Royal College of Physicians

Setting higher standards

Exception reporting

A Royal College of Physicians guide

April 2017

Dr Chris Kirwan, New Consultants Committee, RCP

Dr Nigel Lane, New Consultants Committee, RCP

Dr Orod Osanlou, Trainees Committee, RCP

Dr Jude Tweedie, Clinical Fellow, RCP

Dr Philip Bright, Head of School of Medicine, Health Education England West Midlands (HEWM)

Dr Andrew Goddard, Registrar, RCP

Contents

Summary 3
Background 3
What is exception reporting? 3
Variations from the agreed work schedule 4
Who is responsible for what? 5
What actions result from an exception report? 6
What happens when the issues raised in an exception report cannot be resolved? 8
What about non-training grades? 8
Exception reporting and professionalism 9
Appendix 10

Summary

The Royal College of Physicians (RCP) supports the implementation of exception reporting as a standardised way to highlight issues with training and workload. The mandated mechanisms for responding to exception reports will allow issues to be addressed quickly, which will result in improvements to the working lives of both those trainees who are currently in post and those who are following them.

The exception reporting process will have teething problems due to its complexity, and this guide is designed to help minimise such problems. Exception reporting will work better in practice if it does not rely wholly on educational supervisors to action the reports; clear local guidance is therefore needed for all the individuals who are involved in the process.

National monitoring systems are required to assess patterns of exception reporting in order to prevent under- or over-reporting. These systems are currently not in place, but it is essential that they are created if the benefits of exception reporting to the NHS are to be realised.

Exception reporting will uncover examples of poor practice and highlight rotas that are understaffed. This will not be an easy period for the NHS, the education system and the medical profession. However, exception reporting is necessary if we are to improve how we develop and train our doctors and deliver safe and high-quality care.

Background

A new contract for junior doctors is currently being introduced in England. This contract (and its terms and conditions of service (TCS)) is being introduced for all core medical trainees (CMTs) and higher specialty trainees (HSTs) who are working in NHS trusts, and it will be fully implemented by the end of October 2017.

The fine details and implementation plan for the new contract were not completely agreed with the British Medical Association (BMA), due to a breakdown in the contract negotiations in 2016. This breakdown of the relationships between the medical profession and the government over the new contract demoralised an already overstretched and undervalued workforce, which will make it challenging to implement the contract.

The new contract outlines a system of 'exception reporting'. This document provides a brief guide to exception reporting, and more details and links are available in the Appendix.

What is exception reporting?

Exception reporting is the formal mechanism that doctors on the new contract can use to register variations from their agreed work schedule, in terms of their working hours and training. It allows issues to be escalated to responsible individuals so that they can be resolved and monitored.

A trainee's work schedule is based on a generic template that should be personalised and agreed for each individual doctor. It contains a job description, generic training objectives for the role and a rota that details the hours of work. Once the trainee starts the post they will work with their clinical or educational supervisor to tailor their training objectives to meet their individual needs. The trainee and their clinical or educational supervisor can modify the training objectives to suit the trainee's individual needs.

Exception reporting may also provide a potential mechanism for reporting concerns about patient and personal safety in the right circumstances. The TCS make it clear that such concerns can be reported via the exception reporting process; however, other local incident reporting mechanisms

are likely to provide a better route for dealing with such concerns (as outlined in the 'Patient safety' section).

In the wording of the contract TCS, it appears that much of the workload for dealing with exception reporting will potentially rest with educational supervisors, although much of the practical operation may also be provided by clinical supervisors. The roles of the clinical supervisors and educational supervisors will be explored fully later in this guide. However, the focus on educational supervisors in this context is of great concern to the RCP, as this group of consultants already struggles to fulfil the time commitments that the educational supervisor role entails. Educational supervisors form a critical part of creating a high-quality training experience and it is important that they are supported as much as possible.

Exception reporting will be done through electronic systems and several of these systems have guides to help supervisors to navigate the process.

Variations from the agreed work schedule

There can be three types of variation from the agreed work schedule: working beyond rostered hours; working unsafe hours; and failing to achieve educational goals.

1 Working beyond rostered hours

The old contract allowed flexibility because, while trainees were employed to work 48 hours a week, most rotas were for fewer hours. This allowed doctors to occasionally work more hours when they were needed without breaching their contract or the Working Time Regulations (the Working Time Regulations statutory instrument is the mechanism by which the European Working Time Directive – 93/104/EC – took effect in UK law in 1998, subsequently amended by the European Commission in 2004 and the UK government in 2007 – we will refer to them as the Working Time Regulations throughout). However, under the new contract, agreed work schedules specify the total hours to be worked and so any time a trainee spends working beyond the total hours needs to be reported.

2 Working unsafe hours

The definition of 'unsafe hours' is based on the Working Time Regulations and covers a detailed range of issues. In short, to avoid being unsafe: rotas must cover an average of 48 hours per week or less and no doctor can work more than 72 hours in any rolling 7-day period; no shift can be longer than 13 hours long; and trainees can work no more than eight shifts in a row.

3 Failing to achieve educational goals

This variation from the work schedule is less clearly defined (except when referring to trainees' failure to attend designated teaching sessions). The detail in the work schedule will therefore be key to assessing this type of variation.

A lack of adequate clinical supervision may also be reported by some exception reporting systems, which is both an educational issue and a patient safety issue.

The National Association of Clinical Tutors is producing guidance on designing a work schedule, which will be available in due course).

Who is responsible for what?

Several key individuals, including the trainees themselves, are involved in the process of exception reporting. There is flexibility in some of the roles and common sense should dictate who does what. The timescales for the steps in exception reporting are mandated and there is an escalation policy that can be used if any disagreement cannot be resolved.

There is some confusion about the roles that clinical supervisors and educational supervisors will undertake in the exception reporting process. The TCS place the burden on the educational supervisor to try to resolve exception reports. However, the educational supervisor may well be working in a completely different specialty or even on a different site, so close liaison and discussion with the clinical supervisor will be needed.

Trusts should be clear about the responsibilities of both the clinical supervisor and the educational supervisor. A useful explanation of these two differing roles can be found online: www.e-lfh.org.uk/programmes/educational-and-clinical-supervisors/.

The individual doctor

The trainee is responsible for filing an exception report, usually via an online electronic system, within 7 days or 14 days (depending on whether payment for extra hours is being sought – see the *Exception report flow chart: Safe working practices*). The trainee is also responsible for notifying their consultant about patient and personal safety concerns within 24 hours: the notification should be made in person, but not necessarily face to face.

Trainees themselves are also responsible for not working unsafe hours. Thus if they breach their work schedule hours and they do not report it to their consultant, they are in breach of the contract.

It is recognised that some doctors are better at time-management than others and that this may be highlighted by exception reporting. If this is the case, it should be seen as an opportunity for personal development rather than criticism, and the trainee should be open to being supported to improve this aspect of their professional development.

The clinical supervisor

As stated above, the clinical supervisor has less mandated responsibility than the educational supervisor in exception reporting. However, the clinical supervisor is usually best placed to address any issues quickly, to prevent the need for exception reporting and also to understand the local issues that are involved. The TCS state that the exception reporting role of an educational supervisor can be delegated to the clinical supervisor, provided that this is formally agreed and documented. Even if this delegation of duties is not agreed, the RCP considers that it is the responsibility of the clinical supervisor to communicate clearly and quickly with the educational supervisor to resolve exception reports.

It is unclear what proportion of exception reports will relate to educational issues and what proportion will relate to working hours issues. The clinical supervisor should be able to resolve working hours-related issues quickly and easily and to escalate the issue to the guardian of safe working hours (GSWH) as needed. The educational supervisor needs to be aware of these hours-related issues, but it is important that their limited time is used to focus on the educational-related exception reports.

The educational supervisor

The educational supervisor (or the clinical supervisor whom the work is delegated to) is responsible for arranging a meeting with the trainee within 7 days of an exception report being submitted. As stated above, in practice this may not be necessary if the clinical supervisor has managed the issue and resolved it to the satisfaction of both parties.

If the issue has not been resolved, the educational supervisor should establish the issues that are stated in the exception report and, if they are unable to resolve the issues personally, the educational supervisor should seek the help of others within the trust that employs the doctor who submitted the report. This will be the director of medical education (DME) (or an equivalent role) for education issues and the GSWH for working hours and safety issues.

The clinical director of the clinical area in which the doctor is working may also be involved, if there are significant patient safety concerns. If the educational supervisor is unhappy that appropriate action is being taken, they should report their concerns to the RCP tutor and the trust's medical director.

We agree with the BMA's recommendation that educational supervisors should keep a record of the amount of time they spend on exception reporting and that they should use this information at their job planning meeting.

The guardian of safe working hours

The role of the guardian of safe working hours (GSWH) is to oversee the safety of doctors in training by providing assurance on compliance with safe working hours. These responsibilities are described in more detail in the Appendix. The GSWH has the power to intervene where needed, and this intervention can escalate from mandating a work schedule review to intervening where doctor/patient safety issues are not being addressed.

The RCP tutor

The RCP tutor role varies from hospital to hospital. Most RCP tutors are involved with CMTs and thus they will have a close working relationship with the educational supervisor of those trainees. This may also be the case for HSTs in some hospitals. An educational supervisor may seek the support of the RCP tutor when they are dealing with educational issues and, occasionally, where the GSWH is not seen to be acting to resolve safety or working hours issues.

The DME should be the main source of local support for the RCP tutor, but when further support is required it can be obtained through the relevant RCP regional officer.

The RCP is very willing to take action where patient safety concerns are not being addressed and to work with local Health Education England (HEE) staff regarding unresolved educational issues. This action will always be undertaken in partnership with the employing trust but it will also be escalated where necessary (eg to the Care Quality Commission (CQC)).

What actions result from an exception report?

The actions that result from an exception report obviously depend on the nature of the report and whether the report has been resolved to everyone's satisfaction.

Working hours variation

The preferred response to occasional episodes of doctors needing to work beyond the hours in their work schedule is for the doctor to take 'time off in lieu' (TOIL). This can often be easily

facilitated by the clinical supervisor or the ward consultant. Where this is not possible due to patient safety or because TOIL will impair the educational component of the agreed work schedule, the trainee may be paid for their extra hours, as long as they have not breached the rules about safe working hours (eg working >72 hours in 7 consecutive days).

When the breach of the hours in the work schedule meets certain criteria (eg working >48 hours per week on average, working >72 hours in 7 consecutive days, taking a rest period of <8 hours, or 25% of rest breaks being missed in a 4-week period), the trust has to pay a fine which is split between the doctor and a junior doctor fund. This is explained in more detail in the Appendix.

The GSWH is responsible for escalating issues about working hours that are raised in exception reports to the relevant executive director (or equivalent) for a decision and action, where these have not been addressed at the departmental level.

Inability to achieve educational needs within the work schedule

Where a doctor has been unable to attend one or more formal teaching sessions, the educational supervisor should help the doctor to facilitate ways in which this learning can be achieved by alternative means. Such breaches of the work schedule are easy to identify and relatively easy to address.

Where a doctor files an exception report that claims that they have been unable to fulfil their curricula needs, this may be harder to resolve. The most likely scenario is that the doctor has had a lack of exposure to outpatient clinics or practical procedures due to ward pressures or working in other clinical settings.

Ideally, an exception report will have been submitted early in a particular clinical training post, so that measures that are facilitated by the educational supervisor and the clinical supervisor working together can be implemented. The RCP recommends that trainees do not wait until the end of an attachment to file exception reports, in order to allow sufficient time for resolving measures to be implemented.

Where an exception report is filed at the end of a clinical attachment, ensuring that the trainee gains the relevant educational experience is much more challenging. The educational supervisor should liaise with the RCP tutor to resolve these issues and, if needed, they should also liaise with the DME. It is important to note that some trainees may not take up available training opportunities due to their own poor time-management skills or issues with engaging with the training process. This situation should be clear if the educational supervisor liaises with the trainee's clinical supervisor and/or previous educational supervisor / clinical supervisor.

Local heads of school and postgraduate deans are responsible for overseeing the quality of training in host trusts and they have the power to act to remove training posts as a last resort.

Patient safety

Patient safety concerns that occur because a doctor is working unsafely must be raised with the responsible consultant as soon as possible (ie within that shift), in order to enact a plan to protect the doctor and patients. The GSWH must be informed within 24 hours.

If patient safety has been put at risk or a patient has come to harm, local incident reporting mechanisms (eg DATIX) must be used to record this. Both the reporting doctor and the supervising consultant have a responsibility to ensure that this reporting has happened.

What happens when the issues raised in an exception report cannot be resolved?

The meetings that are held between the reporting doctor and other individuals occur at four levels, and the TCS outline an escalation process that should be followed if the reporting doctor is not satisfied with the outcome. This process is covered in detail in the Appendix and in the exception report flow charts on safe working practices and training issues, but it can also be summarised as follows.

Initial review

An initial review is undertaken to understand the cause of the exception report. If the trainee agrees with the offered compensation and that the event was a one off, the issue proceeds no further. However, if the trainee feels that the exception is representative of a wider pattern the issue is escalated.

Level 1

This is the meeting between the doctor and their educational supervisor (or the clinical supervisor if it is delegated to them). The outcome will be one of the following:

- no change in the work schedule is needed
- changes in the work schedule are needed and are prospectively documented
- TOIL is needed
- organisational changes are needed (eg the timing of ward rounds).

If the doctor disagrees with the level 1 outcome, they can request a level 2 meeting.

Level 2

This is a meeting between the doctor, their educational supervisor and a service representative who is nominated by the DME (if it is an education-related exception report) or nominated by the GSWH (if it is a working hours-related exception report). A level 2 meeting has to be requested in writing within 14 days of the level 1 meeting, and it must take place within 21 days of the request. The outcomes are the same as for a level 1 meeting and they include the level 1 outcome being upheld and also compensation payments (see the Appendix). If the doctor still disagrees with the outcome, a level 3 meeting may be requested.

Level 3

This is a formal hearing under local grievance procedures that involves the doctor, their educational supervisor, the DME and (if it relates to a decision by the GSWH) a BMA or union representative from outside the hospital. The outcomes are the same as for level 2.

The BMA has helpful guidance for any educational supervisor who has concerns about any aspect of exception reporting: www.bma.org.uk/advice/employment/contracts/junior-doctor-contract-2016/exception-reporting/exception-reporting-guidance-for-senior-doctors

What about non-training grades?

Recent guidance from NHS Employers has stated that only doctors who are on HEE-approved programmes should be on the new contract. 'Trust doctors' (including clinical fellows, ie 'F3 posts' etc) who are not in training post or who are currently on the specialty and associate specialist (SAS)

contract should remain on the old contract. It will be up to the employer which contract they are on and the employer's decision will depend on a number of factors, eg whether they have enough staff to put the trust grade on the contract terms.

It is important that the educational needs of these doctors are met and that they have the same high-quality training experience as those who are on the new contract. Trusts must be wary not to disenfranchise a vital part of the workforce, and the protections for education that are afforded by the new contract should be available to all doctors.

Exception reporting and professionalism

The RCP supports the General Medical Council (GMC) guidance on exception reporting that can be found at: www.gmc-uk.org/news/29296.asp.

The RCP is clear that it believes that unsafe working hours and poor training environments are unacceptable and that exception reporting is a means to highlight such instances so that action can be taken. We recommend that hospitals and HEE work together to collate exception reporting data to allow regional and national comparisons and we ask that NHS England, NHS Improvement and the CQC should also expect this collaboration.

Provided that they do it appropriately, trainees and trust grade doctors who report exceptions will be acting professionally. Doctors have a duty of care to themselves as well as to their patients, and working excessive hours on a recurrent basis should not be regarded as acting professionally. On the other hand, no doctor should walk away from a situation where patient safety is in jeopardy simply because their work schedule says that it is time for them to leave.

From the viewpoint of medical registrars and consultants, the implementation of the Working Time Regulations resulted in a reduction in training quality and continuity of care. It is important that this is not the case for the introduction of the new contract, but that will only be possible if the profession, education providers and hospitals work together.

It is also important that the impact that an exception report has on the rest of the doctor's team is not forgotten. It may be that the team is well aware of the issues that have resulted in an exception report; however, it is also conceivable that the exception report could reach the level of the GSWH or the DME without the doctor's team or their consultant knowing about it, which may cause disquiet. Consultants should use exception reporting as an opportunity to improve team working and morale. Furthermore, consultants and team members should not place undue pressure on a doctor to not make an exception report where it is clearly necessary and the relevant issues have not been resolved by agreement.

Appendix

Work schedule

A generic work schedule needs to be completed by the doctor's employer or the host organisation. It is a document that sets out:

- intended learning outcomes (mapped to the educational curriculum)
- scheduled duties of the doctor, including time for quality improvement and research
- patient safety activities
- periods of formal study (other than study leave)
- the number and distribution of hours for which the doctor is contracted (ie a rota).

The details need to be agreed with the trainee, in order to create a 'personalised work schedule'.

- The doctor and their educational supervisor are jointly responsible for personalising the work schedule, according to the doctor's learning needs and the opportunities within their post.
- A meeting should be arranged between the doctor and their educational supervisor as soon as possible after the doctor takes up their post; this meeting should include an educational review and personalisation of the work schedule.
- Once it is completed, the work schedule should be signed off by both the doctor and the educational supervisor.

Fuller guidance on work schedules is being prepare by the National Association of Clinical Tutors and will be available in due course.

Working patterns

Under the new TCS, significant changes have been made to the way that rotas can be constructed, including the following conditions:

- all rotas must be ≤48 hours a week on average
- there is no fixed annual leave
- a breach of the following conditions is considered to be 'unsafe':
    - spending >72 hours at work in 7 consecutive days
    - working >13 hours in one shift
    - working more than five long (>10-hour) shifts in a row (after five long shifts, it is mandatory to have 48 hours' rest)
    - working more than four night shifts in a row (after working three or four night shifts in a row, it is mandatory to have 46 hours' rest)
    - having <11 hours' rest after working a 13-hour shift
    - working more than eight shifts in a row (after working eight shifts, it is mandatory to have 48 hours' rest)
    - working more than one in every two weekends (one rotation in the FY2 year can be exempt from this).

Further information on working patterns in the TCS can be found online: www.nhsemployers.org/case-studies-and-resources/2017/03/junior-doctors-terms-and-conditions-of-service-march-2017

The new contract vs the old contract

If a doctor on the new contract works beyond their scheduled hours, they will not be paid for that time. This was not necessarily true for the old contract. The old banding system was complex, as outlined below.

- The banding system paid for a 40-hour week (on average) at a basic salary, with an additional 8 hours being paid as a 'band' payment for out-of-hours work on top of that (1B, 1A, 2B etc). The band increment was set as a percentage of the basic salary (eg 40%), depending on the frequency of weekends that were worked. It did not make a difference if a doctor worked 41 or 47 hours per week. The banding system also did not distinguish between 'in-hours' and 'out-of-hours' work for payment purposes.
- If a doctor worked less than full time, a 'fudge factor' was used to make a correction to the final pay, which could result in a perhaps generous pay settlement for the hours worked, if certain criteria were met.
- No junior doctor should have been working more than 48 hours (on average) per week and, in fact, rotas were often set at around 46.5 hours per week to allow leeway (eg a doctor needing to staying late on the odd occasion).

Under the new contract, doctors are paid for the hours that they work.

- There are no automatic pay increments: four nodal points of pay are related to the doctor's grade (FY1, FY2, ST1–2 and ST3–8).
- A base rate salary covering 40 hours per week of work (on average) is then supplemented by bonus payments for the number of weekends that have been worked (1:2, 1:3 etc). There is also an additional 37% supplement to the hourly rate (which is the basic salary/52 (weeks of the year)/40 (hours a week)) for each hour after 9pm and before 7am (extending to 10am if the doctor starts their night shift before 11pm). This is universal for every day of the week, including weekends (ie Wednesdays are equivalent to Sundays). This means that, if a doctor is rostered for an average of 46.2 hours a week, they will be paid for working that many hours, and no allowance will be made if they work more hours than this.
- The calculations for pay for on-call work (ie when a doctor is not in the hospital but is available for advice, or when they might go to the hospital to do a ward round etc) are made using a departmental agreement with the trainees, which estimates the average amount of actual work that is done in that on-call period multiplied by the appropriate hourly rate (eg for a rheumatology ST3+ who is on call from home: 5 hours within 24 hours on average on an average Saturday and 3 hours for a Sunday).
- There are additional payments for the number of weekends that are worked (1:2, >1:4, >1:6, >1:7, >1:8, <1:8).
- There are some bonus payments that are associated with 'hard to fill' specialties.

Pay protection (in brief)

Pay protection is very complex and will have a big impact on doctors as the new TCS come into force. The detail is important, and is contained within the relevant section in the TCS, but it can be summarised as follows for doctors who are working at different grades.

FY1–ST2

- Pay protection is in place so that doctors are paid the higher amount, whether that is the amount from the old or the new contract.
- Once a doctor is being paid on the new contract salary scale, they cannot return to the old contract salary scale.

- The pay protection resides with the doctor and not the job.
    - If an FY1 doctor in a 1A post moves to an un-banded post, their pay remains at 1A.
    - If an FY1 doctor in an un-banded post moves into a job that was a 1A, they are paid according to the new salary scale. This may now be less than what would have been a 1A salary, but they are not entitled to pay protection at the 1A level because their last job was un-banded and that is their pay protection limit (and this is obviously less than the new salary scale pay in their current job).

ST3+

- If a doctor is an ST3 or above from 2 August 2016 (or an SpR on a pre-2007 training programme) then they will transfer to the new TCS but they will remain on the old contract pay scales, which increase every year as they would have done prior to the new contract for 4 years (but extended and reduced for part-time work and maternity leave respectively).
- ST3 doctors who started their role after 2 August 2016 will enter the new nodal pay point and pay calculations depending on their rota pattern:
    - these ST3s will be paid considerably more than ST4–6s in the same specialty on the same rota
    - if an ST3+ in one specialty changes to a new specialty and becomes an ST3 in that specialty, they will join the nodal pay scale.

Exception reporting

- Exception reporting is finely detailed in the TCS of the new contract: www.nhsemployers.org/case-studies-and-resources/2017/03/junior-doctors-terms-and-conditions-of-service-march-2017.
- The purpose of an exception report is to ensure prompt resolution and/or that remedial action is taken to ensure that safe working hours are maintained and that the trainee's education is in line with their personalised work schedule.
- By submitting an exception report, the doctor's supervisor is given the opportunity to address issues as they arise and to make timely adjustments to work schedules.
- The response patterns and time frames are clearly set out in the TCS and all trusts must comply with these timescales.
- Exception reporting should be used by doctors to inform their educational supervisor when their day-to-day work varies significantly or regularly from their agreed work schedule.
- Primarily, such variances will be:
    - differences in the total hours that are worked (including opportunities for rest breaks)
    - differences in the pattern of hours that are worked
    - differences in the educational opportunities and support that are available to the doctor
    - differences in the support that is available to the doctor during service commitments.
- If the doctor has concerns about their own or their patients' safety, they should immediately communicate this verbally to the consultant on duty, who will determine the appropriate action to take; an exception report should also be submitted *within 24 hours* of this concern being raised.

- Most trusts are using one of the following main electronic systems:
    - Zircadian (by Allocate)
    - Doctors Rostering System (DRS) (by Skills for Health).
- If an educational or clinical supervisor receives an exception report, they are now obligated to deal with it within the specified time frames (ie *the initial review should take place within 7 days*). Supervisors should look at their local policies for exact time frames or contact their GSWH.

BMA guidance on exception reporting

BMA guidance on exception reporting can be found online: www.bma.org.uk/advice/employment/contracts/junior-doctor-contract-2016/exception-reporting/exception-reporting-guidance-for-senior-doctors

The guardian of safe working hours

The guardian of safe working hours (GSWH) shall ensure that the doctor and/or the trust (as appropriate) address issues of compliance with safe working hours. The GSWH shall provide assurance to the board that doctors' working hours are safe (this assurance is in addition to the provisions and safeguards as set out in Schedules 3, 4 and 5 of the TCS).

The GSWH shall:

- act as the champion of safe working hours for doctors who are in approved training programmes
- provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the TCS
- receive copies of all exception reports that relate to safe working hours, which will allow the GSWH to record and monitor compliance with the TCS
- escalate issues in relation to working hours that are raised in exception reports to the relevant executive director (or equivalent) for decision and action, where these have not been addressed at a departmental level
- require intervention to mitigate any identified risk to doctors' or patients' safety in a timescale that is commensurate with the severity of the risk
- require a work schedule review to be undertaken, where regular or persistent breaches of safe working hours have not been addressed
- have the authority to intervene in any instance where the GSWH considers that the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily
- distribute monies that are received as a consequence of financial penalties, to improve the training and service experience of doctors
- take every possible step to ensure that a doctor who raises issues concerning safe working is treated fairly.

Fines

- Fines can be incurred for the following breaches of a work schedule and are administered by the GSWH:
    - working >48 hours on average per week
    - working >72 hours in 7 consecutive days
    - taking <8 hours' rest when 11 hours' rest should have been taken
    - missing breaks on at least 25% of occasions across a 4-week period (junior doctors are already paid for their breaks, so there will not be a payment to a junior doctor if this occurs, but there will be a fine to the department).
- The value of the fine is related to the hourly rate, and the doctor is remunerated according to the appropriate national locum rate that is applicable for the hours that breached the contract (except in cases of missed breaks). Once the junior doctor has been paid, the remaining funds are kept in an account that is administered by the GSWH, to be spent for the benefit of junior doctors with a specific instruction that it is not to be used to provide a resource that should already be provided by the trust.
- Where a fine is for missed breaks, the whole value of the fine will be paid into the junior doctor fund.

Escalation of exception reporting

It is expected that exceptions that are raised will usually be resolved locally in the first instance through initial review.

Initial review

- A junior doctor will submit an exception report within 14 days of the non-scheduled work occurring.
- Within 7 days of the report occurring, the educational supervisor (training issues) or the clinical lead* (non-training issues) will meet/correspond (this may be verbally) with the doctor, to understand the issue and to agree a solution.
- For non-training issues, an agreement for compensation will be made (TOIL or remuneration).
- The outcome of the discussions and any compensation that is agreed will be recorded through the online reporting tool.

If the junior doctor agrees with the outcome and that this was a 'one off' event, then the issue is closed.

If the junior doctor feels that the issue related to the pattern of work and that it requires a more in-depth review of working patterns, or they are not satisfied with the compensation that is offered, they can request a level 1 work schedule review by 'disagreeing' with the stated outcome in the exception reporting tool. This must be done within 7 days of receiving notification of the outcome of the initial review.

Level 1:

- The educational supervisor (training issues) or clinical lead* (non-training issues) will meet/correspond with the doctor within 7 working days of receipt of the request for a level 1 work schedule review following the initial review (or within 14 days of the original exception report, whichever is sooner).

*A clinical lead may delegate this responsibility to the doctor's clinical supervisor.

- The agreed outcome shall be recorded using the reporting tool as part of closing the exception report.

The potential outcomes of a level 1 work schedule review include:

- no change
- TOIL / remuneration for hours worked / trust fine with junior doctor compensation
- organisational changes (eg timing of ward rounds) – these may take some time to enact, so temporary arrangements may be put in place, which must be agreed with the GSWH/DME.

Level 2:

- In order to trigger a level 2 work schedule review, the junior doctor has 14 days to disagree with the level 1 work schedule review or to show that the agreed outcome is not working. This can be done in one of two ways:

    1 The doctor must disagree with the outcome using the specified response through the reporting tool.

    Or

    2 If the doctor originally agrees with the level 1 outcome yet the problem persists, they will need to re-report the issue via the reporting tool and to note in the text that this issue has already been through a level 1 review and that it needs to be escalated to level 2. The GSWH will automatically receive this notification and will upgrade the level of work schedule review on the doctor's behalf.

- A level 2 discussion shall take place within 21 working days of receipt of the doctor's formal written request for a level 2 work review.
- For training issues, a meeting will be held between the educational supervisor, a service representative (such as a clinical supervisor or rota coordinator) and the DME or their nominee.
- For non-training issues, a meeting will be held between the clinical lead, a service representative (such as a clinical supervisor or rota coordinator) and the GSWH.

The potential outcomes of a level 2 work schedule review include:

- the level 1 outcome is upheld and there is no change to the work schedule
- prospective documented changes are made to the work schedule
- TOIL / remuneration for hours worked / trust fine with junior doctor compensation
- organisational changes (eg timing of ward rounds) – these may take some time to be enacted, so temporary arrangements may be put in place, which must be agreed with the GSWH/DME.

The outcome shall be communicated through the exception reporting tool no later than 21 days after the exception report is received and the clinical lead is notified.

Level 3:

- The junior doctor has 14 days after notification of the level 2 outcome to disagree with the level 2 work schedule review or to show that the agreed outcome is not working. This will trigger a level 3 work schedule review, which can be done in one of two ways:

    1 The doctor must disagree with the outcome using the specified response through the reporting tool.

Or

2 If the doctor originally agrees with the level 2 outcome yet the problem persists, then they will need to re-report the issue via the reporting tool and to note in the text that this issue has already been through a level 1 and 2 review and that is needs to be escalated to level 3. The GSWH will automatically receive this notification and will upgrade the level of work schedule review on the doctor's behalf.

- The level 3 request must set out the areas of disagreement about the work schedule and the outcome or remedy that the doctor is seeking. This should be done via the exception reporting tool.
- The request will trigger the trust's grievance process and will involve a formal hearing.
- The final stage for a work schedule review is a formal hearing under the final stage of the trust's local grievance procedure, with the proviso that the DME or a nominated deputy will submit evidence on behalf of the trust or advise the panel directly at the meeting.
- Where the doctor is appealing a decision that has previously been taken by the GSWH, the hearing panel will include a representative from the BMA or another recognised trade union that is nominated from outside the trust and provided by the trade union within 1 calendar month.

This final panel hearing will result in one or more of the following outcomes:

- the level 2 outcome is upheld and no change is made to the work schedule
- prospective documented changes are made to the work schedule
- TOIL / remuneration for hours worked / a trust fine with junior doctor compensation
- organisational changes (eg timing of ward rounds) – these may take some time to be enacted, so temporary arrangements may be put in place, which must be agreed with the GSWH/DME.

The outcome shall be communicated in writing and a copy provided to the GSWH. The decision of the panel is final and no other recourse is available.

