RESPONSIBLE DIRECTOR:	REPORT FOR:		IMPACT ON BUSINESS:		
Nick Lyons Medical Director	Decision		High	Med	Low
	Discussion				
	Information	X			
LEAD MANAGER:	**REPORT TYPE:**		**BAF REFERENCES & RAG:**		
Chris Lloyd Guardian of Safe Working	Strategic				
	Operational	X			
	Governance		**RELATED WORK: (PREVIOUS PAPERS TO COMMITTEE)**		
PEER ASSIST:	**PEER REVIEW:**				

Report Title: QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING Q3 -2017-18

Executive summary

The 2016 junior doctor contracted has been introduced at the Queen Elizabeth Hospital King's Lynn.

In August 2017 most doctors in training will move to the new, 2016 contract. The PGMEC team have ensured Rota compliance and worked with teams to deliver appropriate cover is provided where there are vacancies.

The detail in this report is limited to those trainee groups currently affected by the 2016 contract.

The 2016 contract requires doctors in training to report exceptions to their contracted work hours. The exceptions are monitored using the Allocate software solution which provides electronic reporting and resolution records which can be monitored by the PGMEC, The Guardian of Safe Working and the Director of medical education.

Introduction

The purpose of this report is to provide an update to the board on the impact of the 2016 junior doctor contract. Its key aim is to provide assurance of the mechanisms in place for safe working practices and compliance with the 2016 terms and conditions of service.

This Q3 report to the board, once again relates to all trainees who commenced a new post from August 2017. There are a small number of senior trainees who remain on the 'New Deal' Contract and they will continue to be offered bi – annual diary exercises to monitor hours. However, PGMEC area encouraging these trainees to complete exception reports in real time as per 2016 contract to allow problems to be addressed promptly.

Prior to the August Changeover PGMEC and HR have reviewed and assessed all rotas affected to ensure compliance with the 2016 Terms and conditions of service for doctors in training. There have been open meetings for staff to raise the overall awareness of the contract. The Guardian of safe working spoke to new F1 doctors during the PFPP week and the JDF met in September to provide open forum for discussion of issues related to the new contract. A further JDF meeting was held in December though was poorly attended by junior staff. The Guardian has raised this issues with the Junior doctors representatives to once again raise the profile and importance of the exception reporting process.

Clinical and Educational supervisors are responsible for the management of exceptions according to the timeline set down in the T&C of work.

Most Medical Rotas are now on e-roster. This system allows rota planners and doctors to identify if there are any breaches of T&C for doctors working at QEH. Easy access to rotas off-site and via mobile device has been well received by medical staff.

High level data

At present the only doctors working the 2016 contract are the foundation year 1 trainees. As such the information within this report is restricted to data relevant to that group.

Number of doctors / dentists in training (total):	120 (plus 26 vacancies)
Number of doctors / dentists in training on 2016 TCS (total):	115
Amount of time available in job plan for guardian to do the role:	1 PA (4 hours per week)
Admin support provided to the guardian (if any):	0.1 WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

a) Exception reports (with regard to working hours)

Since the introduction of the contract junior doctors have been encouraged to report exceptions. This trust, like many others acknowledges that whilst the T&C of service request the exception reports be managed by the educational supervisor this is not always appropriate as the supervisor may not be in the same specialty as the trainee at the time of the exception. In order to address this PGEMC are contacting clinical supervisors who have direct access to the trainee and knowledge of rota/ service issues.
At QEH the clinical supervisor is therefore generally the person delegated to meet with the trainee and undertake the initial resolution. Educational supervisors are informed of exceptions particularly if these relate to training issues.

The data below shows the exception reported as at 31 December 2017 – it should be noted that reports can list more than one exception of the same category hence there may be more exceptions listed than reports generated.

Although all new trainees are now on the 2016 contract there have been no exception reported by any grade of trainee other than foundation year 1 in Q1 and Q2 In Q3 there were two exceptions reported by an F2 in paediatrics and one from an F2 level doctor in General surgery.

This is surprising considering there have been issues identified in hours monitoring exercises in some specialties for a number of years (e.g. orthopaedic), it remains unclear whether rota issues have been fully resolved or whether juniors are simply not engaging with the new contract requirements.. We continue to encourage reporting on the basis that we are trying to ensure safe working practice and patient safety and that the reports are not just about money.

Exception reports by department				
Specialty	**No. exception reports carried over from last report**	**No. of new exceptions raised**	**No. of new exceptions closed**	**No. exceptions outstanding (total)**
Acute Medicine	0	0	0	0
Oncology & Palliative care	0	0	0	0
General Surgery/ Orthopaedic.	0	6	4	2
Paediatrics	0	2 (1 report)	0	2
Total	0	7	0	4

Acute Medicine – There have been no exceptions reported in Q3

Oncology & Palliative care- There have been no new exceptions reported in Q3

General surgery & Orthopaedics- There have been 6 exceptions reported in Surgery in Q3 There were 5 new exceptions reported since April 1 2017. Four out of the six exceptions were been reported by one trainee. This is the same trainee who accounted for the majority of exceptions reported within medicine from August to December. The trainee moved to genereal surgery in December. 4 xceptions have been resolved at first meeting with either overtime payment or time off in lieu.
There are currently 2 unresolved exceptions in general surgery recorded in the reporting system. However, these exceptions were only submitted in after Jan 1st so at the time of writing this report the initial meetings had not taken place but were not overdue. Current trends suggest that these will be addressed within the normal time scales as that has been the case in Q2 as trainers are more engaged.

For the trainees who submitted the exception reports and have now left the trust, I am aware that on trainee contact the trust to claim for additional time worked – however due to the failure to meet with his supervisor or provide any evidence to suggest he had tried to meet with his supervisor in a timely way, the request was declined.
Disappointingly these exceptions remain on the system as unresolved but had been pending for 100+ days.
Trainees were made fully aware that the trust expects them to follow the timeline within the T&C of working but all must be resolved within 30 days.
I am certain there is a lack of confidence in the process by trainees and lack of engagement by Supervisors in some areas. On discussion with some trainees there is a feeling that they are professionals and if they finish late on the odd occasion that 'that is the way things go' and the majority do not feel there is a problem with this. I have tried to reiterate with

trainees that although that may be the case they should reported the fact they are working beyond their rostered hours as unless we know we cannot effect change. Similarly an exception report does not mean that they are asking for more money and 'no further action' is a reasonable outcome.

Paediatrics: There are 2 exceptions (1 report) submitted within paediatrics. These are reported as being a result of delays at handover during a period with high volume of work to be completed. This exception has not been resolved yet though was only received on 2ndJan so at the time of writing this report is currently within accepted timeline and I am aware that the clinical supervisor is investigating the issues around these exceptions so anticipate prompt resolution.

Cumulative Data from December 2016

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	48	5	51	2
F2	0	3	1	2
CT1-2 / ST1-2	N/A	N/A	N/A	N/A
Total	48	8	52	2

Quarter 3 data

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
2016 F1 MAU & Ward w Nt	0	0	0	0
Oncology and Palliative Care F1 (WR)	0	0	0	0
Gen Surgery F1 17wks 2016 (13)	0	6	4	2
Gen Surgery F2 18wks 2016 (11)	0	1	1	0
Paediatrics F2/STI/GPST	0	2	0	0
Total	0	8	5	2

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	3	0	2
F2	0	1	0	2
Total	1	4	0	4

COST of Exception reports.

In Q 3 Trainees have been more proactive and completed the extra duty claim forms required to complete the remuneration process where an exception has led to additional payment.

Whilst there are still 3 reports still to be completed the following is information relating to the cost of additional hours worked by junior medical staff in Q3.

Cost by department		
Department	Hours additional pay	Value of additional hours
General Surgery	6	£74.20
Total	6	£74.20

Total cost at Q3		
Balance at end of last quarter	Unclaimed additional hours payments	Additional hours claimed in Q3
Information N/A	£29.54	£74.20

At present there are 4 exceptions reported that are unresolved at the time of writing this report which may be aware additional payment. In addition one trainee has not completed the duty claim from to ensure remuneration.

b) Work schedule reviews

Exception reports identified in the Q1 report documented the need for a work schedule review in surgery. I am not clear on what changes were made to address the issues identified. However there have been no exceptions reported in Q2 or Q3.
Minor adjustments to medical rotas have been made to address some of the concerns previously highlighted.

At the time of writing this report there are no work schedule review pending (those previously requested were from trainees who no longer work in the trust).

Cumulative data from 2016

Work schedule reviews by grade	
F1	3

Work schedule reviews by department	
Acute medicine	1
General surgery	1
Oncology & Palliative	1

c) Locum bookings

The information aims to represent the locum requirements following the introduction of the 2016 contract in December 2016

i) Bank

I have No information on Bank usage to cover vacancies or rota shortfalls from specialties. I had previously requested this information from the divisional rota coordinators prior to preparing this report. However, no information has been provided. This lack of response had been escalated to divisional managers in Medicine and Surgery. I have not continued to chase this issue at present. As a result, it is not clear that departments/ divisions are fully informed of what their medical bank use and spend is.

ii) Agency

Again additional information is required to understand the reason for the agency bookings i.e sickness/ vacant post etc. and it is intended to include this in the next report.
I have requested this information from divisions but have not been provided with any data for submission to the board. This has been escalated to the divisional managers.

d) Additional in house locum work carried out by QEH trainees

At present the data related to locum bank work undertaken by doctors is collected and collated by the divisions. No information has been provided for this report. The Local bank usage is increasingly significant as more trainees move to the 2016 contract. This is because ALL work counts towards safe working hours. It is clear that many doctors want to do additional work (for multiple reasons). It is essential that doctors take responsibility to ensure they are safe to work and rota coordinators consider the working patterns of r juniors when they are working across specialties.
Doing additional hours as a locum may not be allowable unless the trainee opts out of EWTD but more importantly any additional work undertaken must not breach 2016 contract rules.

e) Vacancies

There are currently 26 vacancies in training posts these are currently filled with temporary staff- agency /bank to ensure safe cover for the wards.

f) Fines

As yet there have been no Fines imposed on any departments for breaches of terms and conditions of service.
The departments are being encouraged to resolve exceptions internally and the preferred resolution for additional hours worked is Time off in lieu. Where this is not possible payment for additional hours may be needed to resolve the exception.
At present the divisions are managing overpayment internally and the process to track payments and resulting costs is still in development as a result some of the data in the report may be incomplete.
PGMEC are requesting that overtime payment forms are submitted with clear reasons which identify payments resulting from exception reports to ensure overtime payments are paid when appropriate and monitor how much is being awarded.

Qualitative information

There continues to be uncertainty about the exception reporting process. Junior doctors are unsure whether senior staff will take things seriously or whether reporting exceptions will give a negative impression to consultants. Recent months have shown as slow rise in the frequency of reporting and we are also seeing exception reports from grades other than F1 however I feel that many trainees are not confident exceptions will lead to change so are do not report.

In addition, it is noted that when asked 'what actions did the doctor take to rectify the situation' in the breach report very little is done. No trainee has recorded that they have spoken to the duty consultant about the exception being reported at the time. At best they may have spoken to the duty registrar. I do not feel this is adequate escalation if the issues are to be addressed in real-time. This has been fed back to junior doctors via the junior doctor forum.

There have been no reports that have identified an 'immediate safety concern' in Q2 It has been discussed at the JDF the importance of contacting the duty consultant at the time should there be an immediate safety concern. It has been identified that this may not be possible during the night shift so I have requested PGMC work with the site team to identify a suitable escalation process for trainees at times when the duty consultant is not on site.

Of importance the exceptions reported in Q3 have been resolved more promptly than in the previous period which is a positive step and shows better engagement from supervisors. However the low numbers of reports cannot be translated to mean full engagement from supervisors.

The Allocate software system can be difficult to access on trust computers as it is best viewed on Google chrome or Firefox browsers which run very slowly on the trust internet.

Issues arising

The trust has 10 unresolved exceptions from prior to the August changeover of staff. The doctors reporting these exceptions have now left the trust or have made no effort to demonstrate attempts at resolving the matters arising. The exceptions are all at least 100 days overdue now. I do not intend to pursue these further as reporting patterns since august suggest problems may have been addressed.

Junior doctors can only report to one named educational supervisor on the electronic system but for practical purposes there clinical supervisor is generally better placed to address the issues being raised. This causes delays in notifications reaching the supervisor – up to 4 days over long bank holiday weekends, which when faced with a 7 day completion time can be challenging to complete due to Rota and clinical schedules. However the time taken to resolve exception reports has been much quicker in Q3 than previously which is a very positive outcome. The prompt resolution of exceptions in Q3 does show better engagement in surgical specialties, Although it is noted that many were managed by physician supervisors rather than the general surgical supervisors.

Engagement of the clinical supervisors to undertake this additional workload promptly is an issue that has been raised with the Medical director and the DME as the short time schedule allowed within the T&C to resolve exceptions increases the pressure on the supervisor.

The proposed uplift of time allocation for educational supervisors to 0.25Pa per trainee is an important step to affording supervisors the time to manage this additional work. This was expected to be in place from April 2017 but has not been delivered. This issue has also been raised in the recent foundation school and GMC monitoring visit to the trust.

There remains a lack of understanding from the trainee in terms of escalation of their concerns as no reports so far show attempts to contact the duty consultant for support when there are exceptions being reported.

At present the trust cannot reliably determine whether a fine is warranted as there is no way to monitor the full work schedule other than by manual review of the previous Rota. The transition of rotas on to medic-online system will support the management and monitoring of this.

The PGMEC staff continue to provide admin support to the Guardian and are available to address queries form supervisors and trainees when needed. The impact of the new contract in areas where there are Rota gaps is significant as the current practice of trainees doing additional locum shifts is a more limited option than with the old contract as even when the opt out of EWTD, any work they undertake will count toward their total safe working hours. So, if a trainee opts to do additional evening and weekend locums for financial reasons or to help out the department at short notice. Whilst they themselves may feel this is acceptable the cumulative total of the hours they work could result in a fine to the department for allowing a doctor to work more than 48hours per week on average (56 if opting out of EWTD).

Unless the trust identifies a robust mechanism to manage Rota gaps we may find that there are unfilled slots as doctors may not be allowed to work despite being willing to do so because of the potential for a guardian fine to be levied. This will be detrimental to patient care, safety and experience.

Actions taken to resolve issues

1: An ongoing task is to fully embed the process of exception reporting and management. This will be via the Junior Doctor Forum, HMSC, Medical Education Forum, Trust induction.

2: PGMEC are requesting that departments clearly identify additional duty hour's payments which result following an exception report. It is essential there is a clear process to follow which will allow monitoring of the additional hours worked and the cost implications.

Summary

Since the last report to the board we have seen the introduction of the 2016 contract to all grades of staff in training. The excepted surge in exception reports has not materialized; there continues to be a relatively low number of exceptions reported. To date the most of the reports have arisen within the surgical directorate. Historically, surgery has not been effective in resolving exception concerns. Overall, there has been good compliance with the resolution timeline stipulated within the T&C of work though in Q3 and this has been seen to improve.

No exceptions have been in relation to training issues, No new exceptions been reported that have presented an immediate safety concern (ISC).

The reports in Q2 have been the result of additional hours worked, the maximum extra time period worked in Q3 was 2.5hrs.

Further work is needed to increase the awareness across the trust about exception reporting and the reporting process. This is still a relatively new process to all those involved and the overall embedding of the process is being monitored. Whilst payment for additional hours worked may be perceived as an easy option in terms of resolution the Guardian of safe working and PGMEC are recommending that the preferred resolution for additional time worked is time of in lieu (TOIL). However, it is acknowledged that allowing TOIL requires clear communication with Rota coordinators to ensure this action does not trigger a further exception.

Questions for consideration

1: In Q 1 2017-18 No reported exceptions have been resolved. In Q2, only 6 reports from F1 trainees and none from other grades of trainee. In Q3 there were 8 reports. Why is this number so low?

2: Despite requesting data on bank and agency usage from divisional Rota coordinators the guardian has not been provided any information about this so cannot provide assurance to

the board that safe working practices are being followed and that divisions are fully aware of the Rota gaps and the reasons behind them nor the total spend.

3: With so many trainees moving to the 2016 contract. The divisions must provide assurance that those doctors on New deal or trust contracts are not required to work additional hours as their Rota rules breach will not generate exception reports.

4: There is no clear guidance on Rota rules for specialties where doctors are off-site on call. e.g. Orthopaedic.

At present the limited data available to me from divisions, the low number of exception reports submitted when there are 26 trainee vacancies in the trust at present suggest a continued lack of engagement in the reporting process by trainees. Where exception reports have been submitted there appears to have been good engagement from supervisors to ensure prompt resolution.

I have stated to trainees that anecdotal concerns about issues in specialties are not a method of effecting change- they should report concerns promptly and escalate directly to me if they are not getting support from seniors.

Nationally guardian forums have gone very quiet, my concern is that this important support mechanism is being seen as simply paying lip service to doctors in training and the process of exception reporting will not actually change anything and could be detrimental to an individual.