism to change band</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The following information must be sent to the regional action team (or equivalent):</td>
</tr>
<tr>
<td></td>
<td>• Details of the change in working practice;</td>
</tr>
<tr>
<td></td>
<td>• Monitoring data;</td>
</tr>
<tr>
<td></td>
<td>• Agreement of postholder;</td>
</tr>
<tr>
<td></td>
<td>• Agreement of clinical tutor.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage Five</th>
<th>Appeals mechanism</th>
</tr>
</thead>
</table>

13.3 Approval to Change Band Proformas

The official Approval to Change Band Proforma issued by the Department of Health following the implementation of the New Deal pay banding system can be found as an annex to this document.

The WDD felt that it might be useful to design an updated Approval to Change Band Proforma, as the original document refers to ‘ND2000’ software and ‘Action Teams’ and could be regarded to be a little out of date. It would also be useful if the revised documentation included some provision for the Clinical Tutor/ Educational Supervisor to sign to show that they agree with the new work pattern, rather than this having to be obtained in a separate letter.

Bearing in mind the sensitivities of the staff side in ensuring that proper procedures are carried out, the WDD have produced revised documentation which Trusts may choose to use as they see fit. The revised proforma, (which can also be found as an annex to this document), has been passed before
NHS Employers for their comment, who agreed that in principle, Trusts simply need to ensure that the data requested on the revised style proforma is collected in the same way and in the same spirit as on the original proforma.

13.4 Re-banding arrangements in Hampshire and the Isle of Wight

In HIoW, the WDD has been specifically responsible for the administration of the approval process for provisional and formal re-banding cases for a number of years. During this time, Trusts have generally built up their own local teams (often with the aid of bespoke WDD funding) and are now far better positioned to maintain up-to-date knowledge and expertise. With effect from 1st April 2006 re-banding will become entirely the responsibility of Trusts themselves, and Trusts will therefore need to establish a robust, internal approval and scrutiny process. This includes ‘ownership’ of the DRS software which, it is envisaged, will be agreed with one of the Trusts.

Trusts are strongly encouraged to engage their junior doctors in developing solutions and deal with disagreements in the first instance and for the Trusts to then liaise with the local BMA office to work together to resolve issues that may arise.

Where agreements cannot be reached, the nationally agreed banding appeals procedure as set out in the Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales, September 2002 (Version 6, 1st June 2005) should be implemented. The residual WDD responsibility will be to establish and maintain a list of suitably qualified Trust representatives who would be available for such appeals.
13.5 WDD recommendations for re-banding

The WDD has produced a checklist to aid Trusts in administering changes to pay bands or work patterns:

<table>
<thead>
<tr>
<th>Step</th>
<th>Activity</th>
<th>Completed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Institute change in working practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a Engage all of junior doctors in the work group to assist with the design of a suitable work pattern.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b Ask the junior doctors in the work group to nominate a representative to act on their behalf.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c Agree the date of work pattern implementation with the work group or their representative.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d Agree a proposed date for diary card monitoring (ideally within six weeks of implementation).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Complete the Approval to Change Band Proforma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trust Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hospital/ site</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Specialty/ department</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Work pattern/ shift type</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of doctors by grade</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Current pay band</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proposed pay band</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Proposed date of work pattern implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Seek agreement and obtain signatures on Approval to Change Band Proforma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trust representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Junior doctor representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Educational Supervisor/ Clinical Tutor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Seek implementation/ provisional approval from senior Trust signatory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The proposed work pattern should be presented to the senior Trust signatory with an analysis of its theoretical compliance with the New Deal.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>Implement the proposed work pattern</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Monitor working practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>Analyse monitoring data</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><strong>Present monitoring outcome and seek formal approval from senior Trust signatory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The results of the monitoring exercise should be presented to the senior Trust signatory including an analysis of the actual compliance with the New Deal, and any other relevant information which may inform their decision of formal approval.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td><strong>Communicate written notification of monitoring outcome and change of pay band (if applicable) to the junior doctor representative (or entire work group)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td><strong>Communicate change of pay band (if applicable) to Trust payroll department</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13.6 Re-banding Timeline

The timeline below depicts the suggested time to complete entire re-banding process, where each block represents one week. It has been produced for illustrative purposes only, in order to give Trusts an idea how long the process might take at each stage, and is not meant to be in any way prescriptive.

<table>
<thead>
<tr>
<th>Steps 1-3</th>
<th>Step 4</th>
<th>Steps 5-7 (first monitoring attempt)</th>
<th>Steps 6-7 (second monitoring attempt)</th>
<th>Step 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Key:

<table>
<thead>
<tr>
<th>Steps in re-banding cycle</th>
<th>Number of weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 Design work pattern with the agreement of the junior doctors and Clinical Tutor</td>
<td>3</td>
</tr>
<tr>
<td>4 Seek implementation/provisional approval</td>
<td>2</td>
</tr>
<tr>
<td>5-7 Implement work pattern, monitor and analyse</td>
<td>6</td>
</tr>
<tr>
<td>6-7 Extended time to re-monitor and analyse if first monitoring attempt is not valid</td>
<td>10</td>
</tr>
<tr>
<td>8 Seek formal approval</td>
<td>2</td>
</tr>
<tr>
<td>Minimum re-banding cycle length</td>
<td>13</td>
</tr>
<tr>
<td>Extended re-banding cycle length</td>
<td>23</td>
</tr>
</tbody>
</table>

13.7 Types of approval

There are three stages of approval available when using DRS. The following ‘Re-Banding Approval System Overview’ is taken from the online help files on the DRS website [www.drsusers.com/help/help.asp](http://www.drsusers.com/help/help.asp)

- **Template Approval**

  This is an optional initial stage. The new work pattern has been designed and the Trust is seeking approval of the concept.

- **Implementation Approval (including the option to request Provisional approval)**

  The work pattern is designed and agreed by all parties at the Trust. An implementation date is been set. The Trust may also ask for provisional re-banding permission so that after implementation the doctors can be paid in line with the new band. Otherwise, pay is at the old band rates until the re-banding is formally approved.

- **Formal Approval**

  The new working practises must be monitored for a reasonable period and the results must support the proposed new band. The SHA/WDC will specify the final band to be paid.
13.8 To re-band, or not to re-band…?

When trying to decide whether it is necessary to go through the re-banding process due to a change to a work pattern, the answer depends on whether the change is deemed to be "substantive". If the core structure of the work pattern remains the same, (in other words, if the educational aspects of the pattern are consistent, and the pattern remains New Deal compliant), and as long as the doctors in post agree to the changes and compliance/ banding is confirmed by monitoring, then the full re-banding process should be unnecessary.

There is, however, a clear protocol to follow when the effect of the change is an increase in hours, and the Trust would be laying itself open to criticism or challenge were it not to go through the process.

In other words, if the Trust feels that the change to the work pattern is not “substantive” and the banding remains the same, the Trust does not need to go through the approval process. You will need the written agreement of the educational supervisor and junior doctor representative, before updating the existing work pattern template in DRS.

If, however, the Trust feels that a change to a work pattern is "substantive”, and may lead to an increase in hours worked, the recommendation is to request senior approval to implement the change. In that case, the recommendation is that instead of changing the existing work pattern template in DRS, the Trust create a new work group, and write the four-digit DRS reference number of the old work group it supersedes in the comments box of the new work group details. Once the new work pattern is implemented, it becomes "live" and the status of the old one can be changed to "dead", electronic record of it maintained for future reference.
14. PAY PROTECTION

Junior doctors have been subject to pay protection since the implementation of the New Deal in 2000. This was initially to safeguard their income with the changeover from the Additional Duty Hours pay system to the New Deal pay banding system, but pay protection also applies to all doctors on rotation who may work at several hospitals during the period of their rotation.

Pay protection is referred to in the junior doctors’ Terms and Conditions of Service and is a complex topic because its application is subject to interpretation and guidance update from time to time. Unfortunately the lack of clarity provided by the Terms and Conditions of Service means that there is no definitive guidance since the application of pay protection is yet to be agreed upon by NHS Employers and the BMA. Whilst the WDD recognises that due to the significant financial savings for Trusts in Hampshire and the Isle of Wight this issue needs to be resolved as quickly as possible, it does not feel that it is in a position to provide a local interpretation for an issue which needs to be nationally negotiated and agreed upon.

The following has been reproduced from the “Terms and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public Health Medicine and the Community Health Service in England and Wales” September 2002 (Version 6 - 1 June 2005) Paragraphs 21a – 21q

21a. Full time practitioners in the grades of SR, SpR, R, SHO, HO and PRHO receive a base salary. Part time practitioners in these grades receive as base salary a proportion of the full-time base salary based on average weekly hours of actual work. An additional supplement will be paid according to one of the pay bands, in accordance with the assessment of their post as described in paragraph 22 below.

b. For practitioners contracted to work 40 or more hours of duty per week, pensionable pay for contributions purposes must be based on the practitioner’s actual whole-time basic pay (1.0) only. Pay supplements over and above base salary are non-pensionable.

Pay protection at transition

c. Pay protection in compliant posts will apply from 1 December 2000 to any junior doctor whose total pay under the ADH system (at current ADH percentages) in the post they are occupying on 1 December 2000, or in any post in a rotation accepted before 1 December 2000, where a formal ADH assessment has been made, would be higher than that due under the proposed new contractual arrangements.

d. Until 1 December 2003 pay protection will also apply to any post or placement in a rotation accepted before 1 December 2000 where no formal ADH assessment was made but where the post, at the time the junior doctor accepted the rotation, was paid at a higher rate under the ADH system than is the case under the new contractual arrangements when the junior doctor takes up the post.

e. On 1 December 2000, where a post attracts a higher rate ADH payment in recognition of excessive intensity, under EL (96)10 or HSC 1998/027 (in England), then the post shall attract the same overall salary for so long as it is more favourable until the intensity problem has been shown to be resolved. This shall also apply where a claim with full supporting evidence has been lodged by 30 November 2000 in accordance with these circulars.

Principles of pay protection

f. The principle of pay protection applies to practitioners in all bands for the duration of the post/placement or within a rotation subject to the conditions set out in sub-paragraphs 21.h to m.
g. Pay protection applies to the base salary on the scale plus the supplement in payment at the time the post or placement is rebanded. The salary shall be increased only to take account of increments in the base salary on the old scale.

Pay protection in New Deal compliant posts

h. Where a practitioner reaches agreement with his or her employing authority on a new or revised contract on or after 1 December 2000, the practitioner’s post shall be re-assessed in accordance with paragraphs 19 to 23, effective from the date of the change. For so long as it is more favourable, and so long as the practitioner remains in the same post, the practitioner shall retain the overall salary applicable to the band he or she was placed in immediately before the change. The salary shall be increased only to take account of increments in the base salary on the old scale.

i. If a practitioner in a rotational appointment has accepted appointment to a future post in that rotation for which a New Deal compliant pay band assessment has been made at the time of appointment to the rotation and the duties of that future post have been changed before the practitioner actually takes it up, then sub-paragraph 21.h shall apply, and the practitioner shall be treated as if he or she had already been occupying the post at the time of the change. If no assessment of the pay band has been made at the time of appointment then sub-paragraphs 21.c, d and e apply.

Pay protection in New Deal non-compliant posts

j. Where a New Deal non-compliant post/placement (pay band 3) becomes compliant before 1 December 2002, the practitioner shall retain the overall salary protected at the pay band 3 rate applicable at the time of rebanding, for so long as it is more favourable and for the duration of the post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.

k. Where a New Deal non-compliant post/placement (pay band 3) becomes compliant on or after 1 December 2002, the practitioner shall have their salary protected at the pay band 2A rate applicable at the time of rebanding, for so long as it is more favourable and for the duration of the post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.

l. Where a future post/placement in a rotation, which has been accepted by the practitioner at pay band 3, becomes compliant before 1 December 2002, the practitioner when they take up that post/placement shall retain the overall salary protected at the pay band 3 rate applicable at the time of the rebanding, for so long as it is more favourable and for the duration of that post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.

m. Where a future post/placement in a rotation, which has been accepted by the practitioner at pay band 3, becomes compliant on or after 1 December 2002, the practitioner when they take up that post/placement shall have their salary protected at the pay band 2A rate applicable at the time of the rebanding, for so long as it is more favourable and for the duration of that post/placement. The salary shall be increased only to take account of increments in the base salary on the old scale.

Definition

n. For these purposes a rotation is a series of posts or placements forming part of a training programme which might be at PRHO, SHO, or SpR level. Such a rotation may involve the trainee having a series of different employing trusts and contracts, but will not involve a new appointment panel.
Backdating of Pay on Re-Banding after Monitoring

o) When following a change of house a rota is properly monitored to be in a higher band than demonstrated by previous valid monitoring, backdating of pay will apply to those doctors currently in post and will not apply to former postholders regardless of when previous monitoring took place, unless former postholders have formally raised concerns and requested monitoring but where that has not taken place. In such cases where the later valid monitoring confirms the concerns of the former postholders, they should receive back pay at the higher rate from the date of the request for monitoring to the end of the placement.

p) In the event of a rota, without any change in working pattern, being shown to belong in a higher pay band as a result of a valid monitoring round, pay at the higher level shall be backdated to the point three calendar months after the first day of the previous successful monitoring round, i.e. that which most recently showed the lower pay band, except:

• where there are postholders who have taken up their posts after the previous valid monitoring round, for whom the most recent round is also their first one in their current post, in which case their pay increase will be backdated to their first day in the post;

or

• when there have been intervening attempts by the trust to monitor, which the trust can demonstrate to have been done in accordance with good practice guidelines and which have not been successful despite the proven best efforts of the trust, in which case pay shall be backdated to the first day of the valid monitoring exercise which led to the rota being shown for the first time to belong in a higher pay band.

or

• where a valid monitoring round which has been requested by the doctors in post demonstrates an increase in the pay band, when backdating will be to the date of the request to monitor if this is less than three calendar months from the first day of the previous successful monitoring round.

Notification of Posts becoming Compliant

q) Where a previously non-compliant rota is shown on valid monitoring to fall into a compliant pay band, an employer shall notify the doctors on that rota of the change in writing, and salaries at the protected level of band 2A shall be paid from the first day of the month following that in which notification was made. An employer cannot require repayment of any salary paid at the higher band prior to the last day of the month in which formal notification was given.

WDD clarification on terms and Conditions paragraph 21q

The WDD sought clarification on the interpretation of Terms and Conditions paragraph 21q with regards to when Trusts can change the banding of junior doctors when implementing a new work pattern.

The clarification was required because paragraph 21q specifically mentions formal notification before a change to the band should be applied.

On investigating this we saw the paragraph above clearly states after valid monitoring you cannot change their banding until the first day of the month following that in which notification was made. The
WDD feel this paragraph therefore relates to *monitoring* and not the implementation of a new *work pattern*.

After establishing this we discussed what would be a suitable period of notice before changing postholders pay when implementing a new work pattern with a project doctor at Portsmouth Hospitals Trust. The project doctor and the WDD agreed that a period of two to four weeks would be sufficient.

The next matter to be clarified is what constitutes ‘*formal notification*’. When a junior doctor is engaged with the design of a new work pattern they should then be responsible of informing their colleagues of the change. When changing a work pattern the Trust must correspond with all doctors working the new rota and receive majority support, which provides an opportunity for the Trust to inform the postholders that a change in band is planned. There should be no reason why this should not also constitute their formal notice.

It should be noted that the only doctors who will be affected by paragraph 21q are those being paid Band 3. No junior doctor is currently being pay protected at this band and is therefore pay protected at band 2A. All remaining doctors on band 2A or lower will be pay protected at that band until they complete their post. New doctors joining the work group will not be affected and will be paid the new band unless employed before the provisional approval date.

The following is reproduced from Advance letter (MD) 1/01: ‘Pay and Conditions of Service of Hospital Medical and Dental Staff and Doctors in Public health Medicine and the Community Health Service’

Steve Barnett, Deputy Director of Human Resources, 7 February 2001, paragraphs 31-37:

**Pay protection arrangements for compliant posts after transition**

31. For compliant posts/placements which are rebanded to a lower band, postholders shall have salary protected at the rate of the original band applicable at the time of rebanding on a mark time basis, i.e. for so long as it remains favourable, for the duration of the post/placement. Salaries to be increased only to take account of increments in the base salary on the scale applicable at the time of appointment, excluding any changes to the supplement rate.

32. For rotations, future posts/placements which have been accepted by the appointee at a compliant band that are rebanded to a lower band shall have salary protected at the rate of the original band applicable at the time of rebanding on a mark time basis, i.e. for so long as it remains favourable, for the duration of the post/placement. Salaries to be increased only to take account of increments in the base salary on the scale applicable at the time of appointment, excluding any changes to the supplement rate.

**Pay protection arrangements for non-compliant posts after transition**

33. All posts which are non-compliant will be paid at the Band 3 rates applicable at the time.

34. For posts/placements which become compliant before 1 December 2002 postholders shall have salary protected at the Band 3 rate applicable at the time of rebanding on a mark time basis, i.e for so long as it remains favourable, for the duration of the post/placement. Salaries to be increased only to take account of increments in the base salary on the scale applicable at the time of appointment, excluding any changes to the supplement rate.

35. For posts/placements which become compliant on or after 1 December 2002 postholders shall have salary protected at the Band 2A rate applicable at the time of rebanding on a mark time basis, i.e for so long as it remains favourable, for the duration of the post/placement. Salaries to be increased
only to take account of increments in the base salary on the scale applicable at the time of appointment, excluding any changes to the supplement rate.

36. For rotations, future posts/placements which have been accepted by the appointee at Band 3 that become compliant before 1 December 2002 shall have salary protected at the Band 3 rate applicable at the time of rebanding on a mark time basis, i.e. for so long as it remains favourable, for the duration of the post/placement. Salaries to be increased only to take account of increments in the base salary on the scale applicable at the time of appointment, excluding any changes to the supplement rate.

37. For rotations, future posts/placements which have been accepted by the appointee at Band 3 that become compliant on or after 1 December 2002 shall have salary protected at the Band 2A rate applicable at the time of rebanding on a mark time basis, i.e. for so long as it remains favourable, for the duration of the post/placement. Salaries to be increased only to take account of increments in the base salary on the scale applicable at the time of appointment, excluding any changes to the supplement rate.
Appendix A

PROTOCOL FOR THE RE_BANDING OF TRAINING GRADE POSTS

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

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

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

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

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

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

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

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

3. In the Proforma, references to the Action Team should be taken to refer to the Regional Improving Junior Doctors Working Lives Action Team or any successor body.

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

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

6. In recognition of the range of different monitoring processes used in the Regions and not wishing either to duplicate current practices or to create an unnecessary burden on Trusts we do not propose to be prescriptive in the way supporting monitoring data is to be presented. However:
   - evidence of monitoring must conform to the requirements of the documentation issued as guidance accompanying HSC 2000/031, and
   - monitoring and/or analysis data produced by some software packages such as ND2000 will be acceptable for the purpose of this exercise – further guidance will be issued in due course.

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

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

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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Evidence Required</th>
<th>Verification</th>
<th>Confirmed Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Submit request for provisional approval of working arrangements to Action Team</td>
<td>Signed letter from Trust giving reasons for inability to fully monitor before re-banding Evidence of full or partial testing/monitoring of proposed arrangements</td>
<td>Letter signed by Action Team Chair or delegated authority authorising an offer of provisional banding.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Banding:</th>
<th>Provisional New Banding:</th>
<th>Implementation Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Team Signatory Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage</th>
<th>Evidence Required</th>
<th>Verification</th>
<th>Confirmed Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Monitoring of working pattern and confirmation of banding</td>
<td>Completed monitoring returns from 75% of doctors on rota over full 2 week period Summary of monitoring results</td>
<td>This signed template</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous banding:</th>
<th>Verified New Banding:</th>
<th>Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Signatory (Designation) Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rota Signatory (Junior Doctor LNC representative) Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Team Signatory (Designation) Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

### CHANGE OF BAND PROFORMA

This proforma is an important document and all signatures required to complete the re-banding process must be obtained below. It is the responsibility of the Trust to obtain and retain this information. If Trusts are found to be breaching the re-banding process, junior doctors may revert to the previous band and back pay will be required.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty(ies)</td>
<td>Working pattern</td>
</tr>
<tr>
<td>Number of doctors in working arrangement by grade</td>
<td>F1:</td>
</tr>
<tr>
<td>Current pay band</td>
<td>Proposed pay band</td>
</tr>
<tr>
<td>Proposed date of rota implementation</td>
<td></td>
</tr>
</tbody>
</table>

**Trust Signatory**  
Agreed Junior Doctor Representative (representing majority of colleagues)

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print</th>
<th>Date</th>
</tr>
</thead>
</table>

**Educational Supervisor/ Clinical Tutor:** "I can verify that this work pattern meets the standards required for educational approval."

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print</th>
<th>Date</th>
</tr>
</thead>
</table>

**Implementation/ provisional approval**

<table>
<thead>
<tr>
<th>Provisional new pay band</th>
<th>Signature</th>
<th>Print</th>
<th>Date</th>
</tr>
</thead>
</table>

**Provisional date of monitoring (1st attempt)**

<table>
<thead>
<tr>
<th>Provisional date of request for formal approval to change band</th>
</tr>
</thead>
</table>

**Provisional date of re-monitoring (2nd attempt)**

<table>
<thead>
<tr>
<th>Date of best evidence re-banding due to failure to achieve valid monitoring data on two attempts.</th>
</tr>
</thead>
</table>

**Formal Approval**

<table>
<thead>
<tr>
<th>Verified new pay band</th>
<th>Signature</th>
<th>Print</th>
<th>Date</th>
</tr>
</thead>
</table>
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Improving Doctors’ Working Lives web forum http://www.idwl.info

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