

ACADEMY OF MEDICAL ROYAL COLLEGES

Chronology of Academy participation towards implementation of the European Working Time Directive (EWTD) in the NHS

Background

Together with its constituent Colleges and Faculties, the Academy Trainee Doctors Group, and the Patient and Lay Group, the Academy has a duty to safeguard the quality and safety of patient care, formal responsibility for which in the NHS lies with SHAs.

The European Working Time Directive aims to improve the health and well-being of workers and their families. Naturally we are also concerned to ensure that the means by which the Directive is implemented in the NHS do not compromise the care of patients or the training of doctors, now or in the longer term.

From August 2004 the provisions of the Directive limited the weekly working hours of doctors in training to 58 hours, with entitlements to daily and weekly rest breaks. The impact of the Directive was widely recognised as presenting a major challenge to safeguard the quality of patient care and the training of doctors.

This statement is a summary of actions taken with participation of the Academy to date. The intention is that it should be updated as events unfold.

2004 onwards

The Academy and its constituent Colleges and Faculties together with the Department of Health (DH), the British Medical Association (BMA), and the NHS Confederation worked to tackle the problems and to develop practical solutions. That work continued in preparation for the next and more demanding stage of implementation of the Working Time Directive in August 2009.

2007

From 2007 the Academy also set up regular meetings with Department of Health MMC team to discuss concerns regarding training and service. These meetings were attended by College Presidents or senior officer deputies.

Meanwhile, in the light of a programme of pilot studies conducted by National Workforce Projects (NWP) the lead NHS organisation, sponsored by DH, and information contained in detailed modelling by Colleges, Trusts were adopting a wide range of approaches towards achieving compliance.

2008

Studies conducted hitherto had provided little objective evidence of any effect of arrangements for implementation upon the quality of care or upon training. However, during 2008 a number of the Colleges reported concerns that methods being used to achieve compliance with the Directive would have a detrimental effect on patient care. In addition there were reports from a number of specialties that a shift in the balance between service work and training, with a reduction in the time and opportunities for junior doctors to receive

training and for consultants to deliver it, would seriously affect the training of future specialists, to the long-term detriment of patient care.

Foreseeable effects of some approaches to compliance differed between services and specialties. Individual Colleges identified concerns in their specialist domains and had taken steps to ensure that they were widely known.

October

In the autumn of 2008 Colleges individually and collectively through the Academy sought urgent meetings with Ministers and officials to alert them to their concerns.

Subsequently meetings were set up with the Department of Health to address a wide range of concerns about implementation of the Directive. They were attended by senior DH officials from the Workforce Directorate and the MMC team.

November

Particularly serious concerns about EWTD compliance were raised at a meeting on 5 November. There appeared to be discrepancies between Strategic Health Authority (SHA) reports of progress towards compliance and the findings of College surveys and information obtained locally. The latter reported both gaps in rotas and a numerical compliance achieved only by reliance on locums and internal cover, a state of affairs that could not be sustained. More comprehensive data collected later [see below] confirmed these reports.

In November 2008 the Royal College of Physicians, London and the Royal College of Paediatrics and Child Health urged the Department of Health to conduct a survey of Medical Directors on the preparedness of their Trusts for EWTD implementation.

December

Early in December the Chairman wrote to the Secretary of State for Health giving the Academy's support to concerns about the impact of the Directive that a number of Colleges had raised with the Department.

In mid-December, at a meeting with the Department of Health EWTD team, the Academy reiterated its concerns, subsequently providing a portfolio of College evidence to the Director of Workforce Capacity. There followed a number of initiatives between the Department and the Academy to triangulate different sources of data and seek to resolve differing views.

In December the Department commissioned Professor Nigel Bax, Professor of Medical Education, University of Sheffield, to examine data from three SHAs and to report on the impact of implementation of the EWTD upon service and training. There was College and Faculty input into the questionnaire being designed by Professor Bax.

2009

January

Colleges continued to survey clinicians, trainers and trainees. In January 2009 the Academy submitted further information to the Director of Workforce Capacity.

National European Working Time Directive Reference Group

In mid-January there was a meeting of the Presidents of Colleges representing specialties that support acute services, the Medical Director of the NHS, the NHS Director General of Workforce, the Director of Medical Education (DME) and the Clinical lead for EWTD. Following this meeting the National European Working Time Directive Reference Group was set up. It is chaired jointly by Dr Patricia Hamilton (DME) and Dr Judith Hulf (Vice-chairman).

of the Academy) and represents all key stakeholders. The Group advises on implementation to support achievement of EWTD by August 2009, with particular attention to any impact on training and patient services.

On 19 January Professor Sir Bruce Keogh (NHS Medical Director), Professor Dame Carol Black (Chairman of the Academy), Professor Ian Gilmore (PRCP), Mr John Black (PRCS), Dr Hulf and Dr Fielden (Chairman, BMA Consultants Committee) met to discuss the Directive and the scope for derogation.

On 21 January the Reference Group held its first meeting. Its purposes were:

- i) to address concerns about patient safety that had been linked to the Working Time Directive;
- ii) to consider the options in respect of seeking derogation;
- iii) to agree advice on the way forward to achieve full WTD compliance by August 2009.

Information on preparations being made by Trusts to reach compliance with the Directive gave confidence that rota-specific derogations would be sufficient to meet remaining needs by August. This was agreed by the EWTD National Reference Group.

The Reference Group prepared a portfolio of evidence for Secretary of State. It was designed to inform a judgement on whether it was appropriate for HM Government to apply to the EU for derogation for the UK. The Reference Group emphasised that the derogation application did not mean that Trusts and services should not continue to work towards compliance.

That month HM Government submitted a *Notification of Derogation for Doctors in Training* to the European Commission. This is a two-stage approach to identify the exceptional cases and provide supporting information. It would allow rotas for trainee doctors to be based on a 52-hour week for up to three years where particular difficulties exist. The Commission would inform the UK of its opinion by the end of May 2009. At that time, based on scrutiny of evidence from the SHAs, a decision would be made on where and how derogation, if granted, might be applied.

February

On 11 February, at its second meeting, the Reference Group agreed with a number of medical Royal Colleges that they should form liaison teams to work with DH and SHAs and Trusts. The aim was to provide professional support to Trusts. This support would comprise collection of data on service and training issues, advice on best practice, different ways of working and models of care, and the specific data required to support the (exceptional) cases for derogation. DH would provide up to £60k to the participating Colleges (RCP, RCPCH, RCOA, RCOG and possibly RCS) to undertake this work. This work would observe the principle of partner co-production, signifying joint working of senior College representatives with DH and SHAs.

Academy/Department of Health Liaison Meetings

These regular meetings between the Academy and senior DH officials enable prompt scrutiny and discussion of data on Working Time Directive compliance now being collected through different routes, and of issues arising out the findings.

Meeting 11 February 2009

SHAs had been asked to submit their plans for EWTD compliance to DH. Meanwhile provisional findings of the survey by Professor Bax showed that Trusts varied in their state of preparedness, the main risks reported being gaps in rotas and dependency on locums and recruitment. These data would be triangulated with data provided by the Colleges.

Quality assurance of compliance arrangements

There were known difficulties recruiting doctors to undertake service roles and middle grade posts. DH indicated that it would challenge compliance plans that were overly dependent on recruitment and/or upon locum appointments.

DH agreed that SHAs would undertake a EWTD Quality Assurance process, with monthly detailed reporting, specialty by specialty, by grade of doctor in individual Trusts, including data on use of locums and internal additional duties. There would be RAG (Red/Amber/Green) rating of plans for compliance. Beginning with Green returns this would be supplemented by detailed work to assess the robustness of the solutions proposed.

Further work would collect service level data in surgery, to assess risks posed by EWTD compliance in the surgical specialties. [The Surgical Royal Colleges had pressed for a 65-hour working week and an opt-out from the EWTD for surgical specialties. It was recognised that increased hours worked in the surgical specialties would have an impact on support services].

In view of the approaching deadline it was emphasised that data provided by SHAs in March would be critical. For example, it would be difficult to achieve recruitment into consultant posts in time unless the process began promptly. Accordingly there was agreement that Colleges would process job descriptions for new consultant posts as quickly as possible, a process that would depend on receipt of relevant information from Trust HR Departments.

DH had allocated £310m of additional funding to SHAs (the funding actually passing to PCTs) to support compliance, with guidance on how it should be spent. This funding included £110m from 2008/2009, a further £150m through the tariff, and £50m specifically identified for trained doctor solutions in paediatrics and obstetrics.

In February Dr Wendy Reid was appointed to the DH Workforce Directorate as Clinical Advisor on EWTD, leading the EWTD programme team which would have links with MMC and MEE as well as the DH Workforce Directorate. The team would be accountable to Professor Sir Bruce Keogh. Dr Reid would act as professional link with Colleges and the Academy. [Dr Reid is an experienced Postgraduate Dean and practising Consultant in Obstetrics & Gynaecology. She previously led for *Hospital at Night*]. Through the Colleges she is now meeting training leads and senior officers, including Regional Advisors and Heads of School.

At this meeting Colleges and Faculties made additional points:

- In Emergency Medicine: difficulties recruiting into service posts; lack of resident out-of-hours surgical cover; was still a major issue. Emergency Medicine was moving towards 24 hour consultant cover but this was not yet in place.
- Reliance on locums to ensure compliant rotas should be quantifiable from SHA data.
- RCOG data showed that middle grade rotas which were compliant on paper varied from relying on a core of 4 doctors up to 24 doctors spread across a wide variety of grades.
- Although some Colleges had close links with training institutions overseas and IMGs could be recruited through the Medical Training Initiative this could only be part of a long term solution and would not ease current problems. DH was keen for Colleges to facilitate the recruitment of good quality IMGs.
- Concerns that unplanned consultant recruitment to meet EWTD requirements might be incompatible with service reconfigurations not yet decided.
- There should be means of monitoring training beyond 1 August 2009.
- In future it might be necessary to concentrate training in a smaller number of units.

The Chairman affirmed the wish to promote joint work between the Colleges and DH to ensure sustainable implementation of the EWTD. Accordingly a summary of information presented by the DH would be prepared for circulation to all Colleges. Dr Reid indicated that she would be in contact with the Colleges representing the acute specialties.

On 2 April the Academy and senior DH officials would discuss data on the EWTD provided by the SHAs (see below).

Academy Trainee Doctors Group (ATDG)

Through the ATDG trainee doctors are also represented at the Academy/DH Liaison Meetings. On 26 February Dr Reid also attended a meeting of the ATDG, heard their concerns, and planned to attend subsequent meetings.

March

Academy/Department of Health Liaison

It had been agreed that during this critical period liaison meetings between the Academy and senior DH officials should be held every 4-6 weeks

April

Meeting 2 April 2009

At this meeting DH reported data supplied by 31 March from the Bax Survey and SHA reports. There was general appreciation of the more detailed data now available which allowed examination of services in individual hospitals. However, there were still gaps and possible contradictions between reports from different sources on compliance with the Directive. An interim report of the Bax survey showed that the data did reflect concerns raised previously by the Colleges.

The SHA data was more comprehensive than that available hitherto and most had been signed off by Clinical and Medical Directors. Though not yet complete it could be broken down between individual surgical specialties. Red ratings, indicating the highest levels of risk, were more prevalent in the surgical specialties.

The data would be collected monthly from this point and made available to Colleges who were working with the SHAs.

Training post vacancies and recruitment

SHAs had been asked to identify training vacancies by specialty in the March return. This data was yet incomplete. There were approximately 1,600 vacancies in training posts though this total included vacancies arising from trainees on maternity leave and/or in out-of-programme experience. They should be measured more precisely and DH would ensure this was done. Most vacancies were in Anaesthetics, Paediatrics and Child Health and Acute Medical Specialties. There was concern about a low fill rate (less than 85%) in the current round of recruitment in some specialties. An 85% fill rate would leave approximately 1,000 vacancies. A second round of recruitment would be progressed quickly to ensure that trainees were in post for 1 August.

Given the numbers of vacancies, there was agreement on the need to ensure wider candidature for specialty training posts and to draw in IMGs alongside doctors who had trained in the UK. This would be helped by a national, centrally coordinated process for recruiting IMGs.

It appeared that Foundation trainee doctors did not always receive or act on advice about choice of region and/or specialty when applying for specialty training posts.

Service post vacancies and recruitment

Although data were incomplete there were evident difficulties recruiting to service posts, in some regions especially. An updated workforce census affirmed the recent expansion in the medical workforce, a factor that exacerbated difficulties in recruitment.

College reports.

Colleges and Faculties reported on matters specific to the specialties they represent, including their work with SHAs.

The point was made that service reconfiguration must reflect the requirement for sustainable solutions to the implementation of a 48 hour working week. There was particular concern about consultant compliance with statutory rest periods in specialties where intense on-call rotas would be required to provide a 24/7 service, and the need to find ways of ensuring the most effective use of available resources to provide comprehensive services across regions.

DH reported that efforts were being made to challenge the rest periods set out in the EWTD. However, the European Parliament had not yet been willing to approve any of the concessions proposed. DH also indicated a May deadline to identify units and services where derogation might be needed.

Communications

Data presented by DH would be supplied electronically.

National European Working Time Directive Reference Group

Meeting 7 April 2009

EWTD funding

The Group requested regular updates on the uptake and use of funding (distributed via PCTs, not SHAs). [It was understood that Royal College Liaison teams (RCoA, RCPCH, RCP, RCOG, RCS) would not take part in this analysis but would review and comment on SHA returns but would not be brought into dialogue].

Opt-out from the 48-hour restriction

The Reference Group had not discussed this topic hitherto and the Chairman invited views. Opt-out was currently available to individuals though anyone electing to opt out remained bound by the restrictions of the New Deal (UK legislation) rest period constraints, and the SiMAP and Jaeger rulings. Although MEPs had voted to recommend that the restrictions be removed their vote had not yet been upheld.

Key points:

- NHS Employers made it clear that they were recommending to their members that they should not use the Opt-out in employing doctors, for any reason.
- Many members expressed fears of coercion should the Opt-out be used in employment arrangements.
- Conversely it was made clear that no organisation or agency is in a position to tell an individual doctor that he/she may not opt out.
- All agreed that Training Programmes could not and would not be built on the premise that some individuals might opt-out, nor could an individual's choice be taken into account when reviewing progress in a training programme.

Additional points touched on:

- Personal choice in the use of time exceeding 48 hours (within the New Deal restriction)
- Questions of remunerated/non-remunerated time
- Locum employment
- Legal challenge in cases of critical incident about the hours worked by the doctor concerned
- The fact that there is no evidence that 48 hours is the 'magic' safe working time although acknowledged that excessive (80) hours is detrimental to doctor and patient
- Threat to the culture of professionalism
- Reports that some employers insisted that doctors in training leave the premises in order to conform with contracted hours
- Unclear definition of what precisely constitutes work; for example, is observing considered to be work?

As reported from the 2 April Academy/DH Liaison Meeting the Bax survey findings were consistent with findings of Colleges and with DH data. SHA returns and recruitment data were as presented to the 2 April Academy/DH Liaison meeting. The meeting noted that data collection seem to have heightened and focused attention to the matter.

Communications

- Each College would receive a detailed report on their specialty data.
- A QA forum would be set up on the website.
- DH would prepare documents giving
 - the process for allocation of EWTD funding, and provide an EWTD funding budget balance sheet at each meeting
 - a summary of National EWTD Reference Group views on the Opt-out
 - SHA Return Data for targeted distribution.
- BMA would share with the Reference Group a Q&A developed by the Association.
- Opt-out views of the Reference Group would be brought into the Q&A

A further meeting would take place in mid May once the next SHA returns were available. The joint work being undertaken by the Colleges and SHAs would be discussed again at the next meeting.

May

An independent Scrutiny Panel, also chaired by the Academy, with membership drawn from the National EWTD Reference Group was set up to:

- Provide the Secretary of State with a list of recommended derogations.
- Ensure that applications adhered to the agreed process with sign off at SHA and Trust level and that the information requested to support the applications had been provided.
- Assess whether a consistent level of quality assurance had been applied to all applications.
- Take a national view of some specialties to identify whether national action was required.

Derogation requests were received from SHAs on 29 May following scrutiny and sign off at Trust and SHA level prior to being considered by the Scrutiny Panel. The Panel reviewed requests from 61 Trusts in England, covering 202 rotas. It recommended 200 for derogation.

Academy Trainee Doctors Group (ATDG)

Wendy Reid attended the ATDG meeting on 21st May 2009, to both give an update on the latest figures and to hear directly from trainees. The ATDG continue to work with the DH and the EWTD Reference Group in developing EWTD FAQs.

June

The approved derogations were included in the Statutory Instrument which was laid before Parliament on 25 June 2009 and amended the Working Time Regulations. The list was prepared in a form to ensure a consistent description of specialty, subspecialty and grade and that appropriate grades are used recognising core as well as run through training.

Meeting 17 June 2009

Derogation

Earlier, in January 2009 information on the preparations being made by Trusts to reach compliance with the Directive gave confidence that rota-specific derogations would be sufficient to meet remaining needs by August. This was agreed by the EWTD National Reference Group. The Academy understood that the level of applications for derogation made subsequently by Trusts supported that position.

Much collaborative work has been done through the Colleges, DH and SHAs to gather further evidence on the preparedness of Trusts and the soundness of their arrangements. Additional new information, particularly that made available through College networks, ignited concerns that rota-specific derogation would not be sufficient meet the needs of all acute specialties. These concerns applied both to the safety and quality of clinical care and to the quality of education and training. Further, it was recognised that experience gained after 1 August might identify additional needs for derogation that were not so far evident.

The main issues were:

- Fewer requests for derogation had been received than had been expected.
- There was considerable variation in the number of requests between SHAs.
- Plans tended to be reliant on recruitment to middle grade non training posts, which was unsustainable because of the lack of a pool of doctors to recruit to these posts.
- International recruitment plans needed to be supported by robust induction processes.
- Potential implications for training with rotas being overly reliant on trainees working out of hours. Consultant based solutions were the most robust and sustainable.

The Scrutiny Panel had been concerned that applications for derogation had not been received from all the areas where they were needed. In addition some of the solutions proposed compromised training and this would impact on patient care in the longer term. A robust review process would be established immediately for all services relying on derogation.

There was unanimous support from a number of Colleges providing acute services for seeking a blanket derogation including the RCOG, RCA, RCPL, RCPCH and RCSEng because of concerns about the low number of rota-specific applications. Solutions proposed by individual SHAs tended not to take into account the national picture, particularly in terms of recruitment given the small pool of service grade doctors available for appointment.

The Academy reiterated these concerns to the Department of Health.

The Government recognises that some services may need more time to be fully compliant and it will use the derogation provision where needed. [News, Department of Health, 26 June 2009]. SHAs have been asked to identify through their continuing assurance reviews any services that may require further support to maintain safe patient care and more time to

embed sustainable solutions. Secretary of State is able to lay further regulations after 1 August to extend the list of derogations if required.

Further action

In response to a recommendation by the Scrutiny Panel that there should be a national process for EWTD compliance in Transplantation, especially Paediatric transplant surgery, Neurosurgery and Cardiothoracic Surgery. Dr Reid would lead a national review to help these services develop long-term solutions to support training within a compliant working environment.

Recommendations to the Secretary of State for Health have consistently emphasised the need for liaison group work established between the Colleges and the SHAs to continue, to support trusts seeking derogation and those where difficulties may persist or arise after 1 August. The Department of Health has accepted these recommendations.

It was agreed that two further meetings would be arranged between the Academy and the DH. The first would need to take place after 22 July when the EWTD National Reference Group was next due to meet and before 1 August 2009 and would be chaired by the new Chairman of the Academy, Professor Sir Neil Douglas.

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