

Righting Wrongs: Our Duty to Exception Report

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Abstract

Objectives: The 2016 Junior Doctors Contract agreed between the government, the British Medical Association (BMA) and NHS Employers made many changes to the working life of junior doctors in England. It also introduced ‘exception reporting’, the system by which doctors can highlight “non-compliant” and “unsafe” working schedules¹. Three years on, as re-negotiations are taking place, we set out to evaluate the effectiveness and perceptions of the exception reporting process. Is the current system a useful reflection of the workplace; and if not, how could it be improved?

Methods: We distributed an anonymous online survey which included both quantitative questions and free-text areas. This was mostly spread via word of mouth. This survey was distributed to British junior doctors both in 2018 and 2019, gathering a total of 964 responses over two years.

Results: Significant factors preventing respondents from completing reports included fear of creating a bad impression, and a lack of change following reports. Over 25% of participants reported that they had been actively dissuaded from exception reporting by their seniors. Many recounted upsetting experiences with colleagues.

Conclusions: Our findings suggest that cultural workplace norms, in conjunction with in-built reporting flaws, constitute a significant challenge to addressing concerns regarding safe working hours. Junior doctors frequently work beyond contracted hours, yet almost half of those surveyed have never filed an exception report. These risks promoting a culture of expected overworking, in which challenging the status quo is met with negativity, projected inadequacy and pushback. Resistance to reporting is multifactorial, however many have suggested changes to the current system which could remove these barriers; improving our ability to understand the lives of our junior doctors and reflect on the safety of their patients.

Keywords: Exception report; Training; Contract; Junior doctor; Safety

Introduction

The 2016 Junior Doctors Contract affected over 55,000 doctors, sparking the largest strike in NHS history [1]. It resulted in many changes to the working life of junior doctors; including the introduction of a new whistle-blowing system referred to as ‘exception reporting’ [2]. A “guardian of safe working hours” was appointed – a senior member of staff responsible for monitoring and raising issues involving patient safety (with regards to overworking junior doctors) [3], and to act as an advocate protecting the rights of junior doctors within the contract.

Exception reporting is the process designed to help protect junior doctors, allowing them to raise issues, including but not limited to; differences between real and contracted working hours, inability to take mandated breaks, missed educational opportunities, and lack of clinical support [2]. Reports generated by junior doctors can also form a basis of evidence to enact change within a hospital, for example by highlighting understaffing, or lack of training opportunities. Anecdotally, we found

that junior doctors neglected to file exception reports, allowing issues to flourish unnoticed and unchallenged.

In this article, we propose to investigate adherence to exception reporting, and factors affecting compliance. We hope that this will enable us to build a picture of the true usefulness of exception reporting, and to suggest changes where reasonable, and possible. Our main aims are to investigate whether junior doctors file exception reports, what dissuades reporting, and whether the process could be improved. As of yet there is no published research on this matter.

Methods

We created an anonymous survey online to be distributed amongst junior doctors. Some disseminated the survey via official newsletters, but for the most part, it was spread by word-of-mouth. Outcomes measures included:

- Frequency of reporting time work beyond contractual hours
- Factors discouraging the completion of reports
- Perceived efficacy of exception reporting

There were also free text areas available regarding obstacles faced when raising issues related to exception reporting. This allowed participants to share experiences and suggest improvements. This was first distributed in 2017. Results were gathered and discussed with junior doctor deanery representatives at the annual Foundation Doctors Advisory Board meeting, where representatives discussed changes that could be made locally, as well as other useful information which could be gathered. In the second iteration of the survey, we included another outcome measure:

- Knowledge of the exception reporting process for missed breaks and opportunities

As with all optional surveys, there may be self-selection bias involved, which could skew results. We also could not prevent participants answering the questionnaire twice and relied on responders’ honesty. Additionally, the anonymity of the survey does not allow us to follow up on comments, and is subject to self-selection bias; however, we feel that this method best provides honest, unfiltered results.

Ethics

Participation in the survey was voluntary, and the guarantee of anonymity is made clear. An explanation of the study was given, with the explanation that responses may be published in research. Consent could be withdrawn at any time by not submitting the survey. It was also stated that if participants choose to self-identify or report anything that raises patient safety concerns then the relevant Guardian of Safe Working hours would be contacted. No further ethical approval was felt necessary.

Quantitative Results

We received 964 responses in total; 652 responses in 2018 and 312 responses in 2019. The findings of the first survey were presented to foundation deanery representatives in late 2018, and following advice from representatives, three changes were made to the 2019 survey:

- In response to the multiple-choice question “Do any of the following discourage you from exception reporting?”; two further options were added. These were: “other difficulties with submission” and “lack of changes made due to reports”
- The addition of the question “Have you ever completed an exception report for missed breaks?”

- Free text areas were provided in the 2018 survey when the “N/A” option was selected, possibly leading to the overrepresentation of this response. The free text was removed in the 2019 survey; encouraging respondents to select the response most closely matching their experience.

Qualitative Results – a Thematic Analysis

The junior doctor experiences

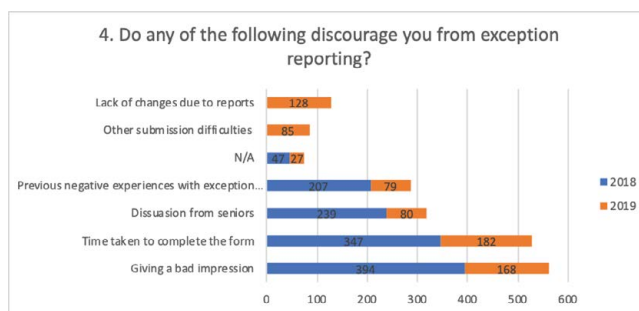
Junior doctors were invited to leave free-text comments in relation to their experience. A total of 394 of the 964 respondents expanded on their answers with free-text comments (191 in 2018, 203 in 2019). Analysing these comments reveal a number of common themes, which we explore in turn. These include:

- discouragement from exception reporting by senior colleagues
- inefficient process for exception reporting
- lack of faith in the process
- cultural barriers to exception reporting
- lack of knowledge around breaks and educational events

Percentages in the following Sections Refer to Only those who Added Free-text Comments

Discouragement by senior colleagues

Over 70 responses (18%) described incidents of junior doctors being discouraged from exception reporting by senior colleagues – two responses even suggest that this discouragement originated from the



guardian of safe working hours. Several stated that “you would feel judged” as being a “lazy doctor”, showing “a lack of commitment”, or running the risk of being “labelled as a trouble maker”. One respondent stated, “I had my supervisor question my dedication, performance and professionalism as a result [of exception reporting],” and another that, “I have heard of supervisors threatening to fail people for ARCP if they exception report.” Some respondents indicated that the reason exception reporting was discouraged was to “avoid drawing attention to the department”.

One recurrent feature is the reluctance of junior doctors to arrange meetings with their supervisors to discuss exception reports; this is a *mandatory* stage in the exception reporting process in order to establish an ‘outcome’ for each exception raised. Some reported that these meetings felt “accusatory” and “patronising” and that they “sour the working relationship between clinical supervisors and [junior doctors]”. One respondent suggested that, “it’s counter intuitive to have the person who is responsible for signing you off on your placement competency being the same person who receives the exception reports”.

Organising these meetings was described as “a hassle” and “a burden” for both supervisor and junior doctor, as well as “often very unrealistic” to get meetings arranged within the dictated time-limit. Some junior doctors were unable to exception report as their particular supervisor was not registered or trained in the process, or, as in the case of one junior doctor, “both my clinical supervisor and educational supervisor deem that it is not their job”.

Inefficient process

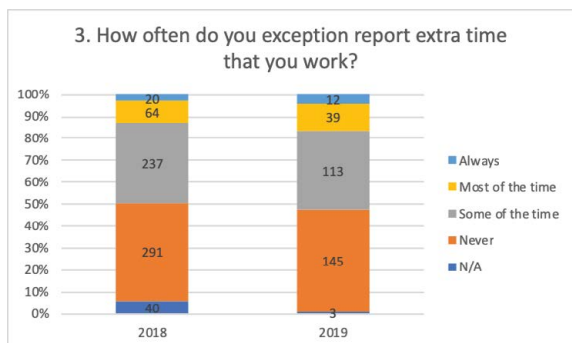
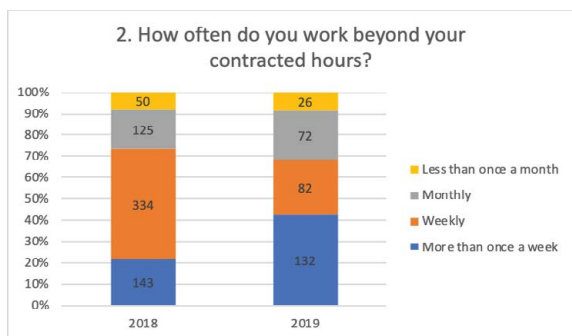
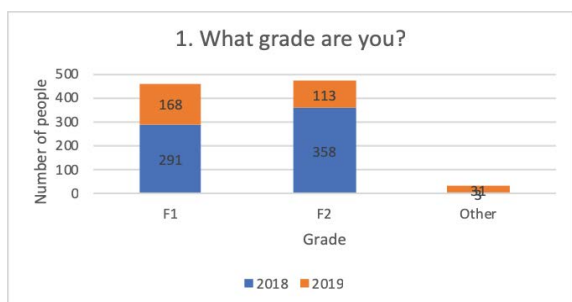
Over 30 respondents (8%) commented that they were put off from exception reporting due to how “time-consuming” the process is, with a further 60 indicating that the system itself is “awkward”, “clunky”, “complex” and “laborious”.

Nearly 90 respondents (23%) described difficulties accessing and using the exception reporting system. Many stated that they had “never been showed how to use the system” and others indicated that they were “given no login.” In some trusts junior doctors have to specifically request access, and delays in this process are not uncommon; “[it] took them 6 months to give us access to the webpage to exception report”.

Beyond access, junior doctors encountered difficulties filling in “tedious” forms, which are described as “quite difficult to get your head around”. The forms require “lots of details [which are] hard to find out”, with “options to pick from drop down boxes” that are often “not intuitive” – for example, “not all of [the clinical supervisors] were registered on the system” and as one respondent explained, “it was difficult to allocate the specialty I was working on as there was no category that was appropriate”.

Lack of faith

Arising frequently was a lack of faith in the exception reporting system. Close to 100 respondents (25%) expressed belief that exception reporting “does not work”, that “nothing happens”, and “nobody reads them anyway”. Many described experiences of filling in exception reports and having “received nothing in return”, with many “still



waiting on a reply". Many more do not complete exception reports at all, citing that – "trainees gain next to nothing from reporting, while suffering potentially significant personal cost in setting consultants against them"; and, with a similar pragmatism, that "esoteric talk about changing systems in the future makes little to no difference to the trainee that will potentially suffer reputational damage from reporting".

Many highlighted issues with the provision of compensatory time off in lieu (TOIL); "the time you get off in lieu never actually comes into fruition" as it is "often not possible due to rota gaps". Of note, the junior doctors that do exception report often do so as a direct result of understaffed wards; there is a sentiment that, "it's frustrating taking time off in lieu because you know by doing so you compound the problem you and your colleagues have, which causes the exception reports in the first place". Although monetary recompense for extra hours worked is a theoretical alternative, for many, this has yet to materialise; one respondent stated, "I have yet to receive this money, and no one in staffing, payroll etc. will accept responsibility for sorting this out".

Even those trainees who did receive financial compensation or time off in lieu report frustration that no real systemic changes are made as a result, with one stating, "I have never known of any other issues to be actually resolved or for anything to change as a result of exception reporting". One respondent iterated that, "little has been done to rectify the difficulties with the poorly designed rota, which was supposed to be highlighted by exception reporting".

Cultural barriers

Pervading much of the feedback is the idea that exception reporting is conceptually opposed to the contemporary working culture of the healthcare industry. More than 70 respondents (18%) described cultural reasons for not exception reporting, such as "starting early and finishing late is the expected thing to do"; "[there is] an environment of expectation and acceptance that the job is done when it is done, and it is not always easy to speak out against this", or that "general culture can make exception reporting feel as if you are letting the team down/weaker than colleagues/not performing with the right spirit". One respondent said, "I feel the culture around exception reporting in the UK is still conflicted. I think the NHS runs on goodwill – everyday hundreds of staff stay late and the exception reporting system is a valuable way of evidencing this, however it only works if everybody does it and...this seems a far off idealistic dream".

Junior doctors who exception report is concerned they may be regarded as "lazy" or "incompetent" for doing so; "I feel the blame can be easily shifted to the junior doctor for not working efficiently enough, which dissuades me from reporting". One respondent stated, "if everyone doesn't do it, you can seem like an outlier in your team for reporting", with another adding that, "no-one else on the ward reported...my clinical supervisor got emailed asking if there was a problem with me and my efficiency". There is not a universal culture of exception reporting, and a common sentiment underlying avoidance is of "other colleagues not reporting and therefore feeling anxious to report as seniors feel that it is only me who 'complains'".

Breaks and educational events

As well as highlighting extra hours worked, junior doctors can use the exception to also highlight missed breaks or educational opportunities. From over 50 responses (13%) received it is apparent that few respondents know this option exists – "I didn't realise we should be reporting this".

Several respondents noted that they are "not aware what breaks [they are] entitled to" with some indicating that, "I miss breaks regularly" and that reporting these, "would be a daily occurrence". A small number of respondents indicated a belief that they are not entitled to any breaks at all, with comments such as, "[I] didn't realise that we have breaks", "are we allowed breaks?"

Some respondents voiced concerns that "if we attempted to exception report missed breaks I imagine we would simply be personally blamed for not taking our breaks and the workload and rota gaps causing the problem [would be] ignored". Another added, "I strongly suspect exception reporting missed breaks would be an instant black mark from the senior team".

Positive feedback

Among the free-text comments there were a number of positive comments about exception reporting. 20 respondents (5%) gave positive feedback, including that, "my trust is very supportive", "[my] educational supervisor was very understanding" and "when seniors are keen for you to exception report it definitely works". On four occasions, free-text comments were used to describe examples where exception reporting had resulted in a positive change to the workload or to the rota. In one case the respondent wrote that, "everyone exception reported each day and it was swiftly dealt with by altering the rota and reimbursement for the hours". This feedback provides evidence that, if used correctly and encouraged appropriately, exception reporting could be a useful and effective tool – but only if the culture changes and the junior workforce accept and acknowledge their role in promoting change.

Discussion Summarising Junior Doctor Suggestions for Improvement

Junior doctors were invited to leave free-text suggestions for ways in which the exception reporting system could be improved. These can be summarised under the following sub-headings:

- Compensation
- Format of exception reporting process
- Technological improvements
- Involvement of the clinical supervisor
- Induction for junior doctors
- Changing the culture

Compensation

One of the suggestions made by junior doctors is to ensure that compensation is received for exceptions that are highlighted by these reports. The main obstacles identified are: supervisors not approving reports in time; difficulty in getting time off in lieu; and the complex paperwork needed to obtain financial recompense.

In relation to response time, one respondent suggested that there "needs to be a default option, if exception report not dealt with/refused after 'x' amount of time then given pay as default". This would then theoretically "incentivise your supervisors...to respond within 7 days".

Time of in lieu is reported as being "impractical", and as one respondent put it, "TOIL is often given but difficult to arrange in practice and little monitoring of whether it is ever used, seems to be a token gesture". Therefore numerous junior doctors indicated that "doctors should be paid for overtime", with one adding, "maybe then there would actually be an incentive to fix the issue".

In terms of payment, respondents were frustrated with the extra paperwork required, and emphasised strongly that, "this should be added to your pay slip automatically".

Format of exception reporting process

In terms of format, the layout of the exception reporting form, the amount of information required and the need to complete an entirely new report for every exception occurring are all sources of frustration for junior doctors. Respondents suggest that it should be, "a quicker

and easier form to complete” with, “fewer steps – at present it is use the online form, have meeting with supervisor (often rate limiting step), fill in paper form, return to admin staff (varies depending on rotation)”. Respondents also felt that junior doctors should, “not have to justify what you did to try to avoid staying late – you are a professional doing things for patient care not staying late deliberately”. To ease the time burden of completing individual reports for each time a junior doctor stays late, it was suggested that, “rather than having to exception report every single event, [there should be] an option for doing a monthly or weekly ‘summary’ of events”.

Several people suggested that the exception reporting system should be eliminated and completely replaced with a more structured system of, “clocking in and out of shifts using smart cards [which] would mean that you got a more accurate picture of how often junior staff work overtime”. This idea was echoed with the suggested advantage that, “if we leave late this is automatically logged”. This would be a difficult system to initiate on a national level, particularly considering the complex shift patterns that most rotas follow, but the automated aspect makes it appealing in terms of limiting the burden of work on the junior doctor. It would also as one respondent emphasised, remove the “voluntary” aspect of exception reporting, making it a more acceptable process.

Technological improvements

One of the most universal areas with suggested need for improvement was the software itself that is used for exception reporting. Junior doctors felt that if the software was “more accessible” and “less cumbersome” it would improve ease of use. Suggestions for making it more accessible included having, “a weblink on the dashboard/desktop of all NHS computers”, an “easily marked link on ePortfolio,” or if it “were linked directly to our individual rota”.

The most frequent suggestion in this domain was development of “a mobile phone App”, by which junior doctors could log in on their own devices and thereby complete exception reports more easily and at their convenience. Respondents thought this would be “simpler” and more “user friendly”.

Involvement of the clinical supervisor

Over 50 (13%) respondents suggested that involvement of the clinical supervisor in dealing with exception reports should be minimised. Several believe that exception reports should be “signed off by your educational supervisor rather than your clinical supervisor”, presuming that the educational supervisor is, “someone working in a different department”. Others emphasised that “the discussion should be with a neutral person” or someone who “does not have a bearing on your performance assessment”. Examples given were the rota coordinator or the guarding of safe working hours. One respondent suggested that, “clinical supervisors should not see exception reports or be involved in the process. Then you would not have to worry about it affecting your end of block report. The initial report should be looked at and accepted by an ‘exception report admin team,’ unless it is clearly not a good reason and then the doctor could be contacted for further information. If you found a lot of reports from the same department then this could be fed back anonymously to an exception report lead for the unit”.

Many respondents felt that there should be no mandated meeting at all, with one stating, “I feel that justifying the circumstances in writing when completing the exception report should be sufficient and there should not be necessary for additional discussion with supervisor. I feel this is [a] waste of time and in a way feels as if we are interrogated”. It was felt by many that reports, “should go directly to the people who sort out payment”. Some respondents argued that it might be an advantage to have an anonymous option; “exception reports should be anonymous and you should not have to put a named consultant on the form”. In

this way, although junior doctors would not be able to benefit directly from compensation for the extra hours, they would avoid the perceived negative implications associated with exception reporting, whilst still highlight rota and workload issues to the trust.

Induction to exception reporting

Access to and awareness of the exception reporting process was highlighted repeatedly as an obstacle to junior doctors completing exception reports. It was clear in the free-text suggestions that the respondents to our survey would appreciate having a formal and clear induction to the system; “it would help if there was a dedicated session during all doctors’ induction about exception reporting and how to access the system as well as receiving a copy of your login at this time”. Respondents felt that this induction should be “compulsory” and that a “mandatory training module” might be helpful.

Changing the culture

Respondents had many suggestions for how to go about changing the culture towards exception reporting. The most frequent suggestion was, “educating seniors on why exception reporting is worthwhile and necessary”. Many want to, “ensure consultants know it is not acceptable to dissuade juniors from exception reporting”, with some suggesting, “sanctions for clinical supervisors who are openly critical of the process and people who exception report”. Junior doctors called for, “compulsory training for consultants on dealing with exception reports” in particular “for clinical supervisors who do the initial review of the report”.

Conclusions

Many respondents called out areas needing change. On the basis of the qualitative data collected and analysed in this study the main suggestions we have developed in order to improve the exception reporting process going forward are as follows:

1. Develop a more user-friendly process (such as an app) through which exception reports can be filled out by junior doctors
2. Consultants, particularly those in supervisor roles, to be provided with detailed training on the exception reporting process
3. Every Trust induction for junior doctors to have a mandatory session on exception reporting and all junior doctors to be provided with log-in details at this point
4. Trusts should be mandated to provide (and enforce) TOIL or pay for all approved reports

Faith in exception reporting is low; and more dangerously, the comments we have received suggest that trust in the idea of reporting unsafe working hours is broken. Urgent work is needed to address this not only for the benefit of junior doctors, but for the patients that we strive to protect.

Acknowledgements

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