European Working Time Directive

Assessing the challenge facing the NHS and possible ways of achieving compliance

**Summary**

By 1 August 2004, NHS organisations will need to make sure that their employment of junior doctors complies with the European Working Time Directive (WTD).

The WTD creates real challenges for the NHS. There could be changes to the directive from 2005, but trusts still face the legal requirement to be compliant from August 2004.

The Hospital at Night project is looking at how medical cover is provided in hospitals out of hours with the aim of developing new ways of working that will support compliance with the WTD. A WTD pilots programme is testing these changes and evaluating their impact on WTD compliance and the quality of patient care. Some key ways of achieving WTD compliance and improving patient care have been identified.

Whilst the European Working Time Directive (WTD) has been a catalyst for NHS organisations’ consideration of new ways of working to help reduce junior doctors’ working hours, improve staff and patient safety and quality of care, there is real concern in the NHS about the ability to achieve compliance by the August 2004 deadline while maintaining existing levels of service. This Briefing summarises the provisions of the WTD as they apply to hospitals, looks at the latest developments, and considers two particular projects – Hospital at Night and the WTD pilots programme – which aim to help trusts achieve compliance and improve performance.

**Background**

The WTD is health and safety legislation, adopted by the European Commission in May 2000. By 1 August 2004, NHS organisations will need to make sure that their employment of junior doctors complies with it. Although the directive already applies to UK employees, there have been some exceptions, including doctors in training. This will change in August 2004 when they too will come within the remit of the directive.

The key points of the WTD are that all workers, except those in excluded groups, must have:

- 11 hours’ rest in every 24 hours
- a minimum 20-minute break when their shift exceeds six hours
- a minimum 24-hour rest in every seven days or a minimum 48-hour rest in every 14 days
- a minimum four weeks’ annual leave
- a maximum of eight hours’ work in every 24 hours for night workers.

Since August 2003, to comply with the new junior doctors’ contract – the New Deal – overall average weekly working hours for junior doctors should be 56 hours. This pre-empted the WTD, which requires a reduction
to 58 hours by August 2004 and a further cut to 48 hours by 2009, or exceptionally, by 2012. The 11 hours’ rest requirement will apply to junior doctors from August 2004.

The original provisions of the directive have been enhanced by two judgements from the European Court:

The SiMAP judgement – named after the Spanish doctors’ trade union that brought the case – ruled that all doctors who are required to be resident on-call in a hospital will be deemed to be working for the whole of the resident on-call period, even if they are asleep. This has major implications for the deployment of junior doctors and means that most current rotas would not be WTD compliant.

The Jaeger judgement ruled that compensatory rest, to make up for any lost rest time, has to be taken immediately the period of duty finishes and before the next duty period begins. This restriction on taking rest at other times creates additional challenges in ensuring the level of services is maintained.

Achieving compliance

To achieve compliant working patterns for junior doctors, the NHS is being encouraged to:

- make effective use of the planned growth in the medical workforce
- use more cross-cover between specialities, and fewer tiers of cover, to reduce the number of out-of-hours rotas staffed by junior doctors
- employ non-medical practitioners more effectively
- move to team working and re-designed working patterns for staff
- develop new service models that support improved patient care and local access to services while delivering WTD compliance.

Hospital at Night

Hospital at Night is a Modernisation Agency project that was set up to look at how medical cover is provided in hospitals out of hours. The aim is to use information about what happens in hospitals at these times to develop new ways of working that will support compliance with the WTD, improve patient care and enhance clinical practice and training. The model being developed is based around the creation of multidisciplinary teams, possessing the full range of skills and competencies to meet patients’ immediate clinical needs.

The starting point is that traditional arrangements for providing medical cover out of hours, which relied on junior doctors being resident on-call overnight, will no longer be possible under the new regulations.

The Hospital at Night project began with a survey to establish what actually happens in hospitals out of hours. It found that evenings – 5pm to 8pm – were very busy, but nights were quieter. More than 75 per cent of the total out-of-hours activity takes place before midnight, although current staffing does not reflect this. The survey also revealed that much of doctors’ time is taken up by tasks that do not necessarily require their level of skill. The evidence points to opportunities:

- for other staff to take on some of the work traditionally done by doctors at night
- to move a significant proportion of the work from the night to the extended day
- to reduce unnecessary duplication of work – especially through a reduction in multiple clerking.

Four trusts are currently piloting a Hospital at Night approach. This involves one or more teams of appropriately-skilled staff covering the whole hospital at night from 11pm to 7am, with the exception of intensive care units, paediatrics and obstetrics. The teams work to agreed protocols and have the competencies to cover a wide range of interventions. They can call in specialist expertise when needed.

Team composition

The composition of the teams depends on the amount of acute work locally and the core competencies dictated by the local patient mix. Core team membership includes senior medical and nursing staff, but the overall size of the team depends on the size of the hospital. The team may also include other healthcare professionals and dedicated support such as portering and administration. It could also incorporate local GPs and clinicians’ assistants with a wide range of skills.

The out-of-hours, competency-based team approach is likely to release the greatest amount of junior doctor time in:

- pre-registration house officer (PRHO) and junior SHO (senior house officer) levels – all specialities
- trauma and orthopaedics – SHO and specialist registrars (SpR)
- medical and surgical sub-specialities – SHO and SpR

‘There could be changes to the directive but trusts still face the legal requirement to be compliant from August this year’
• large district general and teaching hospitals where there are currently multiple parallel rotas.

There are opportunities to contribute to WTD compliance through:

• clear separation of elective and emergency work – with dedicated facilities and workforce
• potential integration of A&E middle grades and inpatient teams
• potential use of consultants in what were ‘junior only’ resident rotas
• reduction in the number of parallel rotas required in anaesthetics between midnight and 8am
• use of clinical networks to enable ‘treat and transfer’ of patients.

Benefits for patients
Benefits include:
• more timely and better co-ordinated care

Benefits for staff
Benefits include:
• higher-quality clinical care
• improved risk assessment
• being seen by better-trained and more senior staff
• being seen by fresh – not tired – doctors
• a decrease in the repetition of tasks and fewer hand-offs.

Key approaches to achieving compliance
The pilots generally involve a combination of several elements:

• new roles for non-medical staff – professional staff such as nurses and pharmacists – and non-registered staff such as medical assistants
• new rotas and working patterns for doctors – consultants as well as doctors in training
• new service delivery patterns – such as nurse-led services, combined assessment units, alternative forms of night cover, and consultant-staffed telephone lines for GP referrals.

A WTD pilots programme, managed by the NHS Modernisation Agency, has been designed to test new service models and ways of working, to evaluate their impact on WTD compliance and the quality of patient care. There are currently 19 pilots, most of which will finish before August 2004, with others completing in late 2004 or early 2005.

Case study: Wirral Hospitals NHS Trust

An audit at Wirral Hospitals NHS Trust found that out of hours:
• there was an uneven distribution of work
• there was a low admission rate in most specialities
• doctors were bleeped unnecessarily
• junior doctors were often left to carry out unnecessary tasks
• much activity was unfinished business from the day.

Wirral’s answer has been to set up a flexible, competency-based team that provides overnight cover for emergency work. It covers a 12-hour shift – 9am to 9pm. The team includes an operational manager who provides a link between staff and allocates work to the most appropriate member of the team. The team also includes medical staff, for example, anaesthesia, critical care, A&E, surgery, orthopaedics and paediatrics, and non-medical staff such as porters and lab staff.

To support the proposals, the trust is carrying out a parallel piece of work that will see an expansion of the role of healthcare assistants, allowing them to handle more complex areas.
of working in anaesthesia covering five trusts. It is producing a national curriculum, developed with the Royal College of Anaesthetists and the NHS University, for training non-medical practitioners to work in the anaesthetic team.

Outcomes of the pilots
Although none of the pilots has yet fully completed its work, there are already successes to report.

• Ten of the pilots have achieved WTD compliance for doctors in training in the pilot area.
• 11 have achieved savings in junior doctors’ time that can contribute towards compliance.
• Eight have demonstrated quantifiable improvements in patient care as a result of the changes they have introduced. These include:
  – reduced time from admission to A&E to transfer to ward
  – shorter waiting time in clinics, and for operations and outpatient appointments
  – reduced length of stay
  – quicker access to medicines
  – quicker access to test results informing diagnosis
  – higher-quality patient care processes, for example, accuracy and completeness of drug charts.

Learning from the pilots
Several lessons have been learnt:
• Staff involvement in change is one of the keys to success.
• Professional issues, particularly the scope of practice of non-registered medical assistants, and the use of non-medical prescribing and supply of medicines, can be a stumbling block.
• Recruitment to highly-skilled roles, such as nurse practitioners, has often been a lengthy process, and some pilots have found developing existing staff a quicker and more reliable route.
• Finding the right level of reward for staff taking on extended roles and integrating this into the existing frameworks of staff pay has been problematic in some pilots.
• Involving patients and the local community has been one of the pilots’ challenges.
• Feedback from patients on new services within the pilots has been positive. For example, in Basildon and Thurrock’s pilot involving briefing 101

Some outcomes from the WTD pilots
Pilots have variously reported the following:
• a mean 14 per cent reduction in ‘door to needle’ time for treatment with clot-busting drugs
• 24 hours per week of specialist registrar time saved by pharmacists
• a reduction in average time from arrival in A&E to transfer to ward from 250 minutes to 90 minutes
• clinic waiting times down by 75 per cent and discharge brought forward by three days
• a net saving of more than £200,000 per year because of changes to doctors’ banding following the introduction of medical assistants
• unnecessary bleeps reduced from 68 per cent of call outs to zero
• reduction in time from the prescription to the administration of analgesia from 35 minutes to seven minutes
• outpatient waiting times reduced to less than eight weeks for routine appointments; cancelled theatre sessions reduced to zero.

‘To achieve compliant working patterns for junior doctors, the NHS is being encouraged to move to team working and redesigned working patterns for staff’

Types of WTD pilot
Pilots are currently examining the following areas:
• working differently in emergency care and admissions
• the role of MEAs and other practitioners
• alternative night cover arrangements
• changing the consultant working pattern
• rota planning and rationalisation
• new roles in surgery and critical care
• new roles in obstetrics, gynaecology and neonatal care
• other professional roles in direct clinical care
• mental health services.
pharmacy technicians relieving junior doctors of some medicines work, 93 per cent of patients were either happy that pharmacy staff rather than doctors had asked about their medicines history, or said they didn’t mind.

How to succeed
At this stage, the key ingredients for achieving the goal of WTD compliance and improved patient care in pilot projects have proved to be:

• a committed clinical leader
• sufficient project management time
• board-level involvement
• integration of change into trusts’ existing clinical governance procedures
• and, crucially, communication with staff, patients and stakeholders outside of the organisation.

General developments
Although the impact of the WTD varies according to how services are organised in different countries, there is growing consensus across the European Union that it creates real challenges for health services – particularly because of the interpretations of the directive in the SiMAP and Jaeger judgements.

European policy
The UK Government supports the directive’s original aim but believes SiMAP and Jaeger create difficulties. Initiation to restrict working hours for doctors in training are not just happening in Europe: similar moves are underway in Australia, Canada and the USA. These are all based on a recognition of the safety implications of working excessive hours for both patients and staff. We acknowledge that past working arrangements in the NHS for doctors in training are no longer acceptable for staff or for service provision.

The need to address WTD compliance has forced NHS organisations to think about how staff might work differently and to explore new ways of providing services. Planning and safety considerations may well have led NHS organisations to consider these issues anyway, but undoubtedly the WTD’s August deadline has prompted greater urgency. Moves

SiMAP and Jaeger significantly extend the practical implications of the directive and could harm the NHS’s ability to provide appropriate patient care

NHS Confederation viewpoint
The NHS Confederation supports the intent and provision of the WTD. The directive is important to staff and patient safety and has provided a catalyst to examine the best way to provide care. However, we are concerned about the implications of SiMAP and Jaeger which significantly extend the practical implications of the directive and could seriously harm the NHS’s ability to provide appropriate patient care. We doubt that it will be possible for a significant number of organisations to meet the August 2004 compliance deadline.

Implementation
Achieving compliance is a key issue for NHS organisations throughout the UK and for the Government. In England, a national WTD implementation board has been set up to oversee the process and strategic health authorities (SHAs) have all designated WTD lead officers. All trusts were required to produce implementation plans by the start of 2004. This is a key performance management issue for SHAs. In Scotland, the Implementation Support Group on the New Deal

will continue to support and monitor NHS organisations’ implementation of WTD.

NHS Confederation viewpoint
The NHS Confederation supports the intent and provision of the WTD. The directive is important to staff and patient safety and has provided a catalyst to examine the best way to provide care. However, we are concerned about the implications of SiMAP and Jaeger which significantly extend the practical implications of the directive and could seriously harm the NHS’s ability to provide appropriate patient care. We doubt that it will be possible for a significant number of organisations to meet the August 2004 compliance deadline.

Initiatives to restrict working hours for doctors in training are not just happening in Europe: similar moves are underway in Australia, Canada and the USA. These are all based on a recognition of the safety implications of working excessive hours for both patients and staff. We acknowledge that past working arrangements in the NHS for doctors in training are no longer acceptable for staff or for service provision.

The need to address WTD compliance has forced NHS organisations to think about how staff might work differently and to explore new ways of providing services. Planning and safety considerations may well have led NHS organisations to consider these issues anyway, but undoubtedly the WTD’s August deadline has prompted greater urgency. Moves

1 “We will continue to press the case for a revision of the directive” – John Hutton MP, Minister for Health, 10 October 2003
Towards compliance have already led to a more effective and efficient use of resources and better service provision in many hospitals. The Hospital at Night project and the WTD pilots programme will both contribute towards the better use of resources and improvements in services in many organisations.

However, despite changes to working patterns and a reorganisation of the way services are provided, there are some hospitals where it will still be hard to achieve the necessary reduction in junior doctors’ hours. In some hospitals and specialities the figures simply do not add up. Some trusts will not be able to continue to provide safe clinical care in certain specialities if they seek to introduce compliant rotas. These organisations would be put in the unacceptable position of having to choose between compromising patient care or failing to comply with the directive.

In these cases the NHS will only be able to provide a safe standard of care by reconfiguring services. The danger is that the options available may not be compatible with local community wishes or the intent of UK government or devolved administration policy, such as that set out in the English Department of Health document, Keeping the NHS local – a new direction of travel.

We recognise that it is the Government’s responsibility to ensure that the WTD is implemented; but where, despite trusts’ best efforts, it is not possible to achieve compliance it is vital that there is a positive and supportive response rather than a punitive one from the four health departments.

The Confederation believes that the directive should be amended to acknowledge the fact that resident on-call time is different from time spent actively working, and to allow compensatory rest to be taken within a reasonable period of time rather than immediately. We also believe that the current provision which allows individuals to opt out of the WTD requirements should not be withdrawn. We will continue to lobby on all these issues.

For further information on the issues covered in this Briefing, contact alastair.henderson@nhsconfed.org.

Further information

Lessons learnt from the WTD pilots’ experience are being shared with the NHS through a monthly bulletin, Calling time. For further information contact Frances.Neate@doh.gsi.gov.uk

For reports of WTD pilots, back issues of Calling time and a library of job descriptions, protocols, audit templates and other useful tools see: www.modern.nhs.uk/workingtime


The European working time directive – NHS Confederation briefing, September 2002
www.nhsconfed.org/docs/briefing70.pdf

The Hospital at Night project
www.modern.nhs.uk/hospitalatnight

Implementation Support Group, Scotland
www.show.scot.nhs.uk/ImplementationSupportGroup

Further copies can be obtained from:
NHS Confederation Distribution
Tel 0870 444 5841  Fax 0870 444 5842
E-mail publications@nhsconfed.org
or visit www.nhsconfed.org/publications

Registered Charity no: 1090329