

# **BOARD LIAISON GROUP**

## **ANNUAL REPORT**

**2009 -2010**

## 1. Introduction

This is the first annual report since the Implementation Support Group (ISG) was formally stood down as the responsibility for overseeing the implementation of the New Deal contract and the European Working Time Regulations (EWTR) was passed to the Board Liaison Group (BLG) of the HSC Board in April 2009. The switch from ISG to BLG reflected several changes in the workforce landscape in relation to Doctors and Dentists in Training. To understand these changes, it is worth briefly revisiting why ISG came into existence in Northern Ireland in 2001, and what changes have occurred over the following 8 years.

ISG was formed in 2001 with representation from the Department of Health, Hospital Trusts and the British Medical Association to oversee the implementation of the New Deal for doctors. The New Deal was a contractual arrangement that came into existence to better correlate antisocial and longer working hours with financial remuneration for doctors in training. By design it sought to discourage average weekly working hours beyond 56 hours per week as well as inadequate rest provision through the punitive additional expense incurred by Hospital Trusts that operated working patterns with long and antisocial hours and insufficient rest periods.

Working practices for junior doctors in 2001 were frequently above 56 hours on average, and ISG was formed as the regional advisory body designed to homogenise the approach to reducing junior doctors hours of work in a consistent and fair manner. ISG's largest and most influential role was to appropriately allocate funds to Trust-driven projects that would enable these hours reductions to take place. Examples chiefly included funding additional medical staff (both training grade and non-consultant grade permanent staff), promoting and funding the use of non-medical staff to perform duties that were traditionally carried out by junior doctors as well as supporting, both financially and strategically, initiatives such as the Hospital at Night model. With an annual budget of £9 million, the subsequent 8 years can be regarded as productive in moving the vast majority of junior doctor working practices across the province to below an average of 56 hours per week.

Looming on the horizon when ISG was established in 2001 was the much debated European Working Time Directive (EWTD). This European Union (EU) Health and Safety Legislation was more ambitious than the New Deal constraints and imposed a maximum average working week of 48 hours for all employees across the EU. Junior doctors were among the last group of employees to be covered by this legislation, which came into effect for them in August 2009. It follows therefore that any Hospital Trust operating working practices requiring its employees to work beyond an average 48 hours per week is, since August 2009,

operating outside the regulations. This carries significant risks that will be discussed later in this report.

ISG, being mindful of the looming deadline for full EWTD implementation, began switching its attention circa 2005 towards building on the work being done in relation to New Deal to meet the conditions for 48 hour EWTD compliant working practices. Hence a gradual province-wide progression from working practices in excess of 56 average hours towards those with average hours less than 48 was embarked upon.

Between 2001 and 2009, Hospital Trusts in partnership with ISG developed working patterns with large numbers of juniors on EWTD and New Deal compliant working patterns, even before the implementation deadline of August 2009. These included many Anaesthetics, General Medical, Psychiatry, Laboratory Medicine and Accident and Emergency rotas. However, as large groups of specialties and sites moved towards EWTD compliance, it became increasingly evident that the remaining specialties and sites that were non-compliant posed considerable challenges if service demands and training needs were to be continued to be met within new hours restrictions.

These rotas included most General Surgery rotas, specialist surgery rotas such as Urology, Paediatric Surgery, Ear Nose and Throat Surgery, Ophthalmology, Cardiothoracic Surgery, Neurosurgery, Obstetrics and Gynaecology but also non-surgical specialties such as Paediatrics. Some of these specialties had endemic problems across the province, others were site specific and those that operated as busy Tertiary referral specialties had additional obstacles in achieving non-compliance. Often, additional medical staff for recruitment to these specialties were not available or affordable and the funding-driven model of ISG was in need of renewal.

BLG was formed as ISG's successor, to address several needs:

- The recently formed HSC Board had taken over the responsibility of junior doctors hours of work from the Department of Health, hence it was logical that the new advisory and implementation group should be based in the HSC Board.
- There was an acknowledgement that achieving compliant, safe and acceptable working practices in the remaining non-compliant specialties and sites would require less emphasis on money and more focus on clinically-driven leadership and reform together with newer ways of working.
- The financial climate and subsequent aspirations for a leaner and more efficient health service management

A centrally based dispersion of funds was succeeded by a more facilitative approach uniting all the main stakeholders involved in improving junior doctors hours of work. As a result the Board Liaison Group (BLG) was formed in April 2009, with its Chair Dr Graeme McDonald and representation from the Department of Health, the Northern Ireland Deanery, Public Health, the Nursing Profession, the British Medical Association, HSC Trust Medical Directors and HR Directors together with Performance Management representation from the HSC Board. The wider BLG group meets every 3 months, with the smaller subgroup meeting on a monthly basis. Minutes for these meetings will be made accessible on the HSC Board intranet.

The Board Liaison Group's principle aim is to improve junior doctors working lives in its widest sense (see Appendix 1 for BLG Terms of Reference). Inevitably, regional sustainable adherence to the European Working Time Regulations has become a major focus for the work of the BLG.

## **2. Background**

### **New Deal Contract**

The New Deal contract came about in 1991 and set limitations to the hours of work to promote safer shift patterns. It is a contractual deal between the employer (the Department of Health and Trusts) and employees (through the doctors union the British Medical Association) that links average hours of work and work intensity with remuneration through the Banding system.

Band 1 working practices: these operate within 48 average hours per week and depending on their intensity are graded Band 1A, 1B or 1C. Band 1A attracts 50% of the junior doctors base salary, 1B 40% and 1C 20%. (It is helpful that New Deal Band 1 practices are typically EWTD compliant since their maximum average hours per week are 48. However, because New Deal and EWTD rest stipulations have subtle variations, it is possible – though rare – that a Band 1A rota may not be EWTD compliant, and a EWTD compliant rota may not be New Deal Band 1 complaint.)

Band 2 working practices : these operate between 48 and 56 average hours per week. 2A attracts an 80% supplement on a junior doctors base salary, 2B 50% supplement with the A and B grades again determined by workload intensity e.g. number of weekends and antisocial hours.

Band 3 working practices – these operate outside of the New Deal restrictions, by either requiring an average of more than 56 hours per week, failing to meet New Deal rest requirements, or both.

Working practices fulfilling Band 3 criteria attract a 100% supplement of the junior doctor salary. This cost pressure to Trusts was engineered as a disincentive to promoting or continuing Band 3 practices, and was hence aimed at limiting hours of work to fewer than 56 hours, or less.

## European Working Time Directive (EWTD) or European Working Time Regulations (EWTR)

Adherence to the EWTR is a legal requirement since August 2009, and in many ways trumps the New Deal as it is not a contractual agreement but Health and Safety legislation enshrined in European Law. Trusts as employers face significant risks operating rotas that require working outside these regulations, by exposing themselves to legal challenges from staff, patients and regulatory authorities. At the time of writing, there have been no legal challenges from any of these groups, but the threat of one remains real and arguably mounting as awareness of the legislation becomes more widespread and compliant working practices elsewhere become the norm.

Many cohorts of junior doctors in 2001 were working an average 56 hours per week. However, since 2009, legislation not only requires attention to rest requirements but a reduction of approximately 8 hours per week for every junior doctor in the province to enable average hours of less than 48 per week. With rising demand on our secondary care services, it is easy to see how the effective cut in junior medical workforce availability crudely estimated at 15% (56hours to 48hours) presents a logistical and creative challenge if service demands and training needs are to be met in the EWTR era.

Coupled to this considerable challenge were the recent changes to immigration rules and a tightening of the restrictions on overseas doctors already working in the UK. The net result of these changes has been a substantial erosion of the overseas doctor pool and its contribution to the functioning of our acute hospitals. This has compounded the pressures on the existing junior doctor pool at an inopportune time.

### **3. BLG Programme of Work August 2009 – August 2010**

#### *A. Rebanding Committee*

The frequency of these meeting was increased after August 2009, with meetings every 4-6 weeks to help HSC Trusts with decision making and to make the process more robust and in line with national Terms and Conditions.

The purpose of these meetings was to accurately allocate a Banding status to working practices for junior doctors in line with the New Deal contract – typically varying between Band 1C (20% multiplier, little or no out-of hours work and less than 48 hours average working work) to Band 3 (100% multiplier, failure to achieve rest requirements and / or working in excess of 56 average hours per week).

Under nationally agreed guidelines between the BMA and the NHS, the Rebanding Committee is the body responsible for ensuring the conditions for provisional and full rebanding of junior doctor working patterns is accurate and accountable. Provisional rebanding status is awarded when Trusts propose new working patterns - on paper - that are either Band 2 or, more usually, Band 1 compliant. There must be a satisfactory rota template, educational approval for the change in working practice, Trust and junior doctor sign-off that the rota could work in principle. If these conditions are met, provisional Banding status is awarded on the condition that the Trust monitors the junior doctor working practices and returns these monitoring results to the Rebanding Committee within 9 weeks of the provisional status having been granted. If monitoring results support the Banding status proposed, the rota is fully rebanded until such time that working practices change or routine annual monitoring of working hours identifies a change in working conditions.

Between August and December 2009, a large number of both provisional and full rebanding applications were received from most HSC Trusts and these were processed according to the rebanding protocol. At least half of applications from across the province have had to subsequently have their provisional banding status revoked either due to insufficient monitoring data or evidence from monitoring exercises that the current actual working patterns exceeded those proposed in theory. Appendix 2 itemises the rotas across the province that were fully rebanded by the rebanding committee following satisfactory hours monitoring results.

### *B. Regional Approach to planning for the EWTR era*

Both between Trusts, and across the region, there has been much speculation about service reconfiguration, especially as the Public Sector purse is being squeezed for efficiency findings. Often equated to hospital site closures or closures of individual units, well designed service reconfiguration is a key strategy to establishing a hospital network across the province that is adequately staffed, accessible and has its staff members operating within the health and safety hours legislation. A major reason for this is that the pool of junior doctors is currently being spread too thinly across too many acute sites.

At present, there are four main acute hospital types in Northern Ireland

- I. Teaching Hospital – the two in this category are the Belfast City Hospital and the Royal Victoria Hospital. By their nature they are large hospitals, with most regional specialties and tertiary referral centres on-site.
- II. Large District General Hospital – this includes Craigavon Area Hospital, Antrim Area Hospital, the Ulster Hospital and Altnagelvin Area Hospital. These large acute centres are usually extremely busy, and offer the full range of clinical services apart from tertiary referral units (with the exception of the Ulster hospital which has the Regional Plastic Surgery and Maxillofacial unit on site).
- III. Small District General Hospital – the Causeway hospital in Coleraine, Erne Hospital in Enniskillen and Daisy Hill Hospital in Newry are all good examples of smaller, yet often very busy, acute units with 24 hr Accident and Emergency units with a range of general medical, cardiology, general surgery and higher dependency beds on-site.
- IV. ‘Partial acute’ hospital sites – Whiteabbey hospital in Newtownabbey, Lagan Valley Hospital in Lisburn, Mid-Ulster hospital in Magherafelt and Downe Hospital in Downpatrick all offer some limited acute services, though may not have full surgical or high dependency provision on-site.

The triple pressures of reduced average hours and stricter rest stipulations, fewer overseas doctors able to work here due to changes in immigration rules and a contraction of training numbers in certain specialties have made the previous arrangements unsustainable for the future. Those acute sites potentially most at risk of losing some of their trainee doctor allocations are the ‘partial acute’ ones referred to above. These sites may have to move towards other models of staffing with a greater emphasis on senior or non-consultant grade staff providing a greater proportion of the service delivery.

Furthermore, at present there are many examples across the province, particularly in Belfast, of units geographically close to each other seeking to provide the same or similar services with borderline understaffed units. Elsewhere, some geographically more isolated units are chronically understaffed. A renewed regional approach is now needed to resolve the current set-up where we have, for example 8 understaffed units struggling to provide a timely and effective service instead of 6 units that are well equipped to meet the needs and expectations of patients and their families. Well designed reconfiguration should entail utilising the resources of many units – both human and financial – and creating fewer but better staffed, better equipped and sufficiently accessible units which can meet the training needs

of juniors, the service needs of patients and the regulatory needs of the legislation.

Members of the Board Liaison Group have been active and consistent in raising these issues at the HSC Board, Department of Health and political level, given any potential solutions require leadership and political courage if they are going to be implemented in a universally fair and effective manner.

### *C. The Hospital at Night initiative*

The Hospital at Night (HaN) initiative is a key component of the strategy to provide safe and effective services within the constraints of the EWTR. Its ethos is centred on dichotomising those medical staff into those who need to be resident (on-site) out-of-hours and those who can provide specialist support and input on a non-resident (off-site) on-call basis. The resident medical staff, typically different grades of trainee physicians, surgeons and cardiologists, subsequently form the core Hospital at Night team together with support from Nurse Coordinators and non-medical assistants. The HaNs principle purpose is to provide on-site urgent and emergency medical cover, with prompt enlisting of specialist support from home as required. By maximising the use of available on-site resources by encouraging a generic team approach, more junior doctor working patterns can move towards hours compliance through cross-cover arrangements, the collapsing of multiple tiers of cover and by supporting those rotas that are non-resident on-call. The components and main functions of the HaN initiative are well described in the literature and NHS Modernisation webpages and therefore will not be discussed in detail here.

ISG both financially and strategically had been promoting the HaN approach as one of the strategies that is a safe and effective response to the challenges of the EWTR. BLG has continued this approach, and when BLG came into existence in April 2009, the majority of large and teaching hospitals either had a functioning HaN model or had aspirations to put one in place. However, a number of sites with HaN models had not fully embraced the multispecialty approach of the original HaN concept, and were in danger of merely creating a more expensive and slightly better provisioned junior physician out-of-hours service. Other, smaller sites, such as Causeway hospital and the Erne hospital did not have a functioning HaN model, coupled with a perception that this solution only reaped benefits on large, well staffed sites.

Elsewhere in the region, the Southern Trust took the HaN model and rapidly developed it further in an innovative way. 5 miles from their Craigavon acute hospital site lies the large elderly care and rehabilitative unit at Lurgan hospital. This non-acute hospital was traditionally staffed with a cohort of four junior

doctors operating a non-ETWR compliant out-of hours rota, with audits of activity indicating the workload after 10pm was infrequent and potentially manageable by a trained Nurse Practitioner with ready access to medical advice and support from the Craigavon site if required. A subsequent pilot project involved the four junior doctors being integrated into the general medical rota based at Craigavon Area Hospital to improve the working conditions and hours of these doctors within ETWR constraints. Lurgan hospital in return retained on-site medical cover until 10pm every day, with a Nurse Coordinator providing initial assessment and management to any calls for assistance from the ward nurses after 10pm. To date, this model is functioning well and is making a significantly better use of a limited junior medical workforce.

Since a variety of HaN models were in operation throughout the province, with several acute sites (including the large Ulster hospital on the outskirts of Belfast) not having an HaN model in operation, BLG and the Southern Trust co-hosted the first Regional Hospital at Night workshop in March 2010. The purpose was to bring together the local knowledge and experience of the different sites to facilitate improvements and share best practice. It also served a useful role in providing insights and advice to those sites considering implementation. Following this workshop, there has been ongoing input between members of BLG and the Causeway site and Ulster hospital site in particular as they move towards rolling out the HaN model.

#### *D. Accommodation and Catering*

The health service Circular 'HSC 2000/036: Living and Working Conditions for Hospital Doctors in Training' in 2000 set the standards for hospital trusts in terms of on-call room provision and access to rest areas and food and drink whilst working out-of-hours, although few hospital sites satisfied the criteria laid out as minimum standards. Furthermore, as 24 hour working patterns based on site have disappeared in line with the working time regulations, there has been an erosion of existing on-call room provision. In particular, under the HaN model a smaller out-of-hours team provides generic emergency medical services whilst specialist support is enlisted as required. In practice this results in increased work intensity out-of-hours for resident medical staff, whilst covering a broader range of clinical sites and being less defined by traditional team structures.

In response to this, efforts are in progress to identify some BLG funds and geographical areas in each acute site that can provide access to a dedicated HaN rest room with limited catering facilities including a microwave, fridge, toaster and tea and coffee making facilities. Such a room would not only improve working lives but it also supports the development of a team ethos given it would be accessed by both, medical specialty doctors, nurse coordinators and practitioner assistants.

In April 2010, a small survey was carried out with junior medical staff across the region to identify current provision out-of-hours and examples of good practice within the province. This information will be triangulated with some site visits planned for the Autumn of 2010 to progress this work further. Furthermore, future site-specific HaN evaluations (next due in October 2010) have a section about accommodation and catering provision as part of the overall evaluation.

### *E. Site visits*

Since August 2009, a large number of site visits have been undertaken to most acute hospital sites in the province by members of the BLG core group (Chair, Medical Project Officer and HR representative). There have been meetings with Medical Director offices and HR personnel, but chiefly with senior and trainee medical staff at different units across the province that currently are struggling to provide EWTR working practices. Specialities include General Surgery, General Medicine in smaller sites, Paediatrics, Neurosurgery, Urology, Cardiothoracic Surgery, Orthopaedic Surgery, Obstetrics and Gynaecology and Ophthalmology. Potential solutions to current problems usually need to be tailor-made given these posts remain as pockets of non-EWTR compliant working practices and require sustained and focused work to move towards hours compliance.

Some of the above named rotas have progressed towards full compliance supported with valid hours monitoring data, whilst others are progressing towards compliance by being fully rebanded at Band 2B level having historically been labelled Band 3. Others, such as Neurosurgery, have specific and unique challenges, not least the difficulty in identifying suitable doctors to staff the middle grade tier sustainably. BLG hosted a number of meetings with Urology clinical and managerial representatives from Belfast and Craigavon to explore whether a cross-cover out-of-hours arrangement could provide a solution to both units currently failing to meet EWTRs. It was concluded that each site would prefer to seek locally-orientated solutions, perhaps with more limited Urology middle grade cover as part of the efforts to improve adherence with the EWTRs.

As more and more rotas move towards EWTR compliance, the remaining pockets of non-compliance remain a challenge given, by definition, there is no 'quick fix' that can swiftly improve working practices in line with the EWTR. These working arrangements will continue to require the focus of Trusts in collaboration with BLG to help identify what needs to change in order to move towards sustainable hours compliance that meets the teaching and service commitments the individual units provide.

## *F. Hours monitoring of junior doctors*

This remains a challenging exercise for all parties concerned. Trusts are coming under increasing scrutiny from the HSC Board's Performance Management Directorate to demonstrate their junior doctor workforce is working safe and legal working hours. Junior doctors, though contractually obligated to participate fully in monitoring, often as a group demonstrate a lack of interest in hours monitoring exercises, particularly when there is no incentive to the individual to participate in what is perceived as an abstract paper exercise. Meanwhile, the Department of Health, having devolved initial responsibility for junior doctors monitoring to the HSC Board, is increasingly seeking robust evidence that junior doctor working hours across the province are within the contractual and regulatory limits.

BLG's contribution has been as follows:

- I. To reemphasise the need for junior doctors to participate fully in hours monitoring exercises through the BMA Junior Doctor Committee where the MPO sits as a non-voting member, as well as in an article by the MPO in the BMA junior doctors newsletter.
- II. To propose a shift from twice yearly hours monitoring (as currently happens for all rotas) to annual monitoring for those rotas deemed stable and operating within the regulatory framework on a consistent basis (in progress – presented at the Joint BMA/Employers Forum in June 2010), thereby releasing time and resources to focus on monitoring unstable or non-compliant rotas in order to better understand the barriers to improvement.
- III. To assist in promoting the widespread implementation of electronic monitoring systems across all five HSC Trusts, thereby reducing the administrative burden of paper hours monitoring and improving return rates.
- IV. To highlight, both at key strategic meetings with Trust Performance Management as well as in face-to-face meetings with different junior doctor cohorts traditionally difficult to engage in hours monitoring, the importance and value of hours monitoring in helping to construct sustainable and appropriate working patterns across the province.
- V. To enlist the help of the Performance Management Directorate of the HSC Board in highlighting the importance of junior doctors hours monitoring to the HSC Trust Chief Executive, Finance Director and Performance Management Director as part of an escalation response to poor monitoring returns.

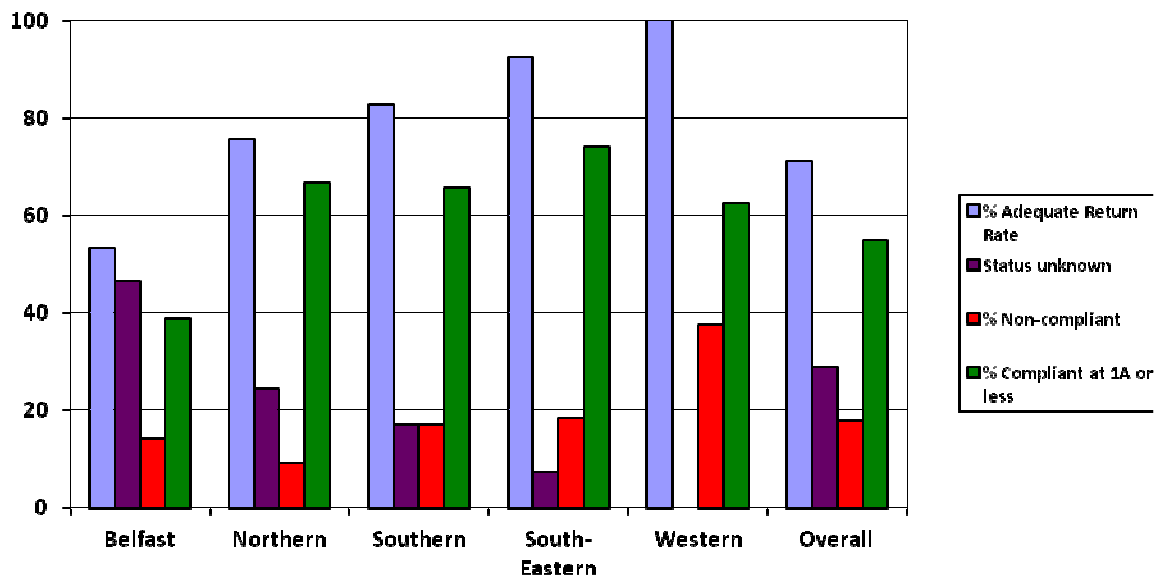
As a result of collective efforts, the Spring monitoring returns for the 5 Trusts were considerably improved on the Autumn 2009 returns. Figure 1 demonstrates the current return rates for monitoring results, together with the compliance rates according to the monitoring results that were returned.

Only the Western HSC Trust was able to achieve a 100% monitoring return, with the other 4 HSC Trusts having variable success in securing sufficient returns. Regionally, approximately 60% of rotas are Band 1 / EWTR compliant, with 20% of rotas known to be non-compliant and a further approximately 20% of rotas for whom the status is unknown.

Of those rotas known to be non-compliant, a small proportion includes the derogated rotas where prior agreement with the Department of Health has been established, permitting certain rotas with specific pressures to allow working practices up to 52 hours per week on average. These rotas are itemised in Appendix 4, and HSC Trust operating these exceptional rotas have until July 2011 before they must implement working practices in line with the 48 hours EWTR legislation.

Figure 1:

**Spring 2010 Monitoring Return rates and compliance for rotas**



## G. Budget

Over 2009/10 the BLG budget was allocated as per the table below:

<b>Starting Budget</b>		<b>£6,151,000</b>
Administration Costs		£134,507
2009/10 Bids		£1,857,645
Subject to Review Posts, previous commitments from 2007/08 and 2008/09		£2,357,384
Pay Protection		£1,046,072
Up-lift for Employers Costs		£95,615
<b>Easement Declared</b>		<b>£480,000</b>
<b>TOTAL COMMITTED</b>		<b>£5,971,223</b>
<b>BALANCE YEAR END</b>		<b><u>£179,777</u></b>

Administration costs included all salaries for the BLG core team, travel costs, communication costs and catering. BLG also held a regional HaN Workshop which was attended by representatives of all 5 HSC Trusts, NIMDTA, BMA and DHSSPS. 4 of the HSC Trusts were successful in securing funding for a number of Bids during 2009/2010 as follows:

<b>Proposal</b>		
Hospital at Night Projects		£719,051
Speciality Doctors		£811,477
Banding Payments		£98,146
<b>Total</b>		<b><u>£1,628,674</u></b>

NIMDTA were allocated £375,050 in basic salary payments.

South Eastern Trust received notification that their Ulster HaN Bid was successful in February 2010. This Bid, totalling £229,777, has been costed for 2010/11.

The breakdown for 'Subject to Review Posts' is as follows:

<b>Costs</b>	
Commitments cont. 2007/08	£334,170
ISG Bids 2007/08	£436,764
ISG Bids 2008/09	£1,534,468
Additional costs 2008/09	£50,000
<b><u>TOTAL</u></b>	<b><u>£2,355,402</u></b>

4 of the Health and Social Care Trusts received Pay Protection totalling £1,046,072. In March 2009, BLG wrote to Trusts to advise them that no further Pay Protection costs would be met by BLG as the implementation deadline for Band 1 level working practices passed in August 2009. As a result, it should be expected that most junior doctors anticipate banding supplements at Band 1 rather than Band 2 or 3 levels.

All monies allocated to Trusts were re-calculated to reflect the increase in employer's costs.

An easement of £480,000 was declared to the Health and Social Care Board.

## *H. Proposed BLG links with Regional and Local Commissioning*

Commissioning remains in its infancy in the Northern Ireland health economy, but a recent new appointment to the Director of Commissioning position at the HSC Board indicates ambitions to develop commissioning as a more effective and accountable model of funding than previous historical arrangements. As BLG moves away from the funding model adopted by ISG, the intention is for it to play an increasingly important advisory role to Commissioning groups where junior doctor staffing and hours of work are a component of HSC Trust proposals. Proposals that involve innovative models of care that maximise the use of the local junior doctor pool in a sustainable way are expected to be viewed more favourably than those that take less account of the availability and contribution of junior doctors – too often service models presume a level of junior medical cover that does not necessarily materialise in practice leading to unsustainable pressures on the existing junior doctor pool. Through more informed decision making with assistance and advice from BLG it is anticipated this will occur less frequently.

## **4. Summary**

A considerable programme of work has been carried out by the wider BLG group and the core team, and this Annual Report is not intended to be exhaustive but sketch out the main areas of work. BLG remains an organisation in transition, from the funding based model of ISG towards a more facilitative and influencing body at regional, local and commissioning levels. The aim of achieving sustainable and viable EWTR working practices across Northern Ireland remains a key focus – balancing this achievement with meeting the service needs of patients and the training needs of junior doctors will require considerable ongoing commitment and change if this is to be achieved fairly and successfully.

## **5. Appendices**

Appendix 1 – Board Liaison Group Terms of Reference

Appendix 2 – Rotas fully rebanded by the Rebanding Committee Aug 2009 – July 2010

Appendix 3 - Regional Rota Guidance

Appendix 4 – Derogated Rotas

## **Terms of reference for Board Liaison Group**

### **Introduction**

The Health and Social Care Board (the Board) now has responsibility for ensuring that doctors and dentists in training work within the legislative requirements of Working Time regulations and the regulatory requirements of the New Deal. The Board Liaison Group (BLG) comprises representatives of stakeholders who have a role to play in delivering a reduction of junior doctors' and dentists' hours of work to within limits set by legislation and regulation while having regard to constraints of workforce planning, education, training and service delivery. It will include representatives of the Board, the Department of Health Social Services and Public Safety (DHSSPS), employing Trusts, the Northern Ireland Medical and Dental Training Agency (NIMDTA) and the British Medical Association (BMA). The BLG replaces the Implementation Steering Group (ISG) of the DHSSPS and will undertake all functions previously the responsibility of the ISG.

### **Objective:**

That doctors and dentists in training throughout Northern Ireland work within the limits set by the European Working Time Directive and the New Deal, while maintaining working lives that promote their wellbeing and professional development.

In order to achieve this, the group will:

- Develop a plan of work to ensure implementation of all necessary changes in order to achieve the objective;
- Review monitoring and banding returns from Trusts;
- Monitor progress towards meeting statutory and regulatory limits in order to report annually, and at such other times as required, to the Board Chief Executive on hours of work and plans to effect change;
- Identify obstacles to progress towards the objective;

- Agree how Board funding may be used to secure improvements, develop a fair and equitable process for the investment of Board finances in working time solutions, insuring financial prudence and value for money are achieved for all spending;
- Provide panel members for Banding Appeal Panels, within a reasonable timeframe;
- Advise on information technology needs for monitoring, rota design and workforce planning;
- Research, evaluate and, where appropriate, publicise initiatives from outside the Province that have reduced hours of work and deliver targeted training initiatives within the Province;
- Deliver educational opportunities for sharing of good practice in service redesign in a manner that supports professional development and work life balance.

### **Meetings:**

The group will meet quarterly in full and will be supported by monthly sub-group meetings. The sub-group will comprise sufficient representatives to manage business delegated from the main group. The meetings of the Liaison Group (BLG) and the sub group will be chaired by Dr Graeme McDonald. Minutes will be kept and shared with all participants.

Between meetings the Chair, the Medical Project Officer and the Human Resources Advisor will carry out site visits and meetings as required by the work programme.

### **Areas of Responsibility:**

- The Board will provide appropriate staffing, supporting resources and accommodation for the work of the Group.
- The Trusts will ensure representation that encourages clinical and managerial engagement with the Group's work. Trusts will facilitate visits by BLG staff to Trust premises and staff at all times necessary to understand and remedy problems.

- Trusts will ensure that monitoring of junior doctors' and dentists' hours is carried out at agreed times and that the banding of junior doctors' and dentists' hours occurs in line with regulation.
- NIMDTA will assure the Group that Training Schools set training programmes deliver College curricula and that the distribution of training between office hours, extended hours and unsocial hours is appropriate to the trainee's educational needs. It is expected that schools will advise on trainee distribution and the requirements placed on clinical and educational supervisors in order to meet educational requirements.
- The Department (DHSSPS) will advise on workforce planning and on terms and conditions of employment.
- The BMA will represent all crafts within the profession.

**Reporting:**

The Group will report through its chair to the Chief Executive of the Board.

**Conclusion of Business:**

The Board Liaison Group will exist for 3 years from 1 August 2009 in the first instance. By 1 April 2012 the Board will have reviewed progress and decided on how the functions of the BLG should be discharged after 1 August 2012.

**Rotas fully rebanded by the Rebanding Committee**  
**August 2009 – July 2010**

<b>Hospital</b>	<b>Specialty</b>	<b>Grade</b>	<b>Banding</b>
Altnagelvin Area Hospital	Obstetrics and Gynaecology	StR,SpR	Band 1B
Antrim Area Hospital	Obstetrics and Gynaecology	SpR	Band 1A
Belfast City Hospital	Clinical and Medical Oncology	StR	Band 1B
	Anaesthetics ICU	StR	Band 1A
	Anaesthetics Theatres	StR	Band 1A
	General Surgery	F1	Band 1A
	Oncology	F2/CT1-2	Band 1A
	Accident and Emergency	F2/CT1-2	Band 1A
Craigavon Area Hospital	General Surgery	SpR	Band 1A
	Anaesthetics ICU	F2/CT1-2	Band 1B
	Paediatrics	F2/CT1-2	Band 1A
	General Surgery	F1	Band 1B
	General Medicine	F1	Band 1B
	ENT	CT1-2	Band 1A
	ENT	ST3+/SpR	Band 1A
	Anaesthetics	SpR	Band 1B
Daisy Hill Hospital	General Medicine	F2/CT1-2	Band 1B
	General Surgery	F2/CT1-2	Band 1A
	General Surgery	SpR	Band 1B
	Medicine	F1	Band 1A
	Surgery	F1	Band 1A
	Obstetrics and Gynaecology	F2/CT1-2	Band 1A
	Paediatrics	ST2/FTSTA	Band 1A
Donard and Minnowburn	Child and Adolescent Mental Health	SHO grade equivalent	Band 1A
Erne Hospital	General Medicine	F2/CT1-2	Band 1A
	Obstetrics and Gynaecology	SHO grade / CT1-2	Band 1A
Gransha	Psychiatry	StR1+/F2	Band 1A
Mid Ulster Hospital	General Medicine	F2/CT1-2/St5	Band 1A
Musgrave Park Hospital	Care of Elderly/Rheumatology	F2-CT1+2	Band 1A
Royal Victoria Hospital	Anaesthetics – Cardiothoracic rota	StR	Band 1A
	Anaesthetics – Obstetrics rota	StR	Band 1A

Royal Victoria Hospital	Anaesthetics – Paediatric rota	StR	Band 1A
	Neonatology	ST3+	Band 1A
	Obstetrics and Gynaecology	Tutors SpR	Band 1A
	Obstetrics and Gynaecology	SpRs / St3+	Band 1A
	General Surgery	SpR	Band 1A
	Ophthalmology	SpR	Band 1B
	Obstetrics and Gynaecology (RVH)	SHO grade / CT	Band 1B
	Obstetrics and Gynaecology (split site with Mater and BCH)	SHO grade / CT	Band 1A
	Cardiothoracic Surgery	SpR	Band 2B
Ulster Hospital	Anaesthetics/Theatres	SpR	Band 1A
	Anaesthetics/Theatres	SHO/F2/CT1-2	Band 1A
	General Surgery	SpR	Band 2B

## Regional Rota Guidance

### Regional Guidance for Individual Units

#### *Optimising Service and Training in the era of Working Hours Restrictions*

#### **Key points**

- The purpose of the hours legislation is as an adjunct to improving patient safety. Under EU law, employers (HSC Trusts) cannot opt-out.
- Maximum average weekly hours are 48. Working 60-70hrs during individual weeks, provided rest periods are adhered to, remain legal and safe although subsequent weeks should be lower intensity to accommodate high-intensity weeks.
- Junior doctor engagement with the design and execution of working patterns are central to successful and sustainable implementation of new working practices.
- Maximum period of duty for non-resident on-call patterns is 56 hrs at weekends, 32 hrs during the week.
- Maximum period of duty for any resident shift pattern is 13 hrs.
- Whether full shift or non-resident on-call patterns, 30 minutes rest approximately every 4 hours work is required.

#### **Practical suggestions**

- Assign a senior trainee the task of rota planning for your unit as part of their management and leadership development.
- Plan unit rotas 2-3 weeks in advance to anticipate gaps in staffing so that contingencies can be made and continuity can be promoted.
- Discourage ward doctors (eg F1s) from operating mainly from lists – promote ownership and engagement eg through encouraging F1 ward rounds
- Foster a culture of goodwill and flexibility, by identifying mutually convenient days off for juniors when they cover gaps at short notice.
- Formalise your handover arrangements for weekends, nights and bank holidays – eg Consultant-led friday lunchtime handover. This enhances the service and training experience of the on-call members through more targeted work.
- Avoid midweek 'off' days where possible to minimise disruption to continuity of care. Coalescing rota 'off' days pre or post nights, or establishing half-days following NROC patterns, promotes improved continuity for junior medical staff.

- Contact the Regional HSC Board Medical Project Officer for advice on improving rota design or more detailed advice or input in relation to working practices and hours restriction regulations.

## Derogated Rotas

1. Belfast City Hospital, Ear, Nose and Throat (ENT), CT1-2/ST1-2/F2/FTSTA
2. Mater Hospital, Anaesthetics, ST3+/ST1-2/CT1-2/FTSTA
3. Royal Victoria Hospital, Neurosurgery, ST3+
4. Royal Victoria Hospital, Fractures, F1
5. Royal Victoria Hospital, Fractures, F2/CT1-2/ST1-2/FTSTA
6. BCH Anaesthetics ST3+
7. RVH Cardiology, F2, CT1-3, ST1-2, FTSTA
8. Antrim Hospital, General Surgery, F2/ST1-2
9. Antrim Hospital, General Surgery, SpR/ST3
10. Mid-Ulster Hospital, General Medicine/Surgery, F1.
11. Ulster Hospital, Obstetrics and Gynaecology, SpR/ST3
12. Ulster Hospital, General Surgery, F2/ST1
13. Craigavon Area Hospital, Obstetrics and Gynaecology, SpR
14. Craigavon Area Hospital, Anaesthetics, SpR
15. Erne Hospital, Surgery, CT1/LAT/CT2
16. Erne Hospital, Paediatrics, FTSTA/LAT