Hours and pay of doctors in training: an update

Introduction

It was widely believed that issues surrounding the working hours of doctors in training would be resolved by August 2009. This was when the final phase of the European Working Time Directive was introduced for this group of staff.

However, this continues to be important, which is testified by the number of project staff still employed within NHS trusts to oversee junior doctors' hours. Implementation may have taken place, but sustainability (carrying on) is still a problem when health care is getting busier, yet there are always restrictions on numbers of training posts.

There are two systems of hours regulation currently in place for doctors in training – the New Deal (NHS Management Executive, 1991) and the European Working Time Directive. The New Deal was agreed in 1991 but not signed till 1993, then it took several years for phased implementation. The European Working Time Directive was phased in from the early 2000s to August 2009.

Doctors can opt out of the European Working Time Directive limit of 48 hours' average actual work per week, particularly if they want to work as locums. However, doctors in training are still bound by the New Deal limit of 56 hours' actual work per week. There is no opt-out from the European Working Time Directive rest requirements, and New Deal rules on time off should not be breached either.

Contrary to popular belief, the current pay system for doctors in training (introduced in 2000) was negotiated with the European Working Time Directive hours reduction in mind (Hooke, 2007). However, the scheme is based on the New Deal, not the European Working Time Directive.

Junior doctors' hours need to be monitored regularly. This obligation is separate from the European Working Time Directive and still applies.

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Hours and pay

Working hours have been reduced over the years for all training grades, but particularly for foundation year 1 doctors. This has meant that many doctors are on basic pay only (for 40 hours a week), with no out-of-hours commitments. A 5% uplift for deanery-appointed foundation year 1 doctors on basic pay only (no banding) was introduced from April 2010.

Most trusts aim for all rota templates to be placed in band 1 or below, for hours compliance and financial reasons. However, pay banding is based on the New Deal. It is actually possible to have a rota that is in band 2 according to the New Deal (at least 48 hours' average actual work per week), but is compliant with the European Working Time Directive (fewer than 48 hours), because some rota software systems work out the two differently. The New Deal hours figure is normally calculated over the number of weeks in the rota cycle and includes prospective cover. The European Working Time Directive is calculated over 26 weeks for all rotas (EWTD Reference Group, 2009) and may not include prospective cover. This can give a lower number.

Changes are still being made to rotas. However, these are less likely to reduce the hours or banding significantly, as most major efforts were made in the approach to August 2009. Despite this, robust processes should still be followed and all parties consulted before a rota template is altered.

Trusts can employ staff grades, associate specialists and specialty doctors to boost rotas and ensure hours compliance. However, these grades are inappropriate at foundation year 2 and specialty registrar 1–2 level. It has been traditional to create 'trust doctor' posts, which are not recognized by the postgraduate deaneries. This is not ideal, as there are issues for:

- Training
- Hours limits, controls and monitoring
- Appraisal and revalidation
- Terms, conditions and contracts.

Since the final implementation of the European Working Time Directive, most existing working patterns are now either full shifts or non-resident on-call rotas. On a full shift or normal working day, junior doctors are entitled to a (paid) 30-minute break every 4 hours. This is a New Deal rule rather than an European Working Time Directive one.

Doctors may have noticed that nurses are very protective over their breaks – this is because non-medical staff breaks are unpaid. Perhaps doctors need to become as assertive and active as nurses at ensuring they take their breaks. Doctors can try to tie their breaks in with patients' protected meal-times. Even doctors on basic pay can potentially claim band 3 (a New Deal penalty payment) for missing breaks, but they must work with their employers to resolve this. Ideally, the break should be bleep-free and could be claimed not to be achieved if the doctor feels compelled to answer the bleep during it.

Some people have difficulty in identifying what is resident and non-resident (Hooke, 2007). The location is, to some extent, irrelevant. For instance, a doctor can be staying in on-site accommodation but still classed as non-resident. On the other hand, the trust may put doctors in a hotel just outside the hospital boundary, but require them to return immediately if called. This means they are resident. The important criterion is the amount of freedom to carry out other activities. The term 'curry test' has been coined to illustrate the difference. If a doctor is at liberty to go to a local takeaway restaurant and collect his/her curry, he/she is non-resident. If the curry has to be delivered, the doctor is resident. This is a similar concept to the so-called 'Eurostar test', where a London-based consultant who does not have to return urgently to the hospital could, in theory, be on call from Paris.

Even though relatively few doctors nowadays are on call in the traditional sense of resting while waiting to be called, the term is still widely used, even on full shifts. Another description is 'on take', where the doctor is called for acute admissions. However, this does not necessarily cover emergency calls for existing inpatients.

Problems can arise when junior doctors want to leave on time at the end of a normal working day. Most posts will have a nominated on-call junior doctor to whom handover is assumed. However, most junior doctors will be of the opinion that some jobs are not appropriate to hand over to the on-call doctor (often on the basis that they 'should' have been sorted out during the day) and would be better done by them before leaving. This may be for reasons of continuity of care or knowledge or 'ownership' of the patient, or that the task is, from experience, one that the on-call doctor may regard as low priority given the other calls on his/her time. Hence, tasks may be done later or deferred to the following day.

In such cases, it is not uncommon for junior doctors to 'choose' not to hand over to an on-call individual, and to end up leaving the hospital late. Hence, there may be an ideological clash between what management think the doctor should be doing, and what the doctor thinks is the right action on a professional basis. Leaving late for these reasons should be captured on monitoring, and could be argued as the doctor not using the available resources appropriately or as reflecting a need for additional staff on that firm during the day or a restructuring of the firm's timetable.

Monitoring

Monitoring of junior doctors' hours is still a contractual obligation on both sides. This is in line with the New Deal rather than the European Working Time Directive. It is usually overseen by human resources or the relevant department or specialty group, depending on how it works in the individual trust.

Monitoring tends to be electronic nowadays, although the anachronistic term 'diary cards' is still used. Doctors are generally sent a web address along with unique usernames and passwords. Once they have logged in, they can record their hours, breaks, rest, leave and comments for the trust coordinator to see.

For a monitoring exercise to be valid, a 75% return needs to be achieved for both the number of doctors and the number of duties. This allows for leave and gives some leeway for doctors not completing it, although it is not ideal to have non-compliance.

Performance management for trusts

Trusts used to have to submit 'ministerial returns' twice a year to the Department of Health, reporting hours compliance. This necessity was abolished for England in 2010. Some regions collect data regularly for themselves, such as monthly European Working Time Directive returns or Hospital at Night benchmarking.

Rota rebanding always used to be overseen at regional level, via a body such as a task force (Hooke, 2000), action team and/or part of the postgraduate deanery. However, in some regions, this has fallen into abeyance and ultimate rebanding authority lies within the trust itself, with no external scrutiny.

General

Doctors should not be afraid to ask human resources or their departmental coordinators to show them the rota software used for the template and/or monitoring.

Doctors should keep their own copies of everything – this helps if trust staff change and/or there is a dispute. It should not be the case that when staff leave, historical memory is lost, but this does happen in reality. Electronic diary records should still be available on line, but it may be advisable for doctors to print them off in case they can no longer use their log-in credentials and/or the trust cancels its contract with the provider.

Conclusions

Junior doctors' hours can still raise significant issues. Although the final phase of the European Working Time Directive has been implemented, sustaining the hours limits can be problematic. Hours monitoring is still a contractual obligation on both sides. **BJHM**

KEY POINTS

- Junior doctors' hours issues have not gone away.
- Both the New Deal and European Working Time Directive hours and rest limits still apply and should be adhered to.
- Pay banding is based on the New Deal, not the European Working Time Directive.
- Monitoring is still a contractual obligation on both sides.
- Oversight of trusts' performance on hours is less robust than previously.
- Doctors should not be afraid to ask if they are unsure.

Conflict of interest: Dr R Hooke has worked in both management and medicine. Her views are her own and do not necessarily reflect those of her employer or any other organization that she is associated with.

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Further reading

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