ACB News

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Culyer and Clinical Biochemistry

NHS Pay

Working Time Advice

Research Matters

About ACB News
The monthly magazine for Clinical Science

The Editor is responsible for the final content. Views expressed are not necessarily those of the ACB.

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Front cover:
The Focus 99 Exhibition in Manchester was a great success.

Pathology 2000
BIRMINGHAM 15-17 MAY

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AGM Votes for Affiliate Members

At the AGM, held at the start of Focus 99, several matters of considerable importance for the future of the ACB were discussed and voted on. The meeting was well attended and here are some of the decisions taken.

The 1999 Annual General Meeting

Affiliate Membership . . . Massive Majority

Dr Mike Thomas spoke to this change in the bye-law which will enable State Registered MLSOs and those in similar employ to join the Association with the creation of a new category of Affiliate Membership. The underlying reasons for this had been presented to Members by ACB Chairman, Dr Ian Barnes, both at roadshows around the country and by letter. This proposal was voted on by a show of hands and the counting of proxy votes, and was carried by a vast majority.

Financial Report and Subscription Increase

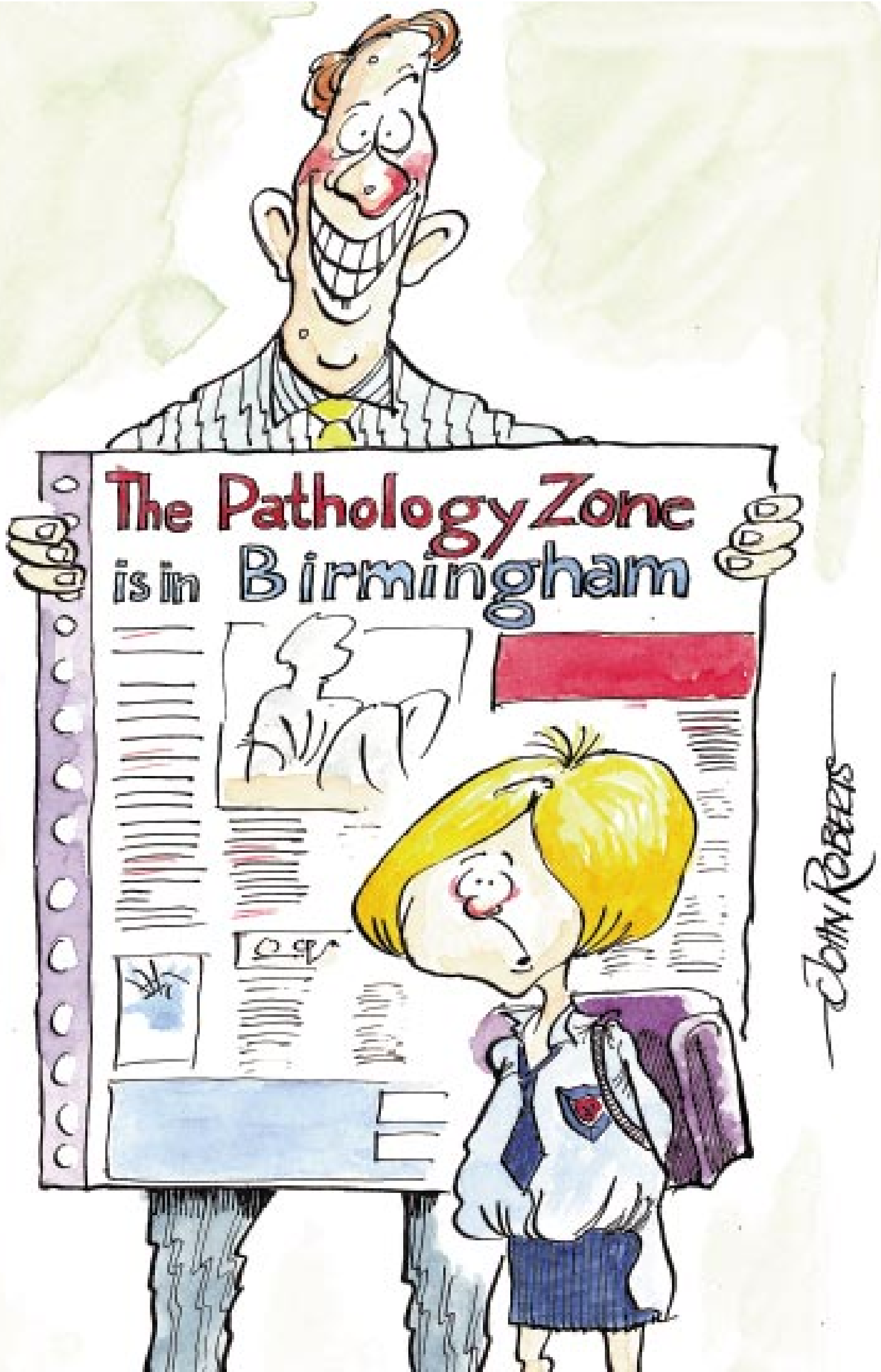
Dr Dennis Wright pointed to the £40,000 surplus of the income over expenditure in the Association Accounts and that £25,000 of this was due to a final payment from the XVI ICCC meeting. Dennis also pointed to the change in the way the £1 million annual turnover was now handled by the ACB Office and he thanked Dragana and Hilary in the ACB Office for all their efforts. Dr William Marshall asked of progress in setting up a finance committee that was discussed at the last AGM. Dennis replied that this had been discussed and the Executive were now putting more emphasis on regular discussion of financial matters but did not feel a formal committee was needed.

Dennis pointed to the need for membership subscriptions to cover the basic costs of running the Association. There are a number of financial pressures which include new office premises, additional administrative support and uncertainty about the continuing surplus from the Focus meeting. The Federation of Clinical Scientists was also an increasing cost pressure. Taking all this into account the Executive believe that subscriptions needed to produce an additional £50,000 of annual income to ensure prudent finances. The Treasurer pointed out that the ACB subscriptions only contributed 14% to ACB income but that this was much higher in other comparable organisations. The proposed increase in subscriptions was accepted by a vote of 212 in favour and 73 against with 10 abstaining.

New Committee Faces

Only single nominations for election of Officers were received and Dr Peter Wood was elected as Secretary. A postal vote for National Member was held and Dr Marek Dominiczak was elected. Professor Alan Shenkin has agreed to be nominated as President Elect of the Association and Council have appointed Dr Ian Barnes as Chairman for a further year. Mr Stephen Halloran has become the Chairman of the Publications Committee. ■

The ACB Executive: Sandra Rainbow, George Elder, Ian Barnes, Mike Thomas and Dennis Wright



"Are they as good as Boyzone Dad?"

Association of Professors of Clinical Biochemistry

By Professor Tim Peters and Professor Chris Price

This year's Annual Awayday Meeting was held at King's College, Cambridge on 9th-10th April 1999

The Heads of Academic Departments of Clinical Biochemistry recently held their annual awayday event; this time in the peace of King's College, Cambridge. The objective of the meeting was to learn about some of the important developments in clinical biochemistry both in research, clinical practice and teaching.

The first speaker was Dr Tom Weaver from Incyte Genetics, a Cambridge biotech company now part of a Palo Alto parent company. He described the expertise of the company and its major objectives. The company had particular expertise in DNA sequencing, in genetic mapping and in micro-array expression and he illustrated some of the novel techniques being developed to attain a physical map of the genome whilst also discovering new genes and their structures. It is the intention to sequence and describe the genome by the year 2000 and the company utilises all of the sequences in the public domain to complement its own discoveries. The work described by Dr Weaver illustrated an interesting trend in scientific research with a huge amount of data generated from a few hours of benchwork requiring several months of data manipulation before a result is produced.

Dr Weaver also described other techniques that are being utilised to probe the genome but which might also have diagnostic applications. He illustrated the unique discriminatory power of MALDI-TOF mass spectrometry and multiplex particle technology. The latter has recently been developed into a commercial assay to enable allergy testing with a total of 64 allergens being probed in a single array.

One of the exciting developments described was the analysis of single nucleotide polymorphisms (SNP) and here Dr Weaver stressed the importance of good clinical material to enable the unique SNPs associated with specific diseases to be identified. He illustrated this with a collaboration in Cambridge on Type 2 diabetes using a population database of 25,000 people in East Anglia.

Trend to More Measurement

Professor Stephen O'Rahilly from Cambridge then picked up the challenge of metabolic medicine and the future role of clinical biochemistry as an academic subject. His message was clear, clinical biochemistry is a core subject both from an academic and a service viewpoint. However, in terms of clinical practice it would be essential to increase the clinical training of medical trainees. From an academic standpoint it was important to recognise the scientific and strategic contribution of the discipline and to make the subject more attractive for both medical and science graduates. At a practical

level there was always going to be a need for biochemical measurements, in fact this trend would increase as more of the techniques in other disciplines became based on biochemical principles.

Professor Tim Cox from Cambridge approached metabolic medicine from a slightly different standpoint describing the on-going discussions between the Royal Colleges of Physicians and Pathologists to develop a CCST in metabolic medicine. The practical fact is that there is an increasing need for physicians to manage patients with metabolic diseases because they are now living longer, well into adulthood. However, it also became clear that there were several views as to what constituted metabolic medicine, the extremes reflected in the management of diabetes and patients with Gauchers disease.

Professor Cox pointed out that metabolic medicine was originally recognised as a clinical specialty but that it had not been included in the European Medical Specialist Qualification Order of 1995. The NHSE were also concerned to not encourage a proliferation of specialties. The initial submission for metabolic medicine to the STA had been rejected because it was thought not to be sufficiently different in its training requirement from existing specialties. However, efforts were continuing to reverse this early rejection. Several speakers supported the need for future Clinical Biochemistry trainees to have the MRCP.

Professor Bloom pointed out that the new PCGs wanted analysis, interpretation and clinical advice on their patients samples. In order to achieve this chemical pathologists must continue to see patients and practice clinical medicine. The non medical clinical biochemist involved in the interpretative function would have to be trained for this role and also demonstrate his/her competence.

Technology Transfer

Professor Vadgama gave an excellent talk on technology transfer, initially describing the increasing opportunities for cooperation between academia and industry and pointing to the recent change in philosophy more explicitly linking scientific research with wealth creation. He outlined the government initiatives to promote research including the Realising Our Potential programme, increasing industry input into the Research Councils, the Link schemes, the Technology Foresight programme as well as the activities of the Office of Science and Technology and the Department of Trade and Industry. Specific funding initiatives included CASE awards, the JREI and JIF programmes as well as the Teaching Company Schemes.

Professor Vadgama described the role of the university in promoting technology development and transfer including the provision of facilities, infrastructure and contacts, together with licensing expertise and loans. He then went on to describe the process of protecting intellectual property. Whilst much of the discussion might have been considered to be most relevant to academic departments the increasing commitment to research in the NHS means that the issues are also relevant to research scientists employed in the NHS. The most important point here is probably the validation of results through signing and dating of work books when filing intellectual property.

Dr David Brown, Director of R&D for Addenbrookes NHS Trust, described the advent of the Culyer funding mechanism in Cambridge. The research component of SIFTR was seen primarily as a means of protecting access for the Wellcome, Research Council and charities funded clinical research which was particularly relevant to those teaching Trusts with portfolio research profiles. He stressed the importance of the outcomes from this first round of funding as being the ability to attract additional research money and in this Cambridge had clearly gone out to attract additional money. This has to be an important message for all Trusts looking to increase their research levy in the future and would be an important factor for non teaching Trusts also wanting to attract funding. Dr Brown also suggested that the next RAE outcome would guide future NHS R&D funding.

Dr David Pilsbury from the Higher Education Funding Council in Bristol then described the organisation of the research assessment exercise and its goal of achieving selective funding, improving quality and providing accountability. He stressed that there was a desire to achieve greater transparency in the process and that there was an intention to consult widely on the detail of the next exercise. Particular concerns were expressed by delegates concerning the effects of declaring all staff including those with honorary contracts, eg NHS staff involved in teaching and research as against declaring only those involved in defined research groups, the influence of multidisciplinary research initiatives, recognising the contribution from clinical biochemistry and the effect of publication behaviour (impact factors, etc). The opportunity to talk directly to somebody involved in the organisation of the research assessment exercise was greatly appreciated.

Professor Percy Robb updated delegates on changes in the undergraduate medical curriculum. He stressed the decreasing dependence on formal teaching and separate teaching of pathology, the advent of problem based learning and the opportunities that have arisen from the use of special study modules (SSMs). The SSMs are short programmes (typically 2-10 weeks depending on the institution) providing an opportunity to study topics in depth. Although some institutions appear to use it as an opportunity to provide a pathology course the intention was to develop innovative projects and approaches to learning; these opportunities existed to involve students in clinical research projects, audits, systematic reviews as well as gaining specific laboratory orientated skills.

Changing Needs of Pathology

Professor Fearns described the changing needs of postgraduate education and training. He particularly emphasised the importance of higher education establishments meeting the changing needs of pathology as well as the changing needs of the workforce in the NHS. He indicated that courses were becoming more flexible in their organisation with modularisation to meet differing needs. It was also important to recognise the need for a balance between academic and vocational training, highlighting the importance of aspects of training that were relevant to postgraduate students studying for higher research degrees.

Dr Stansbie as chairman of the College SAC in Chemical Pathology drew the meeting to a close highlighting some of the issues being addressed by the College at the present time, including training of medical graduates toward a greater clinical role, the involvement of the College in education and other academic activities, workforce planning for pathologists and state registration of Clinical Scientists. Dr Stansbie was able to avoid the vexed issue of the Think Tank document as the President of the College, Professor MacSween, had spoken at the dinner the previous evening. In his speech Professor MacSween described the background to the initiative and the draft report that preceded the published version indicating that he was more than a little perplexed by the fact that Clinical Scientists had objected to the first (unpublished version) whilst the histopathologists in particular had objected to the published version. Whilst there was widespread agreement that closer collaboration was important, the details of the initial remit of the original discussion group was questioned. It was also recognised that it was important to clearly establish the competencies of each professional group with opportunities for transfer, retraining, etc, but in such a way that the interests of the patients were always protected.

The spirit of the meeting was extremely positive and delegates felt that despite the many challenges that beset professionals in clinical biochemistry, both service and academic, there was much to be proud of and that the discipline had an exciting future. However, the importance of good promotion of the subject to undergraduate and postgraduate students, to doctors and other health professionals, to administrators and decision makers and to the patient was extremely important.

Members thanked the Chairman and Secretary for their contributions during the past three years. Professor George Elder and Dr David Stansbie are, respectively, the succeeding Chairman and Secretary of the Association. ■

Academic Departments of Clinical Biochemistry

By Chris Price

Special Study Modules Response to Questionnaire

A total of 17 responses were received, some including a great deal of valuable additional information.

1. Have you introduced a new more problem based undergraduate curriculum for medical students?
Everybody has either converted to a problem based undergraduate course or is in the process of developing such an approach.

2. Is clinical biochemistry taught
a) as a block or series of lectures
b) integrated into a problem based course
c) does pathology appear throughout such a course
d) alternative; please describe
Few departments (2) now appear to teach clinical biochemistry as part of a pathology block, although in some instances pathology (including clinical biochemistry) is a core subject and appears as a "thread" interwoven into various modules that constitute the course. It should be added that there are other core subjects or threads similarly interwoven.

3. Do you offer special study modules as part of the overall course?
A total of 14 respondents indicated that special study modules were part of the course.

4. Do you offer special study modules with a clinical biochemical orientation?
The same respondents indicated that there were special study modules with a clinical biochemistry orientation.

6. Please describe (or send literature) on:
- i) length of module
- ii) style of module, e.g. research project, audit project, systematic review
- iii) number of students per module
- iv) staff support for module
- v) examination/marking of module
- vi) list of current module titles offered
  - a) with clinical biochemistry orientation
  - b) overall (i.e. full list)
- vii) total number of modules offered as part of course

The responses to the questions were very variable, a summary of which is attempted below:

1. The duration was variable but in the main varied between 2 and 4 weeks with one respondent indicating that the modules were more geared to attaining an intercalated BSc and therefore of longer duration,
2. The style varied but included clinical research, clinical skills, audit and systematic reviews. However, some of the modules were based on an extension of "normal teaching methods" allowing the students to specialise/take an interest in the laboratory specialties. This type of approach included a series of lectures, clinic visits, literature reviews and dissertation including topics like hyperlipidaemia, osteoporosis, diabetes, drugs of abuse.
3. The number of students varied from 1 to about 30 as a maximum. The number allocated to a module depended on the type of module; thus a more formal taught course, e.g. on how to use the laboratory could attract more students because they could be supervised as a block!
4. The staff support was very variable but comments suggested that it was a time consuming mode of teaching. The support varied from one member of staff per student (and therefore possibly module) up to one member of staff for 20 students on a single module.
5. The mode of assessment was not clear except to say that there was a formal assessment. In part this depended on the style of module and thus the possible output. Therefore publications and reports could be marked while more formal courses were examined by a set paper or a dissertation, etc.
6. A list of topics was provided by several respondents, albeit as one liners. Some titles were very broad whilst others were extremely detailed.
7. In the majority of cases there were clear objectives identified for the modules together with an outline of what the student(s) was expected to undertake.
8. The number of modules offered in the course varied from 1 to 8 in terms of SSMs available to a student with a range of choice up to about 20 topics.

Summary

The use of special study modules is obviously increasing as we move to a more problem based learning approach to undergraduate teaching. However, there does appear to be considerable variation in the style of module and therefore (presumably) the objectives of this modality for student learning. In some instances the SSM appears to be employed to enable the student to gain more experience of the laboratory disciplines, including case presentations, whilst others give an opportunity to study specific topics in greater depth but using fairly conventional approaches to teaching and learning. In some cases the SSMs have been developed in a more research orientated style, involving short projects (clinical or basic research) in the laboratory or on the ward as well as more literature based projects as in the case of systematic reviews.

One feature of the SSMs that may be of interest to colleagues and worth pursuing is the concept of the learning contract in which the student and the teacher/trainer/supervisor have quite clear learning objectives, knowledge of what is expected of both parties and how the students progress will be assessed.

If colleagues have particular questions it may be possible to put them in touch with the respondent most likely to be able to provide an answer as some clearly have more experience than others. ■

Academic Departments of Clinical Biochemistry

Responses to Culyer Questionnaire

There was a total of 17 responses to the questionnaire with answers given to the majority of questions by all of the respondents. Set out below, are the responses together with some addditional information.

1. Do you have an allocation in your NHS Clinical Biochemistry/ Chemical Pathology set against Culyer?

Five departments had a formal allocation, one an allocation to the whole pathology directorate, whilst two reported a notional allocation.

2. How was this figure arrived at?

Where there was an allocation it appeared to have been arrived at from an assessment of the projects identified, in most cases with some type of formula applied. Clearly the sum of allocations to departments with a Trust equated to the total allocation! In one case specific posts had previously been funded from regional R&D funds and were subsequently entered into the Culyer "pot".

3. Does this figure comprise an element for departmental Culyer research and a component for work undertaken for other departments, ie their Culyer?

Only four departments were able to recognise that their allocation of funds included work undertaken as part of other (clinical) department Culyer portfolios: in only two cases did it appear that the proportion of the total allocation derived from other departments research activities was identified, i.e. the work costed.

4. Do you have a list of projects being undertaken within the department? Please indicate these if you are happy to do so.

All departments maintained a list of projects, the majority of which were held on an R&D office database. In most cases the titles were quite specific, although in some instances the list only comprised general areas of interest. The database entries generally

included lead researcher, title, start date, completion date, funding source and total funding. Typically a department was supporting about 50 projects and several departments were able to differentiate between those projects initiated internally, i.e. Clinical Biochemistry as the lead department, from those initiated externally but in which the department was a collaborator.

5. Do you have a Culyer research strategy? Please indicate, if you are happy to do so.

A total of 11 departments had individual research strategies whilst the strategy of another was part of an overall pathology strategy. In 4 cases the Trust had an overall research strategy which did not cascade down to departments. One respondent made the point that research was multi-disciplinary, a partnership, and therefore a departmental strategy was not necessarily appropriate.

6. Do you have Culyer funds top-sliced within the Trust for which you can compete?

A total of 9 departments reported that theTrust had top sliced funds for which individuals could then compete. Most of the other respondents indicated that their Trusts were moving toward some form of top slicing in order to promote investment in new research with competition for funds.

7. Does your Trust maintain a list of projects being undertaken within the Trust?

All of the respondents maintained a list of projects at Trust level, although several respondents indicated that they were not convinced all of the projects listed necessarily met the criteria for what constituted a project!

8. Does the Trust have a definition of what constitutes a project?

A total of 12 Trusts have some form of guidelines or definition of what constitutes a research project. Although not specifically asked several respondents indicated that a peer review process is in place or about to be implemented. One example of a definition is given in Appendix A kindly provided by a respondent.

9. Does the Trust have a research strategy?

A total of 16 Trusts have a research strategy. The detail of these strategies appear to be quite variable in content from a basic mission statement espousing the goals of NHS R&D, to maintaining the financial allocation through to building on the current strengths of the local Trust and Medical School. In three case more developed strategies were evident with specific identification of themes - a maximum of 10 being quoted.

10. How was any change in allocation as part of the national 1997/98 exercise transmitted to your department? Were you a net loser or gainer as a department and as a Trust?

Nobody appeared to gain as a result of the 1997/98 allocation exercise, which is perhaps hardly surprising. The most common response was that of 'neutral' (with variations) most likely due to an inability to identify the allocation in the first instance because it was nominal or because the overall change in allocation to the Trust was small. In two instances a loss had been clearly identified which was a pro rata refection of the overall loss by the Trust.

Conclusions

Experience is very varied as might be expected and was the main reason for initiating the questionnaire. Although the questions were of a fairly general nature it is clear that the

allocation of resources and the accountability for the use of these resources varies quite dramatically between Trusts.

There is still much to learn about the mechanisms of Culyer funding but most people appear to be responding by doing what they have always done - maintaining a healthy research programme as time permits!

It is probably worth repeating this questionnaire in a couple of years if people have found these reponses helpful in order to assess progress and learn from each others experience. ■

Appendix A: Definition of NHS R&D

The following is the definition of NHS R&D developed under the NHS R&D Strategy with the advice of the CRDC. It sets out the basic criteria which work has to meet in order to be classed as R&D rather than some other form of activity such as local service development or audit. It may not be appropriate in all respects for all R&D funded by other health research sponsors.

All Research and Development whose direct costs are met with NHS funds should:

- Be designed to provide new knowledge needed to improve the performance of the NHS in improving the health of the nation.
- Be designed so that findings will be of value to those in the NHS facing sinilar problems outside the particular locality or context of the project, i.e. be generalisable.
- Follow a clear, well defined protocol.
- Have had the protocol peer reviewed.
- Have obtained the approval, where needed, of the Local Research Ethics Committee and any other appropriate body.
- Have clearly defined arrangements for project management.
- Plan to report findings so that they are open to critical examination and accessible to all who could benefit from them - this will be normally involve publication.

FCS Briefing Paper

Agenda for Change: Modernising the NHS Pay System

G H Lester, *FCS Secretary*

The Government declared its intention to modernise the NHS pay structure when it issued HSC 1999/241 in December 1998 urging restraint by the Pay Review Bodies (PRBs). Its proposals were published under the title Agenda for Change on 15th February 1999. They embody much more than just a pay system and represent possibly the most radical change ever which will affect the grading, pay, career progression and professional relationships of all NHS staff.

Unlike most of the launch documents issued under the broad heading of "Modernisation of the NHS" – the Information Technology Strategy, the Human Resource Strategy and Clinical Governance – which are clearly consultative, inviting input, Agenda for Change is written as an NHSE position statement. Its publication has been followed by a very ambitious timetable of meetings with NHS unions as the "Social Partnership Forum" (SPF). The management-side has consisted of NHSE and Department of Health officials at the highest level and has been attended by the Minister of Health. The FCS is participating actively in the process.

Interestingly, and perhaps tellingly, the proposals were launched a full two weeks before the publication of the Parliamentary Health Committee report on "Future NHS Staffing Requirements" which investigates issues undermining NHS staffing and makes a number of very germane recommendations.

History and Background

The mid 1990s saw a series of increasingly acrimonious NHS pay rounds as the Conservative government tried to put into effect its policy of local determination of NHS pay and to bring about the demise to the Whitley system. Local pay was hated by NHS unions as its only purpose was to hold down pay wherever possible and was felt by many NHS employers, lacking the financial flexibility to exercise the apparent freedoms it affords, to be a waste of time worsening their local industrial relations. The acrimony reached its peak in the 1995 pay round with the RCN, RCM and some other professional organisations rescinding their no strike rules. A settlement was finally reached in July with the agreeing of the so-called "National Framework Agreement". No one expected this to work in practice but with 99% of NHS Trusts settling at the same local element of the pay award and a general election on the horizon that did not really matter.

Another important outcome of the 1995 pay round was the bringing together of NHS unions – under the title "NHS Joint Unions" – in solidarity against local pay. This body has perpetuated and has provided an alternative to the Whitley machinery for the new Government to consult with during its investigation of the problems of NHS human resource management. This NHS Joint Unions "working in partnership" with the NHSE and DoH is the Social Partnership Forum.

At the same time the basis of the established inter-professional differentials were subject to major challenges under the principle of "equal pay for work of equal value". The principle demands rationality and justification for differentials which the disparate Whitley mechanisms could not (at least in a number of key instances) sustain.

The Proposals

1. Aims

The pillars of the current government's 10 year programme for "modernisation of the NHS" are:

- Tackling the causes of ill health.
- Making services quick and convenient to use.
- Improve consistency of services and assure quality.
- Breakdown barriers between services.
- Invest in staff, building, equipment and information technology.

The stated aims for a new NHS pay system are:

- Flexible staff:
  Remove traditional barriers – dismantle staff definitions and professional demarcation based on training, titles and pay in favour of "skills and what they do for patients".
- Fair and equitable pay for work done with career progression through responsibility, competence and performance.
- Simple and modern conditions of service – national core conditions with considerable local flexibility.

2. What the proposals say

- An end to complex separate conditions for each group. "Core conditions of service for all staff with a single negotiating council (General Whitley Council), with a mandate for radical overhaul at local employer level."
- "A national job evaluation framework": to give clear benchmarks for different types of post but covering all.
- "Clear and simplified arrangements for pay spines": merging the many different Whitley scales into just three pay spines: doctors & dentists, (expanded) nursing PRB groups and "the rest". (The Parliamentary Health Committee could see no justification for more than one pay spine.) The benchmarking would indicate a general range for each type of post but without artificial ceilings. Employers would take into account local factors and features of individual posts when assigning precise spine points.
- "Modern, flexible career paths supported by continuing professional development and fair reward": Incremental points would be abolished and progression up a spine would be determined by increased responsibility, competence or performance. There would be outright performance-related pay for senior staff.
- "A national framework for determining pay uplift": The "cost of living" general uplift of pay spines would be negotiated nationally by just three negotiating bodies, one for each spine.

3. Local employers' responsibilities

Local employers should "rethink the way work is done and reflect that in fair pay". Their roles will cover:

- "Responsibility for job design geared to creating new ways of working and posts which cross traditional boundaries, moving away from national grades". This is

usually a euphemism for breaking down professions and for "generic workers".
- Local assignment to pay bands within the national guidance including (ominously) "scope for pay to adjust to the local labour market".
- Responsibility for personal pay progression (career progression) linked to responsibility, competence and satisfactory performance replacing automatic increments.
- Freedom to amend conditions of service other than the national core.

Many of these proposals are very similar to the ideas of the previous government. Despite declaring an aggressive timetable in the document many of the fundamental components are far from being agreed or in place (e.g. an acceptable job evaluation scheme competent to underpin all NHS posts). The detailed model, which is only just emerging, contains a few opportunities and many threats. The FCS has equal involvement with other NHS unions in the discussions. Needless to say continued participation is of paramount importance to all staff, of whatever profession or grade working in clinical science. Though demanding of expertise and time for even the largest unions, we would assure the membership it receives our highest priority.

Copies of the full document should be available from your Human Resources Department or else from the NHSE Response Line, Tel: 0541-555-455. ■

Working Time Regulations

The Working Time Regulations 1998 (SI 1998 No 1833) were passed by the UK Parliament on 30th July 1998 and came into force on 1st October. They represent the UK compliance (5 years late) with the EU 1993 Working Time Directive. Their publication has been followed by many thousands of words of interpretation and explanation from the Government (DTI), trades unions and commentators on industrial relations. Some of these add clarity, others read more like a creditable script for "Yes, Minister".

What do the Regulations give us?

The regulations are quite complex and incorporate a number of technical definitions and subtleties. They demand and deserve informed attention. In essence, they provide for all employees (excluding junior doctors) a legal right to:
- A maximum working week (averaged over 17 weeks by agreement at Whitley) of not more than 48 hours.
- A minimum daily rest period of 11 continuous hours, plus a further 24 continuous hours rest per week.
- If working regularly at night, a maximum average working period of not more than 8 hours (averaging enables shifts of 12 hours duration to be legal).
- A rest break if working more than 6 hours continuously.
- Three weeks paid annual leave, rising to four weeks from November 1999. (The calculation of holiday gives extra payments to some NHS staff who work contractual over-time or on-call.)

For NHS employees collective agreements have already been reached at the General Whitley Council – AL(GC)3/98 - and the Doctors and Dentists Council - AL(MD)6/98 - under

provisions in the regulations, regarding the time over which "working time" will be averaged.

One of the most important documents for us to note is the NHSE guidance on implementation, HSC 1998/204, because this lays out how some of the new concepts enshrined in the regulations will be interpreted for NHS staff. The interpretation is not always to the liking of NHS employers. In some instances it is not as might have been anticipated. For example, Regulation 20 states that restrictions on average weekly working time, night work and the minimum daily and weekly rest breaks do not apply to "managing executives or other persons with autonomous decision-taking powers". This, one might have thought, would apply to Trust senior managers or even consultant medical staff. The NHSE however "does **not** consider that there are any NHS workers whose work may be classified under..." this regulation.

Commentary

We must address a few common misconceptions already prevalent amongst NHS workers:

1. The Regulations do not apply to hospitals

Wrong – they most certainly do. In fact, public sector workers have greater protection than the commercial sector because the NHS is an "emanation of the state". EU rules say that the state cannot legally allow itself to pass laws to the detriment of its own employees. To assure this, public sector employees have final recourse to the more stringent provisions of the 1993 Directive itself.

2. They do not affect me, I'm a Doctor

Wrong – The 1993 Directive allows member states to exclude a small number of employee groups for special reasons. One of these is junior doctors in training. This is because training and study time are counted when adding up "time worked" and it was argued that if this is restricted the number of years required for doctors training in some member states would need to be extended excessively. The UK took full advantage of the allowed "derogations" in drawing up the current legislation. The regulations apply in full to all career grade doctors.

3. They will not bother me, I'll opt out

True, but only in part. An employee can, of their own volition, agree in writing that the 48 hour average working week limit shall not apply to them provided a number of safeguards are in place and records are kept. This will be a particularly complex area for employees working for more than one employer. However one cannot opt out of the minimum 11 hours rest per day nor the additional 24 hours rest per week. Therefore the maximum possible legal working week is 78 hours. **These absolute restrictions present major challenges for departments and services required to provide 24 hour - 7 day cover with only small numbers of staff.** Some Trusts are already adopting the view that, in the spirit of the regulations and in the interests of health and safety, they will implement the 48 hour average maximum limit. They are not obliged to accept an employee's request to opt out.

The regulations do however embody a degree of common sense in their practical application. They recognise that in some activities there will be times when strict adherence to the limits will not be possible or desirable either because "work cannot be interrupted on technical grounds" or there has been "an occurrence due to unusual or unforeseeable circumstances...". The surgeon might be expected to finish the aneurysm repair rather than down scalpel when he reaches 6 hours. Emergency workers would not be expected to

desert a Clapham rail disaster. But it is made very clear that these circumstances should be the exception rather than the rule and must be followed as soon as practicable by a period of "compensatory rest". Certainly these provisions should not be used as the daily basis on which a routine, albeit 24 hour emergency, service is provided. It could be argued that, even in these crisis situations, best performance is achieved by tightly managing the duration of exposure to stressful work. Failure to take compensatory rest is likely to have implications for clinical governance and professional liability.

Implication of the Regulations as Health and Safety Legislation

The 1993 EU Directive was born out of an accumulation of research findings from many developed countries demonstrating that regularly working more than 48 hours per week is associated with a significant increase in work-related accidents and more general morbidity including premature heart disease (x3 risk) and stress related mental illness. The risks are even greater for those working, against normal human biology, during the night. These research findings confirm long-standing popular wisdom: "He'll work himself to an early grave".

There are several important consequences of this health and safety context:

- The regulations will be policed by the Health & Safety Executive.
- Everyone, managers and employees alike, has a responsibility for adhering to them.
- Decisions about work patterns must be based on formal assessments of risk to the worker rather than the needs of the service.
- Contempt of the regulations may result in criminal prosecution of the responsible managers personally, the organisation or both.

Therefore the change in attitudes necessary to move from a workaholic, "must cope at all costs for the sake of the patient" ethos to the care for the worker, "make the work fit the worker" culture embodied in the regulations must be taken very seriously. This will come hard, particularly for healthcare workers subject to the drives toward lean staffing during recent years and now experiencing recruitment problems. **The bottom line of the regulations is that it is no longer an option to cover understaffed services by working the staff in post harder, irrespective of adequacy (or not) of pay for the extra hours.**

It must also be born in mind that the current UK regulations are only the first step, taken later and with less conviction than some of our EU neighbours. The Directive is due for review in 2003 when even some of the flexibility in our current regulations may be taken out.

Implications to staff

So, what of the implications to Clinical Scientists? These fall into two broad categories: as employees participating in the provision of a 24 hour clinical service and, for those with Departmental Headships or other managerial responsibilities, for organising services and staff.

As employees:

- Extended working day clinical support and technical rotas to fill holes in MLSO cover will need to be drawn up with the time limits in mind, particularly the requirement for 11 hours rest break per day.
- Approved, work-related training and study are counted as working time – though unlikely to save any midnight oil as MRCPath exams approach! It remains unclear whether "personal development" will count.

- Those doing research experiments during the evening to utilise equipment in heavy routine use during the normal working day will need to keep working time records.
- The "hours as necessary for the exigency of the service" clause in employment contracts, which never meant open-ended hours, is probably now obsolete.
- Hours spent more generally in support of the subject or the profession, e.g. on Department of Health or NHSE committees, professional bodies, CPA and the many others should probably be counted as working time.

For those with managerial responsibilities:

- As organisers of services: Considerable effort and imagination, requiring close "partnership", to use the Government's terminology, with the MLSOs, Clinical Scientists and their unions, will need to be expended to devise ways of securing 24 hour service cover. This will mean making the commitment of staff to work "on call" formally contractual. That is likely to be only at a cost!
- As managers with health and safety responsibilities: At least some of the "buck" will stop with them.
- As budget holders. The regulations themselves make little reference to pay issues. Clearly those used to the benefit of on-call or extra hours earnings achieved through long hours will be reluctant to give them up. Achieving legal work patterns and hours will require compromise but the need for more staff will certainly increase costs. (In addition the regulations present increased cost pressure Trust-wide resulting from the introduction of statutory annual leave. This will now apply to bank and agency nursing staff. The regulations specify that this statutory annual leave – currently three weeks, four from November 1999 - should be paid at average earnings, which includes contractual overtime and other enhancements, rather than at base rate. The implications may be as much as £1m on the pay budget of a large Trust.

For all of us the regulations set standards of working patterns and utilisation of staff that cannot be ignored. "Working time" is to be regarded as an even more valuable commodity than before. Given recruitment and retention problems it is also an increasingly rare one. It is therefore beholding on us to utilise the "fit the work to the worker" principle to ensure that what must be done in the interest of the patient gets done when it is needed. But we must be prepared to use these challenges as an opportunity to question whether tasks really deserve the attention they seem to command and whether the right staff spend their time pursuing them.

Certainly there are lots of problems but then solving problems is what we are supposed to be good at!

Members who think they may be working contrary to the regulations or feel they need guidance or advice should contact the FCS. We may not have the answers but might find someone who thinks they do! ■

Statement of FCS Members' Rights

To ensure that the FCS National Committee, and the individual representatives that comprise it, can best help members experiencing employment problems we felt we should declare through this explicit statement to all members what they should expect from their elected representatives and how the FCS expects members to behave.

Federation Members have the right to:

- Receive up to date information via the local representatives network, ACB News, and the FCS website.
- Participate in local FCS meetings.
- The opportunity to participate at local, regional and national levels.
- Elect representatives and vote on relevant aspects of policy and negotiations.
- Access to their elected representatives, and to expect a considered response to any issue in reasonable time.
- Receive advice on professional matters in an industrial relations context.
- Have access to a wide range of FCS services including reasonable legal or professional industrial relations representation at the discretion the FCS committee.

What to do if you have an Employment Problem

Outlined below are the steps that you should take if you have a problem or potential problem in the workplace. The steps are the same for all problems, from seeking regrading, dealing with harassment or bullying to facing disciplinary action:

- In the first instance contact your local representative or, if for any reason this is not possible or appropriate, your regional representative whose name and contact number can be found in the ACB Handbook.
- It is a good idea to write down all the details, including as much background detail as possible. It may be necessary to collect relevant local employment policies and procedures. If your representative is not based in your workplace these will be available from personnel or the local staff side secretary. At this stage you may wish to identify potential witnesses too.
- Keep a diary of events. This will allow you to recall incidents that may have occurred sometime in the past. Also keep copies of all letters and documents, those you write and those you receive, preferably at home.
- At all times be honest in your dealings with all concerned, both the FCS and management. Keep your head and at all times behave in a responsible and professional manner. Losing your temper may jeopardise your case.
- If it helps please refer to the guide at the end of this section.

Guidelines for Conduct

As in your dealings with the FCS you expect a reasonable level of professionalism and integrity, so the FCS expects a certain level of conduct from yourself in order to progress

your case to the best of its ability. In order to facilitate the handling of your case the following guidelines have been drawn together for the conduct of the FCS representative and member.

Where members hold dual Trade Union membership they should decide at the beginning of the case which Trade Union is handling it.

If You Have a Problem

- Contact your FCS representative ASAP, see members Handbook
- Précis background, actions and events in writing for your representative
- Collect all relevant information
- Keep a diary of events
- Document all steps in process (keep a copy)
- Be honest in dealings with all parties
- Behave at all times in a professional manner

Member's Guidelines

- Members are expected to be open, honest, and frank in their dealings with the FCS or its agents.
- Members are expected to respond expeditiously to any reasonable requests from the FCS for information.
- A member has a duty to involve the FCS at the earliest possible stage of any dispute in which the support of the FCS may be required.
- In order to facilitate the progress of the case the member must be willing to comply with any reasonable request from the FCS or its agents. Where expenses occur these will normally be met by the FCS.
- Any advice or information given to a member by the FCS or its agents should be treated with discretion and held in confidence.
- Where a member is dissatisfied with the conduct, advice or decisions of a representative or the agent of the FCS, he/she has a right of appeal to the FCS National Executive.
- Decisions given after an appeal to the FCS National Executive are final and this may include withdrawal of support for the case by the FCS and its agents.
- Members should conduct themselves in a responsible manner and should respect the advice and decisions of the FCS or its agents. Failure to do so may lead to withdrawal of support for the case.
- The FCS will appoint a casehandler. In appointing the casehandler the FCS will take into account the views of the member, but can not be bound by the members wishes.
- Under no circumstances can the FCS support a member in a criminal case.
- The member should be aware that involving another Trade Union in a particular case may lead to withdrawal of FCS support. It is generally in the member's interests for one union only to be handling the case.
- Officers of the FCS undertake to represent members to the best of their abilities as lay representatives. Neither the FCS nor its officers accept any liability for the failure of individual cases or consequential loss.

Representative's Code of Conduct

- All members will be treated equally.
- The representative will treat the individual member and their case with confidentiality, compassion, honesty, respect and integrity.
- Where needed the representative will seek advice, from within the FCS National Committee and if necessary their agents.
- The representative will seek the approval of the member before seeking advice outside the FCS National Committee.
- The representative will respond to a members approach in an appropriate manner and a reasonable time.
- With the consent of the member, the representative will check the facts of the case. Withholding of consent may lead to the withdrawal of support of the case by the FCS.
- The representative will deal with management in a professional manner.
- After consultation the case will be dealt with as deemed appropriate, taking into account the views of the member. This may involve an experienced FCS officer and/or an agent of the FCS.
- If the member does not accept the advice or decision of the FCS or its agent, or behaves in a manner detrimental to the FCS, the Union reserves the right to withdraw its support.
- Register case with the FCS Registrar of Cases. (This is to ensure progress of the case is monitored)
- Officers of the FCS undertake to represent members to the best of their abilities as lay representatives. Neither the FCS nor its officers accept any liability for the failure of individual cases or consequential loss. ■

Diagnostics: The Hole at the Heart of Evidence Based Medicine

4th Equinox Symposium

St Anthonys College, Oxford – 12th July 1998

The Draft Programme includes:

Introduction: Key Issues for Meeting to Address *Andrew Moore*
Why Histopathology Falls Short of the Gold Standard *Ken Fleming*
Evaluation of Diagnostic Criteria of Prosthetic Joint Infection *Nick Athanasou/Tony Berendt*
Testing New Markers of Renal Disease *David Newman*
How is Laboratory Medicine Tackling EB Issues? *Chris Price*
Bringing Laboratory Evidence to Diagnostic Decisions *Jonathan Kay*
Genomics: The Ultimate Diagnostic Tests? *Simon Bennett (Oxagen)*

Workshops include:

The Diagnostic Industry *Chris Price*
The Pharmaceutical Industry *Andrew Moore*
Methods *Doug Altmann*
Primary Care Perspectives *David Mant*

To attend this meeting please contact: Dr Eric Sidebottom
Tel: 01865-204951 Fax: 01865-209044 Email: eric.omk@oxtrust.org.uk

FCS Contribution to Central Government Consultations during 1998

Over the past year the FCS has been asked, as a Trade Union, to respond to many Government and NHSE consultation documents. The Secretary and Chairman have given executive replies to most of these as a formal response on behalf of the profession.

Since the 1997 general election the new Government has adopted a very different style of working consistent with its promise of more open government. In particular the "white papers" preceding major changes in legislation are presented in the form of consultation documents which, depending on the importance of the topic to our profession, invite or demand response from us. Where appropriate the FCS has worked with ACB Council to formulate a common view or submit separate but complementary responses. We believe this is the most effective way in which the ACB can fulfil its role as a major pressure-group supporting clinical science and those who practise it.

Members seeking more detail about the responses to specific issues should contact the FCS Chairman or Secretary.

The documents listed here, whilst being part of making "open government" work, add to the already extensive workload of senior officers, such as representing the profession in consultation and negotiation at formal and informal groups - Whitley Council, Joint NHS Unions Group, Social Partnership Forum and issue-specific working parties.

1. Employment Law

1.1 DTI Consultation on Working Time Regulations
1.2 DTI Consultation on revision of TUPE
1.3 DTI Consultation on Consultation on Collective Redundancies
1.4 Fairness at Work – white paper for consultation
1.5 HSE Consultation on requirement for Investigation of Accidents at Work
1.6 Issue of Working Time Regulations (& NHSE guidance thereto)
1.7 Employment Rights (Dispute Resolution) Act 1998
1.8 DTI Consultation on National Minimum Wage Regulations
1.9 DTI Consultation on Workplace Employee Relations Survey, 1998

2. Parliament

2.1 Evidence to Parliamentary Health Committee - Staffing in the NHS
2.2 The Health Bill
2.3 Fairness at Work Bill
2.4 Select Committee Report - Staffing in the NHS
2.5 Cabinet Office Consultation on Better Regulations Unit
2.6 Frank Dobson's Consultation on Improving the NHS

3. NHS

3.1 White paper - "The New NHS"
3.2 Clinical Governance - "A First Class Service"
3.3 "How NICE will work"
3.4 "Working Together" - NHSE Human Resource Strategy
3.5 "Agenda for Change - NHS Pay System"
3.6 A New NHS Charter - A Different Approach ■

The Royal College of Pathologists

Part I Examination – March 1999

Chemical Pathology

First Paper

Candidates must answer FOUR questions ONLY

Time allowed – Three Hours

1. Give a critical account of possible strategies for controlling the workload of a clinical biochemistry laboratory in a district general hospital.
2. Discuss, with examples, the analytical techniques of value for the laboratory investigation of poisoning by heavy metals.
3. Write an account, with examples, of the benefits and limitations of the measurements of the plasma concentrations of drugs used for therapeutic synthesis.
4. Describe the metabolism of urea and the inherited disorders of its synthesis.
5. Describe the physiology of the cerebrospinal fluid. How can biochemical analysis of this fluid help in the diagnosis and management of disease?

Second Paper

Candidates must answer FOUR questions ONLY

Time allowed – Three Hours

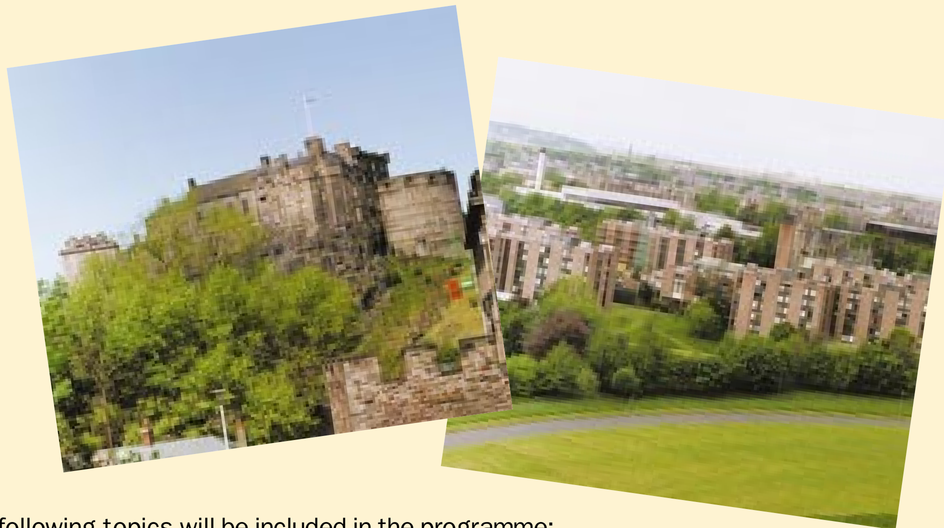
1. Either:
   Discuss how you would investigate and manage a man found to have a fasting serum triacylglycerol (triglyceride) concentration of 18 mmol/L and cholesterol concentration of 8 mmol/L, after his serum, sent to the laboratory for analysis prior to a minor surgical procedure, was seen to be lipaemic.
   Or:
   It is proposed to change a laboratory's method analytical methods for measuring luteinising hormone and follicle stimulating hormone. Describe how you would evaluate the new methods and introduce them into routine use.
2. Discuss the role of the clinical biochemistry laboratory in the management of patients with acute renal failure.
3. Give a critical account of clinical biochemical methods for diagnosis and management of patients suspected of having excessive growth hormone section.
4. Write short notes on:
   a. carbohydrate deficient transferrin
   b. atrial natriuretic peptide
   c. troponin I.
5. Write an essay on the use of biosensors for the measurement of intermediary metabolites.

These examination papers have been reproduced with the kind permission of the Royal College of Pathologists ■

ACB Training Course: Edinburgh

Sunday 12th to Friday 17th September 1999

This course will be held at the Pollock Halls of Residence at the University of Edinburgh.



The following topics will be included in the programme:

- **Calcium and magnesium**
- **Parathyroid function**
- **Metabolic bone disease**
- **Toxicology, clinical and biochemical aspects**
- **TDM**
- **Drugs of abuse**
- **Oncology**
- **Tumour markers**
- **Planning clinical trials**
- **Applying for research money**
- **TLC, HPLC, GC**
- **Electrophoresis**
- **Cancer genes**
- **Assessment of nutrition**
- **Chosing a laboratory computer**
- **Quality assurance**
- **Statistics in research**

The social programme will introduce course participants
to the excitement of Scotland's capital city!

For further information please contact:
Dr Geoff Beckett
University Department of Clinical Biochemistry
The Royal Infirmary of Edinburgh NHS Trust
Lauriston Place, Edinburgh EH3 9YW
Tel: 0131-536-2702 Fax: 0131-536-2758

Application forms are available from the ACB Office:
Tel: 0171-930-3333 Fax: 0171-930-3553

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Higher Specialist Training in Clinical Biochemistry

Clinical Biochemists Grade B (2 posts)

Salary range: £18,915-£22,127
(Scale points 9-13)

Applications are invited for the above posts in the West Midlands Region. The posts are a new initiative designed for Higher Specialist Training and carry a 5 year fixed term contract. The successful candidates will be employed on a rotational basis (2 years) between the two participating trusts (Heartlands Hospital, Birmingham and Russells Hall Hospital, Dudley). The placement for the final year will be decided on the training and development needs of the candidates.

The appointees will have successfully completed a Grade A training course and wil be expected to obtain the MRCPath while in post, As well as contributing to the service commitment of the department, they will be involved in clinical liaison, audit, teaching and research & development.

This is an opportunity to complete Higher Specialist Training at the Grade B level in a supportive and dynamic environment,

For further information or to arrange a visit, please contact Mr E.F. Legg at Heartlands Hospital, Birmingham on Tel: 0121-766-6611 ext 4377 or Dr M. H. Labib at Russells Hall Hospital, Dudley on Tel: 01384-244078.

Closing date for applications: July 19th 1999

MANCHESTER CHILDREN'S HOSPITALS NHS TRUST

Consultant Clinical Scientist

Grade C Clinical Biochemist

This is a new post in a Trust providing tertiary referral paediatric services for the North West. You should have broad experience, have completed all aspects of training and possess the MRCPath or equivalent qualification. A research record and experience of laboratory management is expected but you will not necessarily have worked in a Children's Hospital. we particularly seek those with qualities of leadership, capable of managing change as the Trust is currently planning to move to a new Children's Hospital adjacent to Manchester Royal Infirmary in approximately five years.

The Department is currently based on two sites at the Royal Manchester Children's Hospital and Booth Hall Children's Hospital. It supports a wide range of specialist paediatric services including endocrinology, gastroenterology, nephrology, inherited metabolic disorders, oncology, neurology, and several surgical specialities. There are established intensive care units on both sites.

For further information contact Dr G M. Addison, Consultant Chemical Pathologist on Tel: 0161-727-2250 (am) or 0161-220-5342 (pm). Email: mike.addison@man.ac.uk

For a job description and application form please telephone the Human Resources Department, Hospital Road, Manchester M27 4HA. Tel:0161-727-2352 (answerphone) quoting ref: RM134/99.

Closing date for applications: July 7th 1999

To advertise your vacancy contact:

Dr Simon Olpin, Neonatal Screening Laboratory, Pathology Block, Sheffield Children's Hospital, Western Bank, Sheffield S10 2TH
Tel: 0114-271-7267

Deadline: 26th of the month prior to the month of publication

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