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THE IMPLEMENTATION OF THE WORKING TIME
DIRECTIVE, AND ITS IMPACT ON THE NHS AND
HEALTH PROFESSIONALS

REPORT OF THE INDEPENDENT WORKING TIME REGULATIONS
TASKFORCE TO THE DEPARTMENT OF HEALTH

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1. Executive summary

In the Health Report of the Balance of Competences Review, the impact and implementation of the Working Time Directive (WTD)¹ was identified as a key issue of concern for a number of stakeholders. The evidence presented to the Balance of Competences review did not give a clear enough picture and hence this further report was commissioned by the Secretary of State for Health.

The taskforce was asked by the Secretary of State to review the impact and implementation of the European Working Time Directive, and two questions were uppermost in our mind.

- 1. What impact had the UK working time regulations (WTR)² and court judgments associated with the WTD had on the training of doctors in the UK, and by extension on the delivery of high quality patient care?**
- 2. If significant problems were identified, could solutions be recommended that would allow different specialties in medicine the flexibility to provide streamlined and appropriate treatment for patients, and in a manner which was practical for the NHS?**

In answering these questions, we drew on evidence that we received from a variety of organisations representing employers, professionals and patients. All agreed that the wellbeing of staff and patients is of utmost importance and that it would be undesirable to return to the days when doctors routinely worked for excessively long periods of time. Nevertheless, respondents identified a number of issues and concerns resulting from the implementation of the Working Time Directive (WTD).

The evidence presented to the review fell under the following broad themes:

- » **Patient care**, including the importance of putting patients at the centre of the review's work and ensuring continuity of care so that the number of patient handovers is limited.
- » **Fatigue** and how to ensure that doctors are not exhausted. There is a concern that a significant challenge to the NHS lies in balancing the need to minimise

1 WTD – EU health and safety legislation that limits workers to a maximum 48-hour week averaged over a six-month period.

2 WTR – Working Time Regulations transpose the Working Time Directive requirements in to British law.

fatigue while avoiding the unnecessary transfer of care and cancellation of elective clinical activity.

- » **Implementation of the directive has affected different specialties in medicine in different ways** and any solutions will need to take account of these differences.
- » **Issues relating to education and training** and the fact that the delivery of training in certain specialisms has been difficult to implement, although the impact has been much more limited in others.
- » **Issues related to rota design** and how rotas can best be designed in different NHS trusts, as well as the importance of good service design overall.
- » **The impact of the SiMAP and Jaeger judgments** from the European Court of Justice on flexibility in the NHS, and the related issue of possible future renegotiation of the WTD.
- » **The New Deal Contract** and how this inter-relates with the WTD.

In relation to these, the taskforce has identified the following key points:

- » **The WTD has indeed caused greater problems for some specialties than others.** For example, while surgery and acute medicine have been adversely impacted, other areas such as paediatric medicine have addressed problems resulting from the directive or its implementation by organisational and service model changes.
- » **Local trusts have had mixed success in finding ways to manage rotas so as to mitigate the directive's impact.** In general, it appears this is easier to achieve in larger hospitals or areas of medicine with greater numbers of staff on rosters, although this is a generalisation.
- » **If best practice were to be spread it would to some extent mitigate the WTD's impact on the NHS,** although it would by no means remove all the problems, and it must be stressed that there may well be different solutions for different local areas.
- » **Training and education** in some acute specialties has proved very difficult to implement with the constraints of the directive preventing trainees from achieving the skills and experience required for their specialty.
- » **The individual opt-out for the UK as a whole is a very positive measure.** More thought should be given to how we can ensure maximum benefit is achieved from it in the NHS while at the same time ensuring that appropriate protections for patient safety are put in place.
- » **The impact of court judgments following the original WTD has been substantial.** On the positive side, these judgments have helped protect doctors from long periods of duty and fatigue, but they have also led to a lack of flexibility for the

NHS as a result, with adverse impacts in some specialties on both training and handover of care.

- » **It is possible that in the future the WTD could be revised in Europe to address this lack of flexibility.** The taskforce recognises that the directive covers all workers, not just those in the healthcare sector, and that any new directive could have positive or adverse consequences.
- » **The place of service and education in contractual arrangements is important,** as these components interact with the WTD. Current contracts do not distinguish between service and education as clearly as they could, although it must be stressed that alternative approaches could be equally problematic. This would be a matter for the negotiating parties who are currently discussing new contractual arrangements.

In summary, the UK medical training system produces competent doctors who are fit to practise. However, in certain specialties this is achieved by doctors working voluntarily to gain the skills they require. The spread of good practice and recognition of differences between specialties could certainly benefit staff and patients in the short and medium terms, following some targeted further work. Contractual issues are currently being considered, and in the long term, a new or amended directive could help overcome problems in relation to the SiMAP and Jaeger judgments.

Overall, the taskforce identified three priority areas for further work:

- » the impact of the WTD on education and training;
- » the design of hospital systems; and
- » the continuity and delivery of patient care.

This taskforce therefore makes the following recommendations:

- » The taskforce believes that **NHS trusts should review best practice in the design of working practices and share examples of the successful delivery of patient care and the training of junior doctors.** Where necessary, trusts may need to reorganise their teams and services to deliver their own local solutions.
- » The taskforce believes that **the findings of this report will be of relevance to the ongoing contractual negotiations.** The parties to the negotiations are also members of this taskforce and have agreed to take account of them.

- » The taskforce recommends that **the specific challenges faced by specialities, identified by the GMC survey and in the evidence submitted to the taskforce, should be addressed** as part of our wider recommendations.
- » The taskforce believes that it is essential that the lack of flexibility brought about by the SiMAP/Jaeger judgments is addressed while recognising doctors must not suffer undue fatigue.
- » The taskforce examined the possibility of creating protected training and education time for junior doctors and recommends **that more work should be undertaken to identify 'service' and 'education' elements in the work of doctors in training. This will include how the possibility of separate agreements may contribute to resolving some of the difficulties identified by this review.**
- » There was agreement in the taskforce that **further consideration needs to be given as to how more widespread use of the individual opt-out might be encouraged where safe**, both at sectorial and individual levels.

This report reflects the agreed recommendations of the taskforce, though it cannot be assumed that individuals or organisations are in unanimous agreement on all points.

This report also contains more specific ideas that could be used in either contractual discussions or in future renegotiations of the WTD. However, a number of the solutions are not without risk or legal complexity and that is why it is crucial that DH, Health Education England (HEE) and others carry out more work to look at the ideas outlined in this report, in order to ensure that they bring maximum benefit to health care in the UK.

Finally, it should be made clear that this report has focused on the NHS in England. While it has been strengthened by responses from the other parts of the UK, it is for the devolved administrations to think through any implications the report might have for them, and about how they wish to input into the UK position in future EU negotiations.

2. Introduction

Background

The Working Time Directive (WTD), a piece of EU legislation created with the aim of ensuring that workers have safe working patterns and hours, has been a key consideration for the NHS and for doctors since 1996 when the government first consulted on its application following its adoption by the EU Council of Ministers at the end of 1993. The WTD was introduced as a health and safety measure in response to growing concerns that workers in certain sectors across Europe were being asked to work excessive hours which endangered their lives.

The WTD was implemented in the UK through the Working Time Regulations (WTR) in October 1998, which applied to the majority of UK workers. However, there were initially a number of exceptions, including junior doctors who were given longer to comply with the regulations.

The WTD limits workers to a maximum 48-hour week, averaged over a 6-month period. It lays down minimum requirements in relation to working hours, rest periods and annual leave.

Over time, junior doctors' working hours were limited to 56 hours in 2006 and finally to 48 hours in 2009. In 2009 a small number of rotas were allowed to derogate from the WTD for 24 months as a final step to complying with the 48-hour requirement. This was for operational reasons. By August 2011, all junior doctors' working hours had to comply with a 48-hour working week averaged over 6 months, and no further derogations were allowed under the WTD. Although doctors were allowed to go over those hours for particular weeks, the average over a 6-month reference period must total no more than 48 hours a week. There is also the option for an individual to opt out of the average weekly maximum limit, which is described below.

Locally, NHS trusts, as employers of doctors, are required to monitor and record junior doctors' working hours and have a responsibility to ensure that their staff are compliant with the WTR. This is as a result of the New Deal contract, which is also described below.

European Court of Justice judgments

Since its implementation, the WTD has been interpreted by a number of rulings in the European Court of Justice, and subsequently by UK courts in case law. Two particular judgments have played an important role in the interpretation of the WTD, which we explain in further detail in the report (see section 4). One decision affected the amount of time that doctors may spend on call, known as the SiMAP judgment, and the other decision concerned the interpretation of when compensatory rest must be taken, known as the Jaeger judgment.

The SiMAP and Jaeger judgments have had a considerable impact on the NHS and have contributed to a lack of flexibility in the management of junior doctors' working time, although it should be stressed that not all of the consequences of these judgments have been negative, as they have also helped to ensure that patients are protected from doctors working extremely long hours. However, the judgments state that time spent on call at a hospital or health centre counts as working time, whether or not any work is actually done (for example, the time a doctor spends resident on call but asleep counts as working time). They also mean that compensatory rest to make up for missed rest periods must be taken as soon as the period of work ends, rather than at a later time (for example, the next day), and this has led to a lack of flexibility for the NHS. Member states that fail to comply with the WTD as it is interpreted by these two judgments risk individual case law challenges, and could face infraction proceedings brought by the European Commission.

Individual opt-out

As part of their working arrangements, individual doctors can opt out and work more than a 48-hour week if they choose to do so. Opting out is a voluntary decision taken by the individual in agreement with the employer. Such individual opting-out does not necessarily lead to more flexible arrangements for working hours for the NHS as a whole since these are affected by the overall design of rotas, affordability considerations and other factors. Even where this does facilitate more training-friendly work patterns, all doctors still have to comply with the compensatory rest requirements and with the requirements in the junior doctors' contract. This report examines in further detail the benefits and drawbacks of the current system.

Junior doctors' contract

The training of doctors has been heavily affected by the New Deal, otherwise known as the junior doctors' contract, an agreement reached in 1991 between the government, the NHS and the British Medical Association (BMA). At the time it aimed to reduce

junior doctors' working hours and provide them with adequate rest periods amid growing concerns that many junior doctors were working too many hours each week and endangering patients as a result of their fatigue. In the early 1990s, the average number of hours' work across all specialties was 86 hours a week and there was great concern about the consequences of overtired doctors treating patients. The New Deal was renegotiated in 2000 and introduced pay banding supplements designed to penalise employers with high payments when junior doctors in their trusts worked hours that were excessive. These provided a further incentive to hospitals to reduce doctors' hours in line with the WTR.

Continuing concerns

In November 2009, as a response to the concerns being expressed about the impact of the WTD on the quality of training being received by junior doctors, the government commissioned an independent review, chaired by Professor Sir John Temple.³ Published in June 2010, the report concluded that high quality training can be delivered in 48 hours a week, but not where trainees have a major role in out-of-hours services, are poorly supervised or have limited access to learning opportunities. The report noted that for service-based learning to be successful, this depends on good rota design and handovers between working shifts that are designed to provide an effective learning experience.

Professor Temple also highlighted the fact that the requirements of the WTD differ from those of the junior doctors' contract, and that this interacts with the application of the WTD in unhelpful ways. He suggested that the contract was reviewed and also commented on the need to change working practices and examine how training is delivered.

Following the Temple review, NHS Employers was asked to scope the efficacy of the current national contract and in a report to ministers in June 2011 concluded that there was a compelling case for the contract to be renegotiated to better meet the needs of patients and the training needs of the doctors.⁴ In due course, ministers gave NHS Employers a remit to renegotiate the contract with the BMA. Those negotiations are

3 <http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf>

4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213214/FINAL-PDF-revised-for-DH.pdf

under way with a view to being completed by the end of 2014 and the implementation of any agreed new arrangements to begin in April 2015.

Balance of competencies review

In July 2012 the government started carrying out an audit of what the European Union does and how it affects the UK. The review for health was published in July 2013,⁵ which included concerns about the implementation of the WTD). The findings of the review are summarised at Annex H.

5 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224715/2901083_EU-Health_acc.pdf

3. Current state of negotiations and establishment of the taskforce

Revision to the Working Time Directive – current state of negotiations

There have been two attempts to renegotiate the WTD since its last amendment in 2003, both of which have been unsuccessful. In 2009, following negotiations in Europe, discussions between the European Council and the European Parliament failed to reach an agreement on the common position negotiated by the Commission. The European Commission then moved to consult on attitudes across Europe to the WTD.

At the end of 2010, the European Commission published their second-stage European social partner consultation on working time, together with accompanying evidence about the implementation and impact of current working time law.⁶ This was followed by negotiations between the European social partners on a cross-industry basis. After a period of negotiation the social partners agreed on the principal areas to be discussed. However, despite the commission agreeing an extension, the social partners were unable to reach agreement and the initiative for producing a new proposal has reverted to the European Commission.

Also in 2010, Deloitte published an assessment of the impact of the WTD on the public services sector in response to a request by the European Commission.⁷ The report examined the use of the opt-out in a range of countries and reported that it did not appear to be 'misused' by employers in the UK. The study included a section examining the impact of the directive and the SiMAP/Jaeger rulings on on-call time and compensatory rest across a range of public services. Across nearly all countries, compliance was found to bring the benefits of safer working hours and patterns, but the costs and burdens of compliance were found to be considerable in the health and fire services.

The Department for Business Innovation and Skills and the NHS European Office have suggested that it is unlikely that there will be any further activity by the European Commission in respect of reviewing the WTD until after the impending European elections and changes to membership of the European Commission in the summer of 2014.

6 <http://ec.europa.eu/social/BlobServlet?docId=6419&langId=en>

7 <http://ec.europa.eu/social/BlobServlet?docId=6421&langId=en>

Establishment of the Working Time Regulations Taskforce

In the health report of the Balance of Competences Review, the impact and implementation of the Working Time Directive was identified as a key issue of concern for a number of stakeholders who believed it had had a detrimental impact on the NHS. At the same time, all agreed that it was vital not to return to the bad old days of doctors working extremely long hours, which had a negative impact on patient safety.

However, stakeholders had different views on whether the problems were caused by the actual WTD, court cases following the WTD, the way it had been implemented in the NHS, the way it interacted with UK legislation, or interaction with doctors' contracts. The evidence presented to the health report of the Balance of Competences Review for health did not give a clear enough picture, and so following its publication the Department of Health invited the President of the Royal College of Surgeons to chair an independent taskforce to examine the evidence on the implementation of the WTD and to provide expert advice on the impact it has had on the delivery of patient care and the education and training of the next generation of doctors.

A summary of the findings of the Balance of Competence Review is at Annex A.

Taskforce deliberations

The taskforce membership was drawn from key organisations involved in the areas covered by this report. They are united by commitments to excellence in training, fair employment practices and the safety and quality of patient care. Discussions ranged around and outside comfortable areas. While there has been agreement on many things and on the main recommendations in the report, it cannot be assumed that individuals or organisations are in unanimous agreement on all points. We present the report of the taskforce.

The taskforce convened between the period October 2013 to March 2014, and a total of six meetings were held at the Royal College of Surgeons during this period. While these meetings are where the majority of the group's deliberations took place, additional discussion and consultation took place through email correspondence.

Following the first meeting of the group, a call for evidence was launched (Annex C) and 17 submissions from organisations and 11 individual responses were received. The group also heard oral evidence from a range of individuals, and full lists of both the written and oral evidence received by the taskforce are included at Annexes D and E. In the course of its work, the taskforce also considered a range of published

literature, including research attempting to assess the impact of the implementation of the WTD, and research assessing solutions that have been introduced to meet the new requirements accompanying the directive.

Two additional key components in helping the taskforce reach its conclusions came in the form of independent legal advice focusing on how the WTD is currently implemented in the UK through the WTR, and an analysis of data collected as part of the General Medical Council's National Training Survey for 2013. Legal advice was provided by barristers from 20 Essex Street chambers (who included a qualified doctor) and the analysis by the Centre for Workforce Intelligence.

The taskforce was assisted in its work by the Department of Health, which provided members of staff to carry out secretariat functions in conjunction with the Royal College of Surgeons. The recommendations and findings of the taskforce are independent of government and based entirely on its own work.

Responsibility for the setting of health policy is devolved across the UK and the remit of the group was to just look at the situation in England. However, responses to the consultation were received from the Royal College of Physicians of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow, the Royal College of Surgeons of Edinburgh, and the Royal College of Physicians of Ireland. While this report is produced in response to a request from the Secretary of State for Health in connection with the NHS in England, there may be issues contained in it that are of relevance to the devolved administrations, which they may wish to consider. This document is not intended set government policy either in England or the UK and this remains the prerogative of the Secretary of State.

4. Key issues, challenges and solutions

During the course of our work, we considered and discussed a broad range of issues associated with the implementation of the Working Time Directive (WTD). It was important that we consulted widely and we were heartened to receive so many responses from healthcare organisations, patient groups and individuals working in the NHS. A full list of evidence is provided at Annex D. The responses in their entirety are available online at: <http://www.rcseng.ac.uk/policy/working-time-directive-taskforce>.

This section highlights some of the key issues that emerged from both the written and oral evidence and captures some of the conversations that were generated as a result. On some subjects far more evidence existed than others, but in our deliberations we tried to look at the situation as a whole. We have divided the section into themes, although there is inevitably a large degree of overlap between each. These are:

- » Patient care, including the importance of continuity of care
- » Fatigue and how to ensure that doctors are not over-worked
- » Areas of medicine most impacted by the implementation of the regulations
- » Education and training
- » Rota design
- » SIMAP and Jaeger court judgments
- » The New Deal contract.

1. Patient care

A guiding principle of the taskforce was that our recommendations should be, above all, of benefit to the quality of patient care. This reflects a view expressed by many and was encapsulated in comments made to the group by the Chief Executive of the patient group National Voices, Jeremy Taylor. In the course of his evidence, Mr Taylor expressed concern over the 'binary nature' of the WTD and questioned whether there was greater room for flexibility. He also highlighted the tensions that exist between the provision of continuity of care, the need for intensive training of doctors, and the need to avoid doctors working excessive hours.

The taskforce heard from several groups that the restrictions on working time have had a significant effect on the continuity of patient care. For example, handovers have increased in frequency as a result.

The fragmentation of handovers is one of three particular concerns that the Royal College of Physicians has noted about patient care and the impact of the directive, along with on-call rotas and cancellation of clinics, and disruption to the continuity of care. In their evidence, the RCP explained that many consultants take part in on-call rotas for their specialities and are required to attend out-of-hours to provide emergency procedures, for example endoscopy in gastrointestinal bleeding. These rotas are typically on top of a normal working day. To comply with the directive, compensatory rest to make up for missed rest periods must be taken the following morning, something that has resulted in clinics and outpatient or inpatient procedure lists being cancelled.

The RCP suggests that the cancellation of such appointments can have a detrimental effect on patient care, as it delays vital consultations between patient and doctor, where diagnoses are made and new courses of treatment are determined. The taskforce noted that forward planning can help prevent this, although it can at times prove to be unavoidable in the face of service pressures and some specialities are liable to find this more than others.

The Royal College of Radiologists also highlighted in their evidence that for clinical radiologists, lists are 'frequently cancelled or transferred to colleagues due to the legal restrictions of the WTD and compensatory leave pre and post on-call periods.'

It should be pointed out that it is hard to fully differentiate the effects of the WTD on patient care from the other themes addressed in this chapter. For example, in the section about rota design there is relevant detail relating to the provision of out-of-hours care by junior doctors, and about the use of locums by NHS trusts.

2. Fatigue

There is a common acceptance that patients suffer when doctors are exhausted and the taskforce heard little disagreement to the point that tired doctors can make mistakes. For instance, the BMA noted in their response that, '[i]t is clear from studies in the US, UK and other countries, that fatigue can impair the performance of doctors and can have a negative impact on the safety of patients and doctors.' Accordingly, the majority of respondents stated that the UK should not go back to a situation where doctors who are responsible for treating patients work the long hours routinely seen in the past.

As a piece of health and safety legislation that is intended to reduce fatigue in doctors and to improve both their own safety and that of their patients, a number of organisations responding to the review's call for evidence expressed support for the WTD, although often noting that there have been problems with its implementation. Health Education England expressed the view that any increase in working hours could be dangerous to patients and doctors, while the RCOG view the WTD as beneficial in the context of supporting safe working practices. They do however note that it has had consequences, namely a reduction in the available hours for training for junior doctors. It is possible therefore that as a measure to help combat fatigue, the WTD may also have had adverse impacts on patient care, as is discussed in relation to the cancellation of patient appointments in the patient care section.

The effect on shift patterns was highlighted by many, as training schemes find it hard to provide the continuous rest required and are forced to move to a shift system. This means that fewer trainees are available for a larger number of shifts looking after larger numbers of patients. The latter is particularly true in acute medicine where the medical registrar is under constant pressure contributing to recruitment difficulties.⁸

Overall, it is clear that patient safety is protected by ensuring that doctors do not work very long hours. However, patients are also disadvantaged by a large number of cancellations of elective clinical activity and the transfer of care between medical colleagues. The importance of good rota design is looked at in a later section.

3. Areas of medicine most affected by the implementation of the regulations

While there remains disagreement over what the overall impact of the WTD has been on the health service and the extent to which the problems identified in this report can be specifically attributed to it alone, there is greater consensus around the view that the implementation of the WTD has affected different specialities in different ways. This point was recognised by many respondents, including the RCS, RCP, RCPCH, RCOG and BMA, while Health Education England suggested that the manner in which the WTD has been implemented has not always recognised variations in workload and intensity between different roles and specialities.

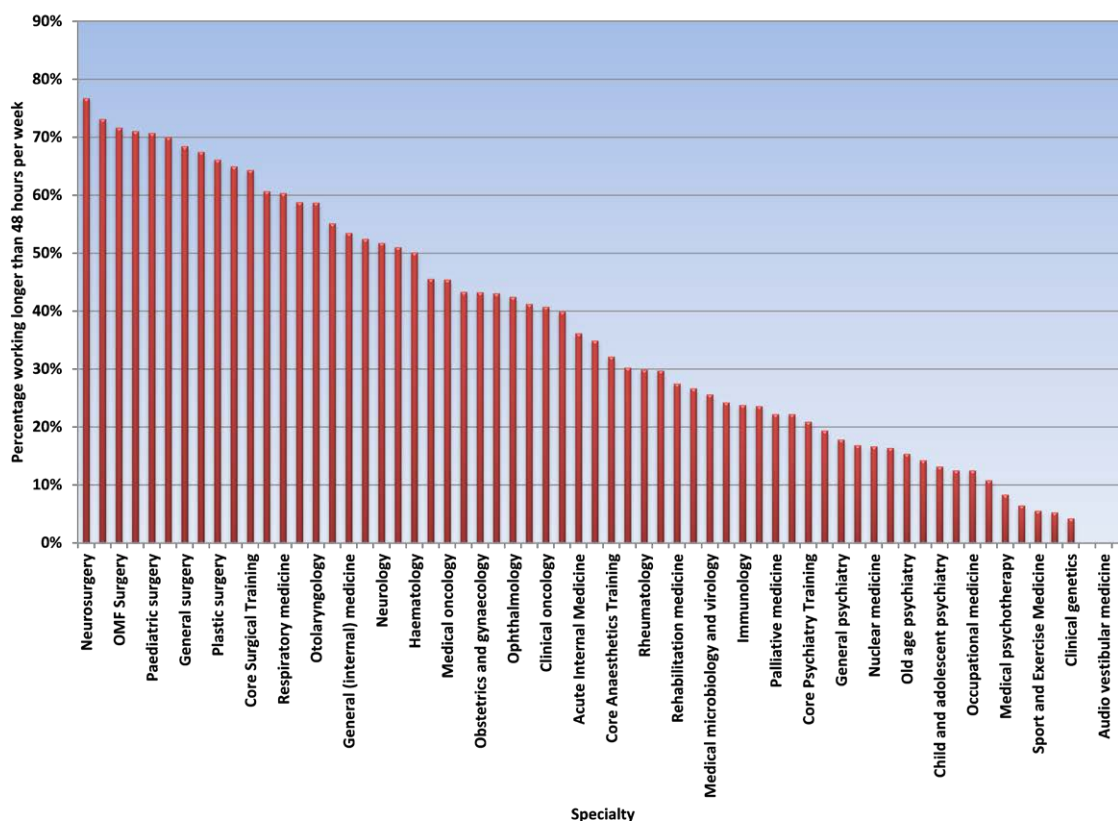
In a statement to the taskforce, the NHS England Medical Director Sir Bruce Keogh, acknowledged that there are, 'views on the impact of the EWTD on different specialties by both trainee groups and professional bodies which remain unresolved'; and that,

8 <http://www.rcplondon.ac.uk/resources/acute-medicine-evaluation>

‘the impact of the EWTD will be felt differently in different specialties and different organisations’.

The taskforce recognised that the variation in workload and in intensity between different roles appears to extend even across speciality groupings themselves. For instance, the Royal College of Radiologists stated that while the biggest impact the WTD has had on trainee radiologists has been around on-call provision, the biggest effect on clinical oncology training has been the reduced daytime staffing levels of juniors, particularly at FY2 level. The taskforce found that this indication is given extra weight by the analysis of data collected for the GMC National Training Survey for 2013. This found that across specialities, there is large variation in the percentage of people working longer than 48 hours, as the graph below shows:

Chart 1⁹



Here we see that surgery is clustered around the top seven percentage values, with the highest percentage of respondents working longer than 48 hours per week coming from the neurosurgery profession, and the lowest from audio vestibular medicine.

9 Source GMC Survey of Junior doctors. All answers are self-reported as to experience of working.

When comparing specialities by group, there is large variation at the group level between those working more than 48 hours per week.¹⁰

In the course of the review, it became clear that the WTR impact on junior doctors differently from consultants, something that may reflect their employment on the terms of the New Deal contract. Hospital consultants, who have completed their specialist training, are also covered by the WTD, but not by the same employment contract restrictions.

In their evidence, the Royal College of Physicians cited their annual Census of Medical Registrars, which states that over 50% of trainees still believe that training was worse or much worse as a result of the WTD. This figure has remained fairly constant over the last four years. The same census does however suggest that there appears to be little support among junior doctors to work beyond EWTD working hours unless there is a substantial increase in remuneration.

In summary, these differences between sectors and specialisms must be at the centre of any solutions or future discussions about the WTD. It is in no one's interest to disadvantage areas where the system currently works, but change is clearly needed in others.

4. Issues related to training and education

An association between the WTD and its impact on the training of junior doctors was a key theme running across a majority of the responses, and it is apparent that a reduction in training time is a particular issue for the craft specialities. In their submission, the BMA cited responses to their national survey to show how different specialities view their ability to deliver training while complying with the maximum average 48-hour week. Those in specialties that require experiential learning of practical procedures are markedly less likely to believe that training can be delivered within a 48-hour week. Around 70% of psychiatry and emergency medicine trainees who responded to the BMA's 2010 survey believed it possible to train in their specialty within a 48-hour week, but only 33% believed this possible in surgical training.¹¹

10 Based on the system of classification used by the NHS Information Centre. For example, the surgical group consists of general surgery, neurosurgery, ophthalmology, cardiac surgery, otolaryngology, paediatric surgery, plastic surgery, trauma and orthopaedic surgery, and urology.

11 The BMA state that in 2010, 50 per cent of respondents to their survey thought it was possible to deliver training in their specialty while complying with the maximum average 48 hour week. 36 per cent disagreed and 16.5 per cent neither agreed nor disagreed.

The Association of Surgeons in Training (ASiT), a professional body with a membership from all 10 surgical specialties, maintains that many trainees report voluntarily working longer working hours than they are supposed to in order to receive the training they need and to ensure the quality of the service for patients is maintained. ASiT, together with the British Orthopaedic Trainees Association, carried out a survey in order to look at trainees' working patterns. More than half of 1,200 respondents indicated that their formal employment contract did not accurately reflect the number of hours they worked (56%), with almost three-quarters (72%) of respondents reported regularly attending on rostered days off (median 2 days per month) in order to receive the experience necessary to protect their training.

The Royal College of Surgeons has argued that the quality of training for surgeons of the future is being endangered as a result of these pressures associated with the WTD. Analysis they have conducted suggests that the number of hours available to surgical trainees for training and experience in compliance with the WTD may have been significantly reduced: That every month 280,000 surgical training hours could be lost owing to the WTD and doctors beginning their surgical training today will have 3,000 fewer hours to learn throughout their training, the equivalent of 128 whole days. Meanwhile, the RCP note in their response that, for some, a reduction in training time, 'may lead to an unnecessary extension of their training period.'

In oral evidence to the group, Professor Tim Briggs, President of the British Orthopaedic Association and representing the Federation of Surgical Specialty Associations (FSSA), said that 48 hours did not allow enough time for orthopaedic surgeons in training, and that they require up to 60 hours a week. From the hospitals he had visited throughout the UK, he reported seeing a reduction in log book numbers and poor morale among doctors. 'The reality is that they are finding it hard within those hours to get their skills up to speed.' He said that some of them were leaving the UK to do fellowships abroad in order to acquire the skills they needed. 'My trainees will all voluntarily do the extra hours, up to 52 hours a week in my organisation, because they know that's how they become skilled. They are not paid for it but they have to learn somehow.'

This picture is complicated by the fact that a reduction in hours available for training appears to have affected groups within specialties in different ways. The Royal College of Obstetricians and Gynaecologists reports that a reduction in hours has had more impact on surgical skill acquisition in gynaecology than in obstetrics. They explain that this is because, while the workload in obstetrics is spread over 24 hours as an emergency speciality, gynaecology largely takes place during the day and rota

changes required to comply with the WTD have reduced net daytime training hours. The RCOG suggests that a reduction in time available for training has affected the ability of trainees to acquire and master skills, both in decision-making and procedure, and has made them less 'visible' to trained staff.

The Royal College of Paediatrics and Child Health said that applying their service standards¹², and by reconfiguring acute services onto fewer sites and implementing consultant delivered care as in Greater Manchester (Making it Better), the concerns that have been expressed about a lack of exposure to training can be addressed.

The effects of a reduction in the amount of training time that junior doctors have with senior consultants were highlighted in a number of responses, including by the Royal College of Physicians and Surgeons of Glasgow who underlined the importance of continuity in the relationship between trainer and trainee. They drew attention to the importance of the personal dimension of this relationship for contributing to a trainer's awareness of issues with the development of their trainee, and for helping to foster excellent skills and clinical leadership in junior doctors. The Royal College of Physicians of Edinburgh suggested that fewer opportunities for consultants to work with their allocated trainees limits teaching, assessment and mentoring opportunities. The Royal College of Radiologists noted that, '[a]s a result of the EWTD, doctors entering speciality training are felt to have less clinical experience and require greater supervision.'

Despite such challenges, it seems that many trainees are accessing the training they need in order to complete their training programmes. The rates of successful progression through the recognised postgraduate training programmes and the achievement of Certificates of Completion of Training have not been affected to date. However, for some specialties this has been achieved by trainees working extra hours that are unrecognised.

Not all specialties believe that the implementation of the WTD has had a detrimental effect on training. While they highlight problems arising from rota gaps and occasions when trainees are put under pressure to cover these, the Royal College of Anaesthetists states that there is currently no strong evidence to suggest that the WTR have had a negative effect on anaesthesia training in the UK. In their response, the Royal College of Paediatrics and Child Health suggested that were there to be a potential derogation beyond 48 hours this would be unlikely to benefit training, as the extra time generated

12 <http://www.rcpch.ac.uk/facingthefuture#FtF>

could be used for the purposes of service provision, particularly for out-of-hours work. The RCOG see the WTD as, 'beneficial to patient care.' They note that many of the issues arise because, 'modifications to training were not made at the time of implementation (length of training or change of delivery of training)'. Similarly, Sir John Temple reported in his evidence to the task force that his own review had heard evidence that suggested it was possible to train within the 48 hours. It was his opinion that the key to achieving this was in getting consultants to work differently.

The taskforce recognises that the issue of education and training is important to resolve, but that once again the problems relate more to some specialties, such as surgery, than others.

5. Rota design

A recurring issue in the evidence was the effect that the implementation of the WTD has had on hospital rotas, with many specialties having moved away from on-call to full shift working patterns. NHS Employers believe that around 90% of junior doctors are now in shifts. Typically, this will mean that a doctor works a 12-hour shift and then has a break until the next day. In the past, they may have been on an on-call rota for 24 hours but sleeping or resting in the hospital during at least part of the quieter night-time period. This is not to say that these periods of rest and sleep were never disrupted. Lengthy and continuous spells of work within the 24 hours were not uncommon, in certain specialties in particular.

HEE expressed concern that a majority of rotas are insufficiently staffed by trained doctors and that this leads to an over reliance on trainees who spend a significant number of hours working without direct supervision. The taskforce was aware of continuing problems relating to hospital care at night, delivered by a largely junior workforce supervised by consultants who will be on call but may not be physically present at all times. There will be even more incentive to address these issues as the NHS moves to delivering a seven day service and this is something that we touch upon later in the report.

RCOG indicated that, as a speciality with a 'high intensity workload', there is some evidence to show that the move from on call rotas to shift working has had a negative impact on training. This view was similarly expressed by other royal colleges including the RCPE, the RCP and RCPSG, who noted that, '[...] the number of medical staff required to sustain a viable acute care rota, is made much greater, under EWTD restrictions, than would previously have been necessary.' The RCS also noted that

there is a cost impact caused by instances where locums are employed to cover rota gaps.

The taskforce were made aware of concerns about an increase in the use of locum doctors and NHS trust doctors/fellows in order to meet the shortfall in staff as a result of a shorter working week. Locums perform a valuable role in the health service, but are by definition not permanent members of a team and are sometimes brought in at short notice to deliver care, something that highlights the need for better planning of locum coverage. It should be noted that an increase in the use of locums is not necessarily caused by the implementation of the WTD, as it can reflect that employers want to employ more doctors on the specialty doctor grade, seeing them as a flexible, effective and affordable grade for the service.

Much of the evidence submitted indicated that there was concern that some rotas were not compliant and that doctors were working more hours [unofficially] and in some cases not being paid for it. The RCS expressed concerns about the disruption to working and sleeping patterns as a result of use of full shift rotas. The GMC noted that the report into the impact on doctors commissioned by them and produced by the University of Durham raised concerns over rota design and training opportunities.

Different solutions were proposed to tackle the issues highlighted around the design of rotas. In their responses, both HEE and the RCPE discussed the need to ensure good or 'intelligent' rota design, while the GMC highlighted the suggestion made by Professor Sir John Temple in his report Time for Training that rotas should be larger and contain more doctors. They also referred to the Shape of Training review, which recommended that consideration should be given to creating longer placements for doctors (<http://www.shapeoftraining.co.uk>). The RCP similarly recommended that hospitals increase the length of time to a minimum of six months for junior doctor attachments to specialties and departments during training rotations.

The increased presence of consultants was highlighted by the GMC and the RCPCH, with the GMC paying particular attention to the report produced by the Academy of Medical Royal Colleges on seven day consultant care. This argues that rotas optimised to ensure continuity of care should be designed to make best use of consultants' time. Another solution promoted by both the RCP and RCPE was that rotas are designed to ensure consistent team membership so as to foster and encourage team working, while the RCR stated in their response that one of the ways in which they have looked to solve problems caused by the implementation of the WTD has been

through designing combined rotas with other specialities in order to provide cover. This taskforce however noted this has the downside of patients being looked after by trainees who have less knowledge of their condition.

Some responses considered the solutions that might be offered by a broader reconfiguration and centralisation of services, including those of HEE and the RCR. In particular, the RCR felt that more could be done to centralise on-call services to major centres, with cover for district general hospitals provided at consultant level. HEE suggested that the reconfiguration of services, either by site or by the way in which the local workforce delivers care and protects training, should be considered.

Some members of the taskforce drew attention to the work of the Royal College of Physician's Future Hospital Commission. The document Future hospital: caring for medical patients sets out the commission's vision for hospital services structured around the needs of patients, now and in the future. The commission's recommendations are drawn from the very best of hospital services, taking examples of existing, innovative, patient-centred services to develop a comprehensive model of hospital care that meets the needs of patients.

Overall, if rotas are designed well and best practice followed, it is clear that the impact of the WTD can be mitigated to a certain extent but it is recognised that this does not remove all the problems in certain specialisms and that the situation is more challenging for some, mainly smaller, NHS trusts.

6. SiMAP and Jaeger Court Judgments

Many respondents highlighted the way in which the WTD, the SiMAP and Jaeger court judgments and the junior doctors' New Deal contract cut across one another, creating tensions around two areas: the need to have highly trained doctors who have been able to develop the necessary skills and experience to progress in their training, and the importance of ensuring that care is delivered safely by doctors who are not suffering from fatigue owing to prolonged hours of work.

The SiMAP and Jaeger rulings of the European Court of Justice attracted significant comment from respondents, with most drawing attention to the impact that these rulings have had in terms of limiting flexibility in the management of working time, although some taskforce members such as the BMA stressed the positive nature of the Jaeger judgment in preventing doctors from over-working, and all taskforce members recognised this point. The RCP noted that the SiMAP ruling led to the

widespread adoption of full shift rotas, and consequently to, '[...] significant disruption to working patterns for junior doctors, including disrupted sleeping patterns, job dissatisfaction and sickness rates.' NHS Employers recognise the need to review the interpretation of the judgments at a European level in order to deliver greater flexibility, while maintaining safe working practices for doctors and their patients.

Accordingly, there is a common desire to find a solution to the impacts these rulings have had, and a call on the part of some to 'renegotiate' the WTD to interpret the judgments in a more flexible way; something that should perhaps be interpreted in the context of a review of the WTD as a whole. The RCS have advocated that the European social partners should recommence discussions on moderating the impact of the WTD, with a view to delivering a sector specific solution for healthcare. In the event that this is not possible, they suggest that the European Commission should propose new changes 'as a matter of urgency'.

In recognition of the number of comments that expressed a wish for there to be derogation or an opt-out of the SiMAP and Jaeger judgments, the taskforce explored this in more detail with its legal advisors. The advice highlighted a number of provisions in the WTD that may be used with regard to when compensatory rest may be taken and these are detailed in Annex F. However, with regard to derogation from the rulings, the legal advice was unequivocal in stating that it is not possible for the UK to opt out or derogate from these rulings. In respect of renegotiation, the legal advice was clear that it is not possible to renegotiate a ruling of the EUCJ and that a renegotiated directive is the only remedy. As has been stated earlier, it is unlikely that any renegotiation will commence before 2015 and a revised directive would be unlikely to be effective until two years after agreement.

7. The New Deal contract

The GMC noted that when the SiMAP and Jaeger judgments are coupled with the current 'New Deal' contract, the challenge of balancing appropriate staffing and training, while protecting the rights of the individual, is made even more complicated. As explained earlier, the introduction of pay banding supplements when the New Deal was renegotiated in 2000 provided a strong incentive for NHS trusts to reduce junior doctors' hours in line with both the contract and the WTD.

The interplay between the New Deal and the WTD was highlighted by Dr Andrew Goddard, who suggested that the problems with the New Deal need to be addressed. In addition, the RCP's written response to the review noted that the effects of the

New Deal and the WTD are so intertwined that any changes to the former would undoubtedly have an impact on the latter.

Similarly, NHS Employers highlighted in their response how the New Deal includes detailed restrictions on doctors' work and duty hours, saying that in many cases these go beyond or cut across the requirements of the WTD. They state that, '[...] Employers have made the point that, although compliance may have been achieved there are still very significant challenges ensuring that service delivery and standards of training are maintained. This is particularly the case in the craft specialties such as general surgery where the twin restrictions of the New Deal contract and EWTG have perhaps had more impact on the traditional 'apprentice' and 'firm' based approach to training [...]' NHS employers have also noted that the different requirements of the WTD and of the New Deal contract create unnecessary administrative burdens and provide for conflicts between junior doctors and their employers, particularly staff in medical staffing departments. NHS employers aspire to a national terms and conditions contract that would be administratively easier and would reduce the potential for local conflict.

Health Education England makes the point that the imperative to maintain compliance with the 'New Deal' contract has meant that it has become increasingly difficult to maintain non-resident on-call arrangements. This is because of the impact of 'Band 3' costs being incurred by the employing organisation in the event that a doctor works in excess of 56 hours.

The RCS recognises that some of the negative effects of the WTD could be addressed through the agreement of new contracts for consultants and junior doctors. The RCP suggested that flexibility in the application of restrictions on working times is essential in order to deal with specific local issues, given that needs for staff cover in a rural district general hospital are very different from those in a large urban centre. ASIT were very succinct in their call for 'appropriate remuneration for actual working hours', something that reflects the suggestion made by themselves and others that working often takes place in personal time and on a 'voluntarily' basis, in order to avoid a breach of working hours limits. Finally, NHS Employers have noted that there is an opportunity to use the contract negotiations to improve training and patient care, and this sentiment was very much shared by all taskforce members.

5. Discussion and recommendations

In the following section we explore the three key areas emerging from the evidence and discussions in which we believe action can be taken. These are: the impact of the WTD on education and training, the design of hospital systems and the continuity and delivery of patient care. In each area we summarise our discussions and put forward possible solutions.

Education and training

In the previous chapter we outlined some of the challenges facing the education and training of junior doctors that have emerged following the introduction of the WTD. Many of these challenges have been associated with the widespread adoption of a full shift system in the NHS, compounded by inflexibility in terms of when compensatory rest can be taken by and the requirements of the New Deal contract.

We heard that this has led to a loss of training time for some specialities, with the craft specialities experiencing this more than others. For example, as a result of the decrease in average hours worked per week from 56 to 48, the Royal College of Obstetricians and Gynaecologists estimates that training time in their specialty has reduced by 36 weeks over the full programme.¹³ While it does not suggest that those gaining a Certificate of Completion of Training are not competent, it points to them having less experience than before the introduction of the WTD. As Professor Temple noted in his report, the new CCT holder today needs more coaching and mentoring than previous generations.

For those doctors affected, a reduction in the exposure they have to opportunities for training has led to a number of concerns, including about the frequency with which they are working voluntarily above their paid hours to mitigate this, the effect it is having on the relationship they have with their trainer, the possibility they might have to train for longer, and the detrimental effect that it could have on their training as a whole.

As we have seen however, this is not the case for all, with the GMC survey giving an indication that, while 41% of junior doctors' work in excess of 48 hours, it is doctors in surgical specialties who are more likely to do so than others.¹⁴ Given this, **the taskforce**

13 This is based on a 7-year training programme and assuming there to be 42 working weeks per year.

14 This figure is based upon the analysis of data collected for the General Medical Council's national training survey for 2013 and a summary of the analysis can be found at Annex G. It has to be noted that this data is self-reported and reflects the responses at a point in time. However, there is a clear indication that in

recommends that the specific challenges faced by specialities, identified by the GMC survey and in the evidence submitted to the taskforce, should be addressed as part of our wider recommendations. This should be led by the relevant medical royal colleges, in partnership with Health Education England, the General Medical Council and NHS Employers.

Running through the debates described is the tension that arises from the need to balance the time available for training and education with the requirements for the delivery of a good service to patients, something that was a theme in much of the evidence that we read and heard. This is not a new phenomenon, but it is indisputable that the demands on junior doctors to play a greater role in service delivery have increased in recent years. An ageing population, coupled with the targets that have to be met; such as the 4-hour A&E waiting time target, the 18-week maximum wait for an operation, and the 2-week wait for a cancer appointment, have made the wards and clinics far busier. The effect of these changes may indeed make a return to an on-call system undesirable and impractical.

As the Academy of Medical Royal Colleges' Trainee Doctors' Group describe the situation, 'the stress on the service has overwhelmed the influence that education and training has on the overall system.' They add that, 'the training of junior doctors is poorly understood by most organisations' management.'

On graduating from medical school, doctors begin a path of lifelong learning and education. These junior doctors are of course professionals who should know the limits of their own knowledge and expertise, but they also need to enhance and improve their skills over time. Medicine requires the continual acquisition of knowledge, as therapies, treatment and technology constantly change. So too does patient need, and seeing and treating patients in an appropriately supervised environment forms the backbone of the education, training and development of undergraduate and postgraduate doctors.

In addition to their working hours in a hospital, clinic or a GP surgery, junior doctors will be working in their own unpaid time for exams and postgraduate qualifications, as well as taking part in committees, undertaking audit and research and attending courses. All of these contribute hugely to the NHS and to medicine and junior doctors rightly understand some but not all of these activities will be carried out in their

some areas of medicine at least doctors are likely to work in excess of 48 hours, although (this does not necessarily mean that doctors are in breach of the directive).

own time. To achieve the balance between delivering patient care and ensuring that junior doctors are able to acquire the knowledge, skills and behaviours expected to complete their programme of training within the 48 hours of the working week requires employers and trainers to work together to optimise the scope for learning and make every patient contact a potential educational opportunity.

One problem heard by the taskforce was that the WTR have been interpreted in an overly rigid manner in some organisations at a local level, and that legitimate ways to achieve more flexibility need to be sought.

The possibility of creating protected training time for junior doctors is something that was examined by the taskforce. This came about as trainees and others made the point that the system needed to be redesigned so that it could balance the needs of both training and education and service delivery.

The possibility of such a separation opens up the prospect of improving training and education. Highly trained doctors produce higher standards of overall care, better outcomes for patients and greater efficiencies for the health service. The possibility of moving to a system that allowed protected time for learning was examined by legal counsel.

The key issue to confront was the need to support the quality of training by ensuring that all junior doctors have protected training time distinct from service delivery (noting however that the nature of the role may mean in some instances that there may be an element of incidental service delivery as part of the ongoing training of junior doctors).

The taskforce was advised by its legal counsel that it is possible to isolate 'education' from service (see annex F). The advice made it clear that for this to happen certain key characteristics must be met; namely that protected time for training and education must not be used for service provision and that it is clearly identifiable as training separate to any such service requirement.

In order to address the financial needs of those who were in education, counsel advised that the separation could involve having a separate specialty specific educational grant to pay for the time spent in protected training and education, which would be wholly outside the junior doctors' pay arrangements. The taskforce is aware of the wider contractual situation but it is not within the remit of the taskforce to consider

these other than to note and acknowledge the implications would need to be carefully considered.

Such a solution, where education and training are protected and separated, allows the potential for the profession to set down the core educational requirements that can be managed outside the core service requirements. With each specialty determining their needs based on the nature and intensity of the training they require, this would allow for differential time requirements. The protected training and learning time would lie outside the requirements of the WTD so long as it did not constitute 'working time' under the WTD.

The taskforce recommends that more work should be undertaken to identify 'service' and 'education' elements in the work of doctors in training. This will include how the possibility of separate agreements may contribute to resolving some of the difficulties identified by this review.

Working arrangements in hospitals

As outlined earlier in the report, there is a shared commitment to avoid a return to the days when doctors worked excessive hours. However, there is also widespread concern about the impact of constraints on the working time of doctors and the need to ensure that access to training is not compromised. It was made clear by Sir John Temple in his report that training could be delivered within 48 hours but to do so would need changes to working practices and service delivery. The approach was agreed but it was considered that, because any substantial changes would take more than a decade to achieve, action in the short to medium term was needed. It should be noted that the WTR have been fully implemented since 2009 but, as can be seen from the evidence, major challenges remain in several specialties despite attempts to mitigate them.

The taskforce heard evidence of how NHS trusts across the country have reformed the way they deliver services to mitigate any negative impact of the WTD on training. These changes have either improved, or at least maintained, patient safety, service quality and training accountability. In addition to trusts implementing local solutions, there are a number of national programmes of work underway that should deal with some of the challenges associated with the WTR.

For example, Health Education England is leading a programme of work, known as Better Training, Better Care, in line with the aspirations in Sir John Temple's report.

This programme seeks to improve both the quality of training and learning and, consequently, the quality of patient care. It focuses on two overlapping components:

- » the identification, piloting, evaluation and dissemination of good education and training practice; and
- » improvements to curricula and the underpinning of education and training frameworks to ensure training is fit for the purpose of providing safe, effective and improving patient care.

NHS England's National Medical Director Sir Bruce Keogh also set out a plan in December 2013 to drive seven-day services across the NHS over the next three years, in response to concerns about significant variation in outcomes for patients admitted to hospitals at the weekend across the NHS in England.

The plan points to a number of causes, including variable staffing levels in hospitals at the weekend; fewer decision-makers of consultant level and experience; a lack of consistent support services such as diagnostics and a lack of community and primary care services that could prevent some unnecessary admissions and support timely discharge. Its proposals represent a significant change in the system that will have a profound effect on the way care is delivered, and discussions on the WTD need to be viewed in this context.

These programmes are broadly welcomed by the taskforce and there is general agreement that they may deal with some of the challenges associated with the WTR. However, there is still a significant body of opinion, particularly among the craft specialities, that the restrictions on working time are having a negative impact on the training time that junior doctors receive and that this is set to continue in the foreseeable future.

Evidence considered by the taskforce from ASiT and the GMC survey suggests that a considerable number of junior doctors are working additional hours both to maximise the training opportunities but also to maintain service. This is not a common view across all specialties, some of which seem to experience fewer problems with ensuring that junior doctors receive the training they require. However, there was a general acceptance by the taskforce that the restrictions on working time affect specialties differently depending on the specifics of training within those specialties.

The evidence considered by the taskforce seems to support full shift patterns being appropriate for some specialities but not for others – in particular the acute specialities. In its evidence, the RCS expressed concerns about the disruption to working and sleeping patterns as a result of use of full shift rotas. The GMC noted concerns over rota design and the impact on training opportunities. It was noted that it is important to differentiate between training required to qualify and ‘additional’ training undertaken by individuals on a personal and professional basis.

Evidence of effective rota design and working patterns in a number of hospitals, that support high quality training and service delivery, were presented to the taskforce. However, although there were many examples from which lessons can be learned, it was less clear that there was a specific hospital wide solution that could be universally adopted.

The taskforce therefore believes that NHS trusts should review best practice and share examples of how to maximise patient care and training to mitigate against the deleterious effects of reduced hours. Where necessary, local trusts may need to reorganise their teams and services to deliver their own local solutions. However it remains the view of the taskforce that at least in some cases there is a need for greater flexibility to ensure that junior doctors are not constrained from getting the training they need, and this should be supported by local trusts.

The taskforce received evidence from Germany concerning surgery, in this case it was clear that as part of the sectorial solution the social partners (employers’ organisations and trade unions) had negotiated an agreement that allowed those doctors who chose to opt out the ability to work up to 58 hours (a personal commitment is still required even though a sectorial opt-out exists). The EU 2010 implementation report describes other German agreements that allow 60 hours and in special circumstances up to 66 hours. What is clear from the information available to the taskforce is that an opt-out is more consistently used by doctors in Germany than here in the UK. There is no indication that patient care is compromised in the German system despite the increase in hours.

The taskforce has discussed the use of an opt-out and is in complete agreement that individual opt-outs should be freely given and that no disadvantage is suffered by any individual choosing not to opt out. However, **there is agreement in the taskforce that further consideration needs to be given as to how more widespread use of the individual opt-out, where safe, might be encouraged both at the sectorial and**

individual levels. The taskforce believes that such a scheme is worthy of exploration and perhaps provides a specialty specific way forward but this must not be at the expense of quality of patient care; neither does it feel that this approach should have a deleterious impact of the doctor opting out (or indeed those who choose not to).

Continuity and coordination of care

The impact of the WTD on the continuity of patient care has been a subject of debate since the WTD was implemented. Patient safety is paramount in all the respondents' submissions. The RCOG suggests that handovers cause confusion for patients who would prefer an individual named specialist. The taskforce discussed the meaning to the patient of continuity of care and agreed that it means both the extent to which a person experiences an ongoing relationship with a clinician and the coordinated clinical care that progresses smoothly for the patient. It was also noted that the time a patient spends in hospital has reduced significantly over recent decades as technology and practice has changed and improved and it is now the case that most patients are not in hospital for long periods, therefore making it even more difficult for patients to experience an ongoing clinical relationship in the same way as might have been the case in the past.

The taskforce heard and received evidence that noted that since the application of the WTD and specifically the SiMAP and Jaeger European Court judgments have reduced the flexibility that the NHS has with regard to rota design. This has seen a move towards full shift rotas and an increase in the number of handovers that occur.

The taskforce heard evidence that handovers are inevitable and in intense specialities, such as paediatrics, intensive care, emergency and acute medicine and obstetrics, junior doctors will always have to work full shifts and will need a very detailed handover. It was noted that handovers offer valuable opportunities for training but also are an area where continuity of care can be negatively affected. It was a general comment that minimising the number and quality improvement is important. However, there was a concern among members and this was particularly highlighted by the RCP that the SiMAP/Jaeger judgments have led to disruption in continuity of care by increasing handovers including at crucial stages in the care pathway.

The RCP was clear that handovers have safety implications that can lead to incorrect diagnosis and treatment, though make clear that they provide advice and a toolkit on how best to manage handovers. The RCPE pointed to this increase in handovers resulting in lost training opportunities as well as lost continuity of care.

The interplay between the New Deal and the WTD was acknowledged by the taskforce, and it was suggested that some of the negative impacts of the WTD could be addressed through the agreement of new contracts for junior doctors. There was agreement that an opportunity exists to use the current contract negotiations to improve training and patient care. **The taskforce believes that the findings of this report will be of relevance to the ongoing contractual negotiations. The parties to the negotiations are also members of this taskforce and have agreed to take account of them.**

Both the RCPE and ASIT point to surveys where doctors are reporting a decline in the standard of care since the implementation of the WTD. ASIT also noted that there is an 'apparent' reliance on 'goodwill' service provision with 75% of respondents to a recent survey noting that they work late to ensure service quality is maintained.

The RCS notes that handovers are more common under the (full) shift system and thus the risk of errors or something being missed increases, although it was also noted that doctors are also more likely to make errors when they are tired.

There was some discussion about possible solutions to minimising the risks to care presented under the current circumstances and there was discussion recognising that the move towards seven-day services, increased consultant presence and maintenance of a proper regime of planned handovers would be helpful in alleviating and minimising risks. Some went further to recognise that in some smaller specialities it would be sensible to look at reconfiguration as a solution as a way to ensure units have sufficient 'critical mass' to deliver services that are currently under pressure.

The taskforce is clear that the SiMAP and Jaeger judgments have had a significant impact on the NHS. It was recognised these judgments are important in ensuring that doctors do not suffer undue fatigue from working excessive continuous hours and therefore patient safety is not jeopardised. However, it is also true that the impact and application of these judgments have caused the NHS service delivery problems resulting from a lack of flexibility.

The taskforce believes it is essential that the lack of flexibility brought about by the SiMAP/Jaeger judgments is addressed while recognising doctors must not suffer undue fatigue.

6. Table of recommendations

Recommendation	Organisation responsible
<p>The taskforce believes that NHS trusts should review best practice in the design of working patterns and share examples about the successful delivery of patient care and the training of junior doctors. Where necessary, trusts may need to reorganise their teams and services to deliver their own local solutions.</p>	<p>NHS Confederation / Foundation Trust Network / Health Education England</p>
<p>The taskforce believes that the findings of this report will be of relevance to the ongoing contractual negotiations. The parties to the negotiations are also members of this taskforce and have agreed to take account of them.</p>	<p>Department of Health / NHS Employers / British Medical Association</p>
<p>The taskforce recommends that the specific challenges faced by specialities, identified by the GMC survey and in the evidence submitted to the taskforce, should be addressed as part of our wider recommendations.</p>	<p>Medical royal colleges / Health Education England / General Medical Council / NHS Employers</p>
<p>There was agreement in the taskforce that further consideration needs to be given as to how more widespread use of the individual opt-out might be encouraged where safe, both at the sectorial and individual levels.</p>	<p>Department of Health / NHS England / Medical royal colleges</p>
<p>The taskforce recommends that more work should be undertaken to identify 'service' and 'education' elements in the work of doctors in training. This will include how the possibility of separate agreements may contribute to resolving some of the difficulties identified by this review.</p>	<p>Department of Health / Health Education England in consultation with the royal colleges, NHS Employers and the BMA</p>
<p>The taskforce believes it is essential that the lack of flexibility brought about by the SiMAP/Jaeger judgments is addressed while recognising doctors must not suffer undue fatigue.</p>	<p>Department for Business, Innovation and Skills / Department of Health</p>

7. Annexes

A. Taskforce objectives, terms of reference and membership

Objectives of the review

The taskforce will:

- » consider what can be done to ensure that all doctors have flexibility within the current working time regulations to provide continuity of care for their patients and opportunities for training and learning;
- » review evidence on the impact and implementation of the reduced working hours on the delivery of care and training of medical professionals;
- » identify areas of medicine most affected by the implementation of the regulations and identify nationally and locally driven examples of best practice and practical solutions for these issues;
- » consider the impact of contractual arrangements on the implementation of the regulations and advise on practical solutions; and
- » make recommendations for providing continuity of care for patients and ensuring doctors receive high quality training and the experience they need.

The taskforce will report to the Secretary of State for Health in January 2014.

Independence

Any recommendations or findings of the taskforce will be independent of government and based on the work carried out by the group. The taskforce will provide advice directly to the Secretary of State. The taskforce will be supported in its operations by the Department of Health.

*Note on remit of the review

The remit of the group only extends as far as the implementation of the Working Time Directive on the NHS and health professionals. It does not encompass broader consideration of the Working Time Directive as a whole.

B. Taskforce membership

Professor Norman Williams: President, Royal College of Surgeons [Chair]
Andrew Beamish: President, Association of Surgeons in Training
Andrew Foster CBE: Chief Executive of Wrightington Wigan and Leigh NHS FT
Chris Hopson: Chief Executive, Foundation Trust Network (FTN)
Dean Royles: Acting Chief Executive, NHS Confederation and Chief Executive, NHS Employers
Dr Diana Hamilton-Fairley: HEE representative and South London LETB, Director of Education & Quality
Dr Clifford Mann: President, College of Emergency Medicine
Dr Hilary Cass: President, Royal College of Paediatrics and Child Health
Dr Kitty Mohan: Co-chair, BMA Junior Doctors Committee
Dr Patricia Wilkie: President, National Association for Patient Participation
Dr Paul Flynn: Chair of the BMA Consultants Committee
Dr Ted Adams: Academy of Medical Royal Colleges Trainee Doctors' Group
Professor Patricia Peattie: Chairman, Academy of Medical Royal College Lay Advisory Group
Professor Terence Stephenson: Chair, Academy of Medical Royal Colleges
Sir Richard Thompson: President, Royal College of Physicians

The taskforce will also co-opt external expertise from within and outside government as required.

C. Call for evidence

Background

A taskforce considering the implementation of the European Working Time Directive and its impact on the NHS and health professionals has been convened at the request of the Prime Minister's office. The taskforce is chaired by Professor Norman Williams, President of the Royal College of Surgeons, and includes representatives from: The Association of Surgeons in Training; The Royal College of Paediatrics and Child Health; The British Medical Association; Health Education England; The Foundation Trust Network; The Academy of Medical Royal Colleges; The College of Emergency Medicine; The Royal College of Physicians; The NHS Confederation; NHS Employers; a representative from an NHS Foundation Trust; and lay representation.

Call for evidence

To aid this process, the taskforce want to hear from as many stakeholders as possible and ask you to consider:

- » Have you or your organisation encountered any problems relating to the Working Time Regulations and, if so, around what issue in particular?
- » What have you or your organisation been able to do to solve these problems?
- » What more could be done to solve these problems?
- » Is there specific evidence (such as publications or studies) you would highlight to the taskforce?
- » Are there any examples of ways in which the Working Time Directive has been successfully implemented that you would like to highlight?

We invite you to submit responses to the taskforce secretariat (WTDreview@dh.gsi.gov.uk).

Timetable

Given that the taskforce will be reporting to the Secretary of State for Health by January 2014, the timetable is short. As a result, we must request that any responses are submitted by no later than [22 November](#). We will try to accommodate any individuals or organisations that believe themselves to be unlikely to be able to meet this deadline.

D. Evidence received

Organisation

Association of Surgeons in Training
British Medical Association
General Medical Council
Health Education England & England Postgraduate Deans
Medical Protection Society
NHS Employers
Royal College of Anaesthetists
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Physicians and Surgeons Glasgow
Royal College of Physicians of Edinburgh
Royal College of Physicians of Ireland

Royal College of Radiologists
Royal College of Surgeons
Royal College of Surgeons of Edinburgh
Royal College of Surgeons, Women in Surgery

Individual Responses*

Andrew Frankel, Tim Swanwick & Julia Whiteman - Postgraduate Deans of the London LETBs
Associate specialist surgeon, Maxillo-facial unit of a hospital trust
Consultant Anaesthetist
Consultant Occupational Physician & Medical Director, private sector
Consultant Orthopaedic Surgeon
Consultant Paediatric Nephrologist and RCPCH College tutor, NHS trust
Consultant Urologist, district general hospital
Deputy Director of HR, NHS hospital trust
Name but no details provided
Name but no details provided
Orthopaedic Registrar

*Identifiable details of individuals who submitted evidence to the review in a personal capacity have been removed.

E. Oral evidence received

Professor Tim Briggs: Royal National Orthopaedic Hospital
Dr Andrew Goddard: Royal College of Physicians
Dr Jill Donnelly: Wye Valley NHS Trust
Jeremy Taylor: CEO, National Voices
Sir John Temple

F. Note of legal advice

Legal advice was provided in response to the following questions:

1. Is there scope within UK Working Time Regulations, or any other relevant contractual documents, in order to provide greater flexibility to the hours or the

- patterns of work, worked by doctors in the health service, while remaining within the requirements of the European Working Time Directive?
2. In the context of the SiMAP and Jaegar court judgements is there any latitude in the UK Working Time Regulations or European Working Time Directive requirements in respect of implementing on:
 - a. When compensatory rest is taken
 - b. On-call time and classification as working time
 3. With reference to the Deloitte report on the implementation of the Working Time Directive (<http://ec.europa.eu/social/BlobServlet?docId=6421&langId=en>), do any of the member states' applications of the directive described in that document (or elsewhere) provide an avenue for use within the context of the UK regulations, and if so would they place the UK in danger of infraction?
 4. Within the implementation of the working time regulations, provision was made up to 2011 to derogate for junior doctors who provide 24-hour health services that deliver immediate patient care. Does flexibility still exist to enable further derogation for junior doctors vis a vis working hours within the context of any other contractual constraints? Is there scope for improving flexibility for particular medical specialties that require it?
 5. Within the UK Working Time Regulations, does the definition of training exceed the requirements of the Working Time Directive? If so, does this allow any flexibility for the separation of training and/or education from service provision and would this take those training elements outside of the hours considered as 'work' with regard to the working time directive and the UK working time regulations?
 6. Has there been an 'over-implementation' or gold-plating of the UK's interpretation of the directive? Are there other contractual factors which impinge on the interpretation which need to be considered?

The advice centred on assessing the current scope of the WTD and the WTR, in particular in relation to the non-service elements of the activities of doctors in training. It considered the potential for making the most of the flexibility within the WTD by using the derogation provisions. The advice looked at what was required for compliance with the WTD and WTR as matters stood. Further, the possibility for future change in both the WTD and the WTR was noted.

G. Note of analysis

1. The Centre for Workforce Intelligence was asked to support the review by conducting an analysis of data collected by the General Medical Council for their national training survey for 2013, with a focus on the impact of the WTD. Based on 52,679 responses to the survey, the analysis was conducted according to speciality and training stage, asking whether some specialities are more prone to working longer hours than others and if some stages of training have different hours of working than others. It attempted to consider the impact of working longer hours on the quality of care provided and looked at data in respect of the respondents' gender and deanery.¹⁵
2. In terms of the number of respondents working longer than 48 hours by speciality, the data shows that 41 per cent of all respondents reported working longer than this amount of time per week. There is clear variation by specialities, with some specialities (for example, surgery) seeing a majority work more than 48 hours per week versus other speciality groups (for example, psychiatry) where the majority work less than 48 hours per week.¹⁶
3. When the data was analysed for the percentage of respondents that work longer than 48 hours by training stage, it was found that core/lower trainees are the largest group for working longer hours on average (39 per cent). This was followed by foundation trainees (35 per cent), and finally higher trainees (26 per cent).
4. Across all deaneries, the majority of respondents were found to work less than or equal to 48 hours per week, although there was variation across deaneries. Meanwhile, for those respondents working more than 48 hours, there was no real difference by gender (49 per cent male, 51 per cent female). However, for those working less than or equal to 48 hours, only 42 per cent were male and 58 per cent female.
5. The analysis identified a clear difference in responses to how the quality of patient care was rated by those working longer than 48 hours and those working less. Those working more than 48 hours per week answered 'poor' or 'very poor' five times more than those working less than or equal to 48 hours per week; a result that is statistically significant. For those who rated patient care as 'very good', 25 per cent worked longer than 48 hours per week versus 38 per cent for those doing their contracted hours. However, this difference was not statistically significant.

15 Analysis by gender and deanery was conducted using a smaller sample size of 51,373 respondents.

16 Based on the system of classification used by the NHS Information Centre. For example, the surgical group consists of general surgery, neurosurgery, ophthalmology, otolaryngology, paediatric surgery, plastic surgery, trauma and orthopaedic surgery, and urology.

6. Of those respondents working longer hours, the majority who answered to say that the working pattern in their current post left them feeling short of sleep at work felt this way on a weekly (29 per cent) basis. When comparing the responses of those who said that they work longer hours versus those who said they work no extra hours (with the exception of 'never' and 'rarely'), those working longer hours all had higher responses to the 'daily', 'monthly' and 'weekly' categories. There was no clear relationship between those who felt short of sleep on a daily basis and those who felt the quality of patient care being delivered was 'poor' or 'very poor'.

H. Review of the Balance of Competences – summary of health report

The Balance of Competences report for health was published in July 2013, as part of the wider Balance of Competences review that is being led by the Foreign and Commonwealth Office.¹⁷ This review is taking forward the coalition government's commitment to examine the balance of competences between the UK and the European Union (EU) and aims to provide an analysis of what the UK's membership of the EU means for the UK national interest. Its intention is to deepen public and Parliamentary understanding of the nature of the UK's EU membership and to provide a constructive and serious contribution to the national and wider European debate about modernising, reforming and improving the EU in the face of collective challenges. It is not tasked with producing specific recommendations or looking at alternative models for Britain's overall relationship with the EU.

The health report, which is based on the findings of a three-month public consultation, examines the EU's role in three distinct areas: medicines and medical devices; public health; and the NHS and patient services. It concludes that stakeholders were clear that the current balance of competence is broadly right and that this should remain the case, but it suggests that there is potential for taking forward further work in relation to specific concerns that had been expressed, with the WTD's impact on the NHS being one.

The report highlights a number of issues that stakeholders had raised in relation to the WTD. Some respondents mentioned that the WTD can bring benefits for staff and patients, but others questioned whether it delivers a work-life balance for all staff, and the impact it has on continuity of patient care as well as junior doctors' training.

17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224715/2901083_EU-Health_acc.pdf

Specific concerns were expressed about the impact of the WTD on training and the suggestion that it limits the time available for training.

Restrictions on working hours imposed by the junior doctor's contract were also highlighted and the report found the main point of disagreement to be about whether the problems highlighted are due to the directive itself or other factors, such as its interaction with domestic arrangements or problems with its implementation.

Concerns were raised about an increased number of handovers of patients and how a reliance on locums, owing to the various rules governing working time constraining staff capacity, is negatively affecting safe and continuous care as well as driving up temporary staff costs for NHS trusts. A number of stakeholders suggested that there is a lack of operational flexibility, particularly around the on-call time and compensatory rest requirements caused by the CJEU judgments SIMAP and Jaeger. The evidence also showed some stakeholders to believe that more needs to be done to ensure rules governing working time allow suitable training opportunities for doctors to deliver a health service that operates on a 24-hour basis.

Some respondents commented that the impact of a cross-sectoral one-size fits all approach is not helpful because it does not take into account the difference between the operating environment in the health sector and other sectors or between different medical specialties. Similarly, some stakeholders said that the WTD does not take into account that member states have different approaches to training their health professionals.

Particular concerns were raised about the consequences for specialisms, such as surgery, which noticed deterioration in training and exhausted surgical staff owing to full shift rotas, including surgical training and in maternity and paediatric units. While these issues are most acute for junior doctors, the impacts are inevitably felt by others as well.

In relation to the WTD, the Balance of Competences report for health concluded that as part of the government's commitment to limit the application of the WTD in the UK, the Department of Health would be:

- » working with the Department for Business, Innovation and Skills (BIS) to seek greater flexibility in the areas of on-call time and compensatory rest;

- » maintaining the facility of individual doctors and other health workers to opt out of the directive;
- » considering the interaction between the WTD and other current contractual provisions (such as the junior doctors' contract) and how the WTD is implemented in the UK in the health sector;
- » undertaking a survey to gather junior doctors' opinions of the WTD so that the underlying principle of any future reform produces regulations that are fit for purpose and meet the needs of the service; and
- » continuing to work with BIS and with partners in Europe, on any renegotiation of the WTD with the aim of providing the flexibility the UK needs.

I. Glossary of Key Terms

Derogation – A deviation or exemption from a law or rule, in this context the European Working Time Directive.

Full Shift Rota – A working pattern in which the blocks of time are limited to 14 hours or less (13 hours under the Working Time Regulations) and in which the doctor can expect to be working throughout the whole duty period, except for natural breaks.

Jaeger – European Court of Justice ruling concerned the definition of doctors' working time. The court held that the directive must be interpreted as meaning that on-call duty performed by a doctor where he is required to be physically present in the hospital must be regarded as constituting working time in its totality for the purposes of the directive, even where the person concerned is permitted to rest at his place of work during the period when his services are not required. Periods when the doctor was on call but not working should not be treated as rest periods. Compensatory rest periods must immediately follow the periods worked.

Junior doctor/doctor in training – Junior doctors, also called doctors in training in the NHS, are doctors who have completed a medical degree and are employed in posts providing approved postgraduate training programmes.

The junior doctors' contract (also known as the 'New Deal') – The contract that covers working time and terms on conditions (including pay) of doctors in training. When introduced it aimed to reduce junior doctors' working hours and provide them with adequate rest periods amid growing concerns that many junior doctors were working

too many hours each week and endangering patients as a result of their fatigue. In 2000 it was renegotiated and introduced pay banding supplements designed to penalise employers with high payments when junior doctors in their trusts worked hours that were excessive.

NHS trust doctors/fellows – Doctors who are not in recognised training posts.

Opt-out – The individual opt-out is the mechanism under the WTD that allows doctors to work more than 48-hours a week by agreement with their employer.

Out-of-hours service – Under the current terms and conditions of service for doctors in training, the out of hours period is time outside the hours of 7am–7pm Monday to Friday.

SiMAP – European Court of Justice ruling dealing with ‘on-call’. The court ruled that ‘time spent on call by doctors must be regarded in its entirety as working time. If staff merely have to be contactable [at all times] when on-call, only time linked to the actual provision of primary health care services must be regarded as “working time”’.

Working Time Directive – EU legislation introduced as a health and safety measure, and a response to growing concerns that workers in certain sectors across Europe were being asked to work excessive hours that endangered the lives of both themselves and others. The directive limits workers to a maximum 48-hour week, averaged over a 6-month period. It lays down minimum requirements in relation to working hours, rest periods and annual leave. The WTD was enacted in the UK through the Working Time Regulations in October 1998.

Working Time Regulations – The Working Time Regulations transpose the Working Time Directive requirements in to British law. On their introduction they applied to the majority of UK workers, with some exceptions, including junior doctors who were given longer to comply with the regulations. The Working Time Regulations now apply to all staff in the NHS.

J. Further reading

1. Professor Sir John Temple. Time for Training: A Review of the Impact of the Working Time Directive on the Quality of Training. Medical Education England; June 2010. <http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf>.
2. European Commission. Reviewing the Working Time Directive (second phase consultation of the social partners at European level under Article 154 TFEU). Brussels; 2010. <http://ec.europa.eu/social/BlobServlet?docId=6419&langId=en>.
3. Deloitte. Study to support an Impact Assessment on further action at European level regarding Directive 2003/88/EC and the evolution of working time organisation. December 2010. <http://ec.europa.eu/social/BlobServlet?docId=6421&langId=en>.
4. HM Government. Review of the Balance of Competences between the United Kingdom and the European Union: Health. July 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224715/2901083_EU-Health_acc.pdf.

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