The Insight Papers: Medics Series

Junior Doctor Rota Review

The rapid route to savings and productivity
Introduction

This document aims to show how significant efficiencies can be achieved by more effective organisation of the junior doctor workforce. This white paper has been produced by the Allocate Software Zircadian Medics team. The white paper is a direct response to a need articulated by a number of trusts, all of which are keen to establish an informed approach to rota design resulting in robust, stable and compliant arrangements. Critically rotas should be aligned to a trust’s service and help deliver its financial objectives.

Zircadian performed an expert analysis of the junior doctor workforce at participating trusts in order to

Best practice rota design driven by the service

Historically, the design of rotas has been primarily driven by two concerns: firstly, the number of junior doctors available in a department and, secondly, the limits on work and rest imposed by the New Deal and EWTD. This approach to rota design is underpinned by the belief that the availability of doctors never exceeds the demand for them. However, this assumption is almost never tested, e.g. does a department really need ‘x’ number of doctors to deliver its service effectively? The size of a rota and the number of training posts on it has traditionally been determined by conversations between the deanery and the trust. These assumptions are rarely objective and are often outdated. But how can trusts make objective assessments of their need for junior doctor capacity? How can a trust identify if its rotas are overstaffed and it is paying for junior doctors it does not need?

The solution is to build rotas based on the requirements of the service. The service plan and its associated activity should be translated into a demand for junior doctors. This approach has a number of benefits. The principle one is the ability to identify the number of juniors required to deliver the clinical service commitment to and compare this to the existing establishment of junior doctors, but it has many other benefits as well. This approach results in safer and more stable rotas, more efficient use of junior doctors’ time, better training, and increased productivity (and income) for the trust.

This white paper will model findings from four NHS trusts, to detail the benefits that can be directly delivered to all NHS organisations through involvement in a rota review. The ultimate aim is to demonstrate the scope of opportunities for savings and productivity improvements that can be made across the wider health service. Zircadian performed an expert analysis of the junior doctor workforce at participating trusts in order to

Executive summary

A The number of junior doctors on a rota and the requirements of the New Deal and EWTD have historically been the principle factors shaping rota design.

A By not basing rotas and their design on the needs of the service it is not possible to establish how many doctors are required on a rota. This means that a significant number of rotas could be overstaffed, not just resulting in wasted costs but giving poor training opportunities.

A This white paper shows the results of 82 rota reviews across 4 trusts. The review identified £1,070,000 worth of savings per annum across 29 rotas. This equates to an average saving of £36,896 per rota per annum.

A For an average sized trust (with 28 rotas) this equates to an estimated saving of £365,000.

A Across all acute and mental health NHS organisations in England this equates to savings of £70,508,000 per annum.

A The rota reviews did not consider the impact of aligning rotas to the service. If they had we believe that the identified savings would be significantly greater.

A Rotas should be reviewed, and possibly re-designed, every time the needs of the service change in order to ensure both are optimally aligned. This principle applies just as much to consultant job plans as it does to junior doctor rotas.

A A diagnostic tool is included in this document as a starting point for assessing the current performance level of your junior doctor rotas.

Income

Given the approach advocated above, junior doctors’ work should be strongly linked to the income of a trust through either assisting in the delivery of consultant-led activities (e.g. theatre session or clinic) or leading the delivery of such activities (e.g. registrar-led endoscopy list, ECG stress testing, etc). Under Payment by Results these activities generate income. What is interesting however is that the fact that rota design has never considered the income potential of a rota to the employer. Where rota design is linked to a service plan that includes productivity and income metrics it is possible to assess the likely income that could be generated from a rota. This approach can be used by a trust to model the impact on income of increasing or decreasing the number of junior doctors in a department. For example, it might be financially wise for a trust to optimise the number of registrar led endoscopy lists. To achieve this goal the registrar rota may need to be updated to reflect the additional service needs. In addition any training required by the registrars to achieve this goal, such as focused, one-to-one training with a consultant, can then be built in to the service plan and subsequently reflected in the consultants’ job plans.
Pay and locums

Good rotas design must always consider the cost of a rota. Both pay bandings and locum costs should be considered when deciding the overall cost of a rota. The majority of bandings are now 1A (50% supplement) or 1B (40% supplement). However, often the immediate desire to reduce the banding of a rota may be counterproductive. In some instances it may be cheaper to increase the banding rather than doggedly stick with a lower band. For example, if a trust reduces the hours on a rota to below 48 in order to secure Band 1 payments, it may no longer be able to include prospective cover on the rota and locum costs will rise significantly. A more cost-effective solution would be to assign prospective cover to the rota. This will push the hours above 48 which may result in a higher band but these should easily be offset by the reduced locum bill. This solution is only possible if the employer understands the subtle differences between the New Deal and EWTD. It also demonstrates the complexity of the task and the need for the right tools. As a result many employers overlook these opportunities.

The cost of locums goes hand-in-hand with the design of rotas. Poor rota design can have a significant financial impact in the over-use of external and agency staff to plug service gaps. Trusts often do not maximize the use of internal resources before turning to agency staff, either through poor capacity planning or through poor operational procedures. This can lead to locum expenditure of approximately £1,000,000 per 100 substantive posts. An increase in banding can be a more cost-effective option for increased productivity rather than a reliance on locums for extra service delivery. By optimising use of internal resources, rather than over-relying on external locums, good rota planning also avoids issues with doctors who are not familiar with trust sites and practices, helps ensure trust standards are maintained and safeguards against clinical risk.

Training

Training junior doctors is vital for ensuring the consultants of the future can provide high quality patient care. It is widely believed that such training has suffered in recent years as a result of rota design focusing on EWTD compliance. This view tends to be based on a like-for-like comparison between the time spent by junior doctors in the in-hours period on ‘old’ and ‘new’ rotas. Since August 2009 the time spent in this period has definitely fallen. But does this fall translate into reduced and/or poorer training? The problem is a general lack of information relating to the level of training juniors were getting before and after the introduction of the EWTD. One reason for this is that most rota design has focused on generic duties as opposed to the actual activities worked by a doctor during each duty. Without this vital information it is very difficult to assess accurately the skills required to work the rota and the training potential resulting from working that rota. By linking rota design to the service plan (and in turn consultant job plans), it is possible to carry out a qualitative and quantitative assessment of the training provided by a rota. These could be in the form of formal training sessions, consultant led clinical activities or general exposure to clinical activities. Another benefit to this service driven approach is that it exposes training gaps on new rotas, which can then be corrected on the service plan and consultant job plans. This approach is essential for any organisation wishing to retain its allocation of trainees and the associated tariff.

Multi-disciplinary working

Typically the design of rotas has not considered the requirements of other staff groups that a junior doctor works with in a trust. If these different groups do not work cohesively it is impossible to achieve maximum productivity and income for the trust. Well designed rotas should consider the multi-disciplinary team and eradicate siloed working. This solution is only possible if rota design is based on service planning that recognises the input of all staff groups in the delivery of each clinical activity.

New Deal and EWTD

Once the factors above have been considered the rota needs to be organised in such a way that it complies with both the EWTD and New Deal. But these considerations should only impact the way a rota is organised and shouldn’t determine the number of posts on the rota.

The terms & conditions of service for doctors in training, colloquially known as the New Deal, set out limits on work and rest designed to reduce doctor fatigue and increase patient safety. Trusts are expected to comply with these rules for all junior doctors. Failure to do so can result in punitive financial penalties known as band 3 payments which extend to all junior doctors on a rota, can be backdated to the start of employment on the rota, and pay-protected to the end of a doctor’s time in a trust. The recent ‘Know Your Contract, Know Your Rights’ campaign by the BMA has increased contractual awareness amongst junior doctors and has resulted in an increasing number of banding challenges across the country. Understandably this need to ensure compliance has significantly shaped rota design over the years. However, when compliance is attained without any consideration to the service, the resulting rota may perversely be at increased risk of non-compliance. Consider a clinic that runs until 6pm. The attending junior doctor will breach the New Deal if they work beyond 5pm yet the service demands this. In this instance there is an immediate risk of non-compliance if the arrangement is allowed to persist. The solution can only be found by balancing service needs with contractual restrictions. In this instance the clinic could be moved to an earlier slot or the junior reassigned to an alternative activity.

Since August 2009 all doctors in training have had to comply with the 48-hour limit on working time and the daily and weekly rest provisions set out by the EWTD. This is to ensure the health and safety of the junior doctors themselves by preventing fatigue in the workplace.

Rota review project summary

This white paper looks at the recommendations that have come from our work with a number of trusts and which are applicable to all NHS trusts with junior doctors. The Zircadian Medicus team undertook to review the key processes surrounding the management of junior doctor rotas and analysed the rotas at four different NHS trusts.

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- Milton Keynes Hospital NHS Foundation Trust
- Shrewsbury and Telford Hospital NHS Trust

These trusts cover areas such as Milton Keynes, Wakefield and the surrounding areas. The trusts have approximately 280 junior doctors.

Barking, Havering and Redbridge University Hospitals NHS Trust

Barking, Havering and Redbridge University Hospitals NHS Trust operates across two main sites serving a population of around 700,000, making it one of the largest acute hospital trusts in England. The trust has circa 700 junior doctors.

Mid Yorkshire Hospitals NHS Trust

Mid Yorkshire Hospitals NHS Trust provides community, acute and specialist health services to around 500,000 people living in the Wakefield and North Kirklees areas. The trust has approximately 280 junior doctors.

Milton Keynes Hospital NHS Foundation Trust

Milton Keynes Hospital NHS Foundation Trust provides acute and specialist services to around 300,000 people in Milton Keynes and the surrounding areas. The trust has approximately 180 junior doctors.

Shrewsbury and Telford Hospital NHS Trust

Shrewsbury and Telford Hospital NHS Trust operates from two main sites and provides acute medical services for 500,000 people in Shropshire, Telford & Wrekin and mid-Wales. The trust has over 230 junior doctors.
The trusts which chose to participate in this paper span a range of sizes and geographical locations. Each trust had its own challenges to be addressed as part of the project, but the common theme amongst them all was a wish to confirm that the working practices on the rotas offered the trust the best value for money and ensured the rotas were at maximum capacity whilst maintaining compliance.

In performing the rota reviews the Zircadian team checked current rotas at each trust, with a view to:

- assessing potential risks to New Deal and EWTD compliance;
- minimising banding costs whilst maximising use of available time on each rota;
- modelling the impact of increases and reductions to number of doctors on the rota, rota costs and coverage;
- comparing rota bandings and costs against rotas from similar specialties around the country, in order to validate rota design and cost.

### Summary of results

We calculated that of the 82 rotas we reviewed, 53 (64.6%) were running with minimal risk and with appropriately designed working patterns and optimised pay and coverage.

Out of this group of 29 rotas, the majority of potential savings at each trust could be realised through revised New Deal bandings or removing surplus, non training grade doctors. There were also a significant number of rotas where productivity could be improved by increasing hours whilst maintaining costs, or by rebuilding the rota so they were more in line with the service’s needs.

The rota review project at each organisation was also able to identify good practice and make recommendations encouraging a consolidation of these practices. It also identified risks and made recommendations for mitigating those risks. These recommendations are another key factor in protecting the trusts from future penalties and ensuring that the junior doctor rotas remain sustainable, cost-effective and safe.

Obviously the impact of a re-build varies from rota to rota, but the review highlighted that realistic efficiency savings and productivity gains could be realised at each trust, even without the need for a full review of the service. The study also highlighted the benefits that can be gained from such an exercise to all trusts running junior doctor rotas, regardless of size or type. The graph on the facing page sets out the potential savings that could be realised by a trust depending on the number of rotas they have. In the current climate these opportunities cannot be ignored.

### Predicted savings by number of rotas in a trust

This graph shows the correlation between the number of rotas in a trust on the vertical axis, the number of rotas where savings could be made on the horizontal axis and the predicted savings per annum.

If every acute and mental health trust was to apply the findings of this paper to their junior doctor workforce, then extrapolated over the next three years, this equates to a total possible saving of just over £200m, or approximately 1% of the savings that Sir David Nicholson recommends trusts need to make in the same period.

### Financial Benefits

29 (35.4%) of the 82 rotas we reviewed had potential financial savings. The average saving per rota was £36,896. This means that from just 29 rotas we were able to identify over £1 million of potential savings.

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### £70.5 million

Predicted savings per annum across all 224 acute and mental health trusts in England
Diagnostic tool for poorly performing rotas

Through the rota review projects it became clear that the answers to a number of key questions helped identify the worst performing rotas and those for which large savings could be achieved if they were re-designed. The following questions can be a useful diagnostic tool for helping identify those rotas where improvements can be made.

Questions To Ask

The fastest way to pinpoint badly-performing rotas is to ask some key questions. The questions below can help to identify rotas in which improvements and savings can be made.

1. Robust planning

Rota planning is the foundation for successful rota management. It involves a deep understanding of the contract, the EWTD and the interpretations associated with the different rules and regulations.

Q: Have all your rotas been centrally checked by an expert source?

Q: What is the locum expenditure across the trust and why is it so high?

Q: Are your rotas running with a high level of vacancies that never get filled?

Q: How well linked are your junior doctor rotas to the working arrangements of your other staff groups, e.g. consultants, nursing staff and AHPs?

Not having central control means that rotas are often built with a local perspective and don’t always consider the wider needs of the trust or department. Best practice is unlikely to be followed. This leaves the trust at huge risk of facing challenges, either to the rota itself or to the complex process for implementation of new working patterns and management of existing ones as set out in the contract.

Locum costs are a key indicator of how well managed a department is. All leave should be covered from within the department, whilst rotas should be designed to cover all shifts necessary without external resource.

If so, you could be paying a large sums for external cover (possibly six figure sums). It is possible with expert support to reconfigure these rotas so that your internal resources are used more effectively to fill any gaps in cover.

There are large efficiency and productivity gains to be made from properly connecting the work plans of your disparate staff groups to create efficient multi-disciplinary team working. However, this is often a complex and multi-faceted project; the right tools and experience are vital for success.

2. Access to sufficient knowledge and expertise

Junior doctors are governed by two distinct sets of regulations – the New Deal and the European Working Time Directive. As one might imagine, understanding and managing these regulations and all the overlaps and differing interpretations is extremely complex. Junior doctors are generally managed by a medical staffing team within a trust, but these teams often suffer from high turn-over and are facing budget cuts. There is also often a lack of detailed knowledge at executive level and little centralised NHS help to provide a back-up knowledge base to trusts.

Q: Does the team checking your rotas have expert knowledge of best practice rota building methods and in depth knowledge of junior doctor regulatory frameworks and contractual issues?

Q: Are you following contractual processes for implementing new or changed rotas?

Q: What training and support is available for your rota coordinators?

Regulatory guidance is incredibly complicated and open to interpretation. A working knowledge takes time to develop. High staff turnover and a lack of training and external support can have a profound effect on medical staffing teams responsible for managing junior doctors who bring inherent financial risks and account for a large proportion of a trust’s staffing costs.

Not following contractual guidance leaves the trust open to band 3 payments.

For such a detailed area there is very little external support available. You need to ensure that your staff has access to the highest quality training and support from leading specialists in junior doctor working practice.

3. Strong audit processes

It is a contractual obligation for a trust to monitor its doctors twice a year to check for continued contractual compliance. If monitoring is unsuccessful, then a re-monitoring exercise is required. This process and the subsequent analysis is critical to demonstrating compliance from an employer’s perspective. If not performed with strict processes in place, it can leave the trust at significant risk of band 3 challenges, unexpected increases in banding supplements.

Trusts should ensure there are mechanisms in place to quickly identify potential issues highlighted during monitoring. It is vital that these are investigated and solved in a timely fashion. This can be greatly assisted by the use of software that electronically collects monitoring data and allows for daily reporting of issues and returns.

This monitoring data also provides the evidence required to optimize the rotas and introduce changes that can bring financial savings or increase productivity, e.g. modify coverage to cover gaps or increase clinic attendance.

Q: How robust are your monitoring practices?

Q: Do you have good monitoring returns?

Q: Are your monitoring rounds valid?

If you’re not confirming the rotas being worked are consistent with the planned rotas you leave yourself open to banding challenges and you have no knowledge if anything has changed. If a banding challenge is successful the penalty payments are often backdated to the last confirmed, compliant monitoring round.
Conclusion

The NHS is faced with the challenge of improving productivity and managing the medical workforce, yet one staff group still remains relatively untouched. Junior doctors, and the manner in which they work, have largely been overlooked, even though there are huge opportunities to unlock savings and maximise efficiency. Now is the right time for reviewing junior doctor work patterns and aligning their design to service objectives, whether those objectives are to achieve financial savings, increase productivity, protect against penalties or to improve training opportunities.

Junior doctors account for a significant proportion of staff costs. A trust with 100 junior doctors will have related salary costs of approximately £4.5 million. Worryingly, for every 100 junior doctors an additional locum spend in excess of £1 million is not uncommon. There is a huge opportunity to look at this expenditure and ensure that the working patterns are optimised to deliver a cost effective work force and reduce locum spend.

Most recently the focus on junior doctor rotas has been on maintaining the EWTD compliance levels achieved in 2009. Since then too many rotas have remained static with minor tweaks rather than wholesale change to reflect the changing needs for service and education. This white paper has highlighted the challenges involved with junior doctor rotas and demonstrated the scope of benefits that can be achieved from aligning rota design to service needs, and the potential financial gains that can be realised from reviewing all rotas on a regular basis. The rota review service is an essential health check for a trust and can provide quick and achievable wins.

Key Point

With every 100 junior doctors in a trust generating salary costs of approximately £4.5 million, locum costs in excess of £1 million due to badly performing rotas are not uncommon.

Authors

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Dr Henry Carleton trained as a junior doctor at Barts, where he developed an interest in effective medical workforce management. In 1999 he joined the Thames Regional Action Team as Junior Doctors’ Advisor, where he helped NHS trusts tackle the challenges of rota design and the New Deal. In 2000 Henry co-founded Zircadian to provide expert support to trusts in managing their doctors more effectively. Over the course of the next twelve years, as Managing Director, Henry established and grew the company’s reputation as leading specialists in the organisation of the hospital doctor workforce, building relationships with over 140 NHS organisations. By the time Zircadian became an Allocate Software company in 2011, approximately 50,000 junior doctors and 16,000 consultants and SAS were using its systems. Henry now brings the benefit of his experience and expertise to his role as Director of Medical Workforce Planning for Allocate Software, leading the Zircadian Medics team.

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Senior Account Manager
Richard Lucas is Senior Account Manager for Allocate Software’s Zircadian Medics team. He is one of the company’s leading specialists in junior doctor working arrangements, particularly in the complex area of rota design and management. Richard’s detailed working knowledge of both the New Deal contract and European Working Time Regulations enables him to regularly advise trusts on complex rota builds, contractual processes and best practice methods to help them keep rota costs to a minimum and avoid costly non-compliance issues. Over the course of his six years in this field Richard has led on a number of high profile consultancy projects, including complete reviews of all rotas across both Wales and the West Midlands to help meet the 48-hour working time targets introduced in 2009. On a smaller scale he has worked with numerous individual trusts throughout the UK to maximise their use of the junior doctor workforce by, for example, advising on the introduction of Hospital at Night working practices to streamline emergency care provision, improve patient care and release efficiency savings. Richard also regularly runs training workshops on medical workforce management for professionals working within the NHS.

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Dee Enright is Marketing Manager for Allocate Software and has extensive experience of working both in and with the NHS. Prior to her work in the private sector, she was Communications Manager for a mental health, learning disability and community trust in Cornwall with over 2,000 staff across multiple sites throughout the county. There she managed both internal and external communications, print and digital publications, and public and media relations. She later went on to work in freelance journalism before joining Zircadian, now an Allocate Software company, in 2008. Since then the focus of her role has been marketing specialist software and services for the management of hospital doctors to the acute and mental health sectors. Upon Zircadian becoming an Allocate Software company in 2011 Dee joined the Allocate marketing team, handling activity around integration of the company’s respective software and service ranges. She now works across a global healthcare solutions portfolio.

Dr Masood Ahmed
Director of Medical Services
Dr Masood Ahmed is one of a handful of medics with a detailed knowledge of the European Working Time Directive (EWTD) and the New Deal contract for doctors in training. He is the author of ‘Rota Design 2009’ and ‘A Compendium of Solutions for Implementing the Working Time Directive for Doctors in Training from August 2009’. In his previous role as Associate Medical Director of the West Midlands Deanery Action Team he was the deanery lead for the first stage of implementing the EWTD for over 4,000 junior doctors. As former Chairman of the BMA Junior Doctors’ Committee Negotiating Team, he led on the current specialist trainee pay scales negotiations. He has worked in close partnership with the Skills for Health Workforce Projects Team and the NHS North West EWTD Medical Development Team in tackling the challenges of the EWTD. In recent years Masood has led the Zircadian Medics banding appeals team and is now Director of Medical Services for Allocate Software.

Engage

To explore any of the points raised in this white paper contact Dee Enright at Allocate Software
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