BMA response to Working Time Directive Taskforce call for evidence

November 2013

Introduction

The BMA strongly supports the Working Time Regulations (WTR) and the related "SiMAP" and "Jaeger" judgements. Their introduction has reduced fatigue among doctors and improved the safety of both patients and doctors. The days of habitual 100 hour weeks for junior doctors are, thankfully, behind us and we would not, under any circumstances, want to see a return to the problems of the past.

However, we recognise that implementing the WTR has brought new challenges. Complex, intense and anti-social rotas have become increasingly common, and concerns have been expressed that the implementation of WTR has not worked well in some places. Some rotas still cause fatigue and this can impact on patient and doctor safety. Concerns have also been expressed about some reduction in training opportunities.

We believe that many of the concerns that have been expressed about the negative impact of the WTR are linked to poor implementation and poor leadership at a local and national level. Better implementation and stronger leadership within the framework of the current WTR is required.

1. Have you or your organisation encountered any problems relating to the Working Time Regulations and, if so, around what issue in particular?

The BMA regularly asks doctors for their views on working hours. In addition to its ongoing cohort study,[1] the BMA conducted two major surveys on working arrangements in 2008[2] and 2010.[3] The feedback[4] we received after the initial phase of the junior doctor contract negotiation focused heavily on working hours and their impact on patient safety, doctors' safety and wellbeing, and training.

Although the WTR applies to all doctors, GPs, consultants, staff grade, associate specialist and specialty doctors rarely report significant or sustained problems with implementation, although there is still some confusion about the calculation and timing of compensatory rest, particularly as it applies to doctors in secondary care. Although the BMA fully supports the concept of compensatory rest, concerns exist over its interpretation and application. Consultants, when on-call, are often called for relatively short periods but their sleep can often be disrupted for considerably longer than the duration of the telephone consultation. For example, a consultant may be called at 2am, 3.30am and 5am for 5 minutes at a time and may only be offered 15 minutes compensatory rest as a result when clearly the vast majority of their sleeping time has been disrupted. Compensatory rest must properly recognise the impact of short periods of work on rest.

Medical academics and other groups of doctors with multiple employers also face a lack of clarity about how WTR apply to the commitment they have to more than one employer. In the case of medical academics, university employers argue that the WTR do not apply in the academic sector as academics are in control of their own hours.

Junior doctors are the group most affected by long hours, fatigue, and complex implementation of the WTR. In addition, a number of specialty doctors continue to work on the same rotas and face a number of the same problems. While the WTR have undoubtedly improved the situation, junior doctors have consistently expressed concern about the impact that long, intense and irregular shifts have on patient safety, doctors' own safety, and on training.

Safety of patients and doctors

It 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.

1 http://bma.org.uk/working-for-change/negotiating-for-the-profession/workforce/cohort-study
2 BMA Health Policy and Economic Research Unit (2008) *BMA survey of members views on the European Working Time Directive – Final Report.* London: British Medical Association
3 BMA Junior Doctors Committee (2010) *BMA Survey of junior doctors' working arrangements 2010.* London: British Medical Association
4 http://bma.org.uk/-/media/Files/PDFs/Working%20for%20change/Negotiating%20for%20the%20profession/BMA%20Junior%20Doctors%20Report%20220713.pdf

In 2010, the BMA's Board of Science produced a report entitled 'Health effects of working unsocial hours and shift work'[5] which examined the impact working unsocial hours can have on health. It concluded that shorter sleep duration and/or poor sleep quality could have a significant impact on health.

A summary of research on the impact of fatigue on doctors can be found in the literature review of the 2012 GMC report 'The Impact of the Working Time Regulations on Medical Education and Training',[6] and the BMA concurs with the conclusions of this report.

There are two key factors that drive fatigue among doctors in the UK. One is long working hours over short periods, for example one to two weeks. The other is shorter, but more intense and anti-social, rotas which often only allow a short recovery time between shifts.

The GMC report concludes[7] that:

"Fatigue is generally associated with deficits in cognitive abilities and psychomotor skills (e.g. memory, attention, simulator performance), as well as negative consequences for patient safety (e.g. clinical errors, diagnostic mistakes), personal safety (e.g. injury at work, vehicle accidents), and wellbeing (cardiovascular problems, burnout)."

"Reduction of working hours has positive effects on fatigue and related variables in many cases, but not always. It is important to recognise the role of different work patterns and schedules, as fatigue is also affected by, for example, the number of consecutive days or nights worked, the length of intervals between shifts, and the timing of shifts (day/evening/night)."

The average number of hours that doctors work has come down dramatically since the introduction of the Working Time Regulations. The BMA believes that this has, on the whole, improved safety within the NHS. In the BMA's 2010 survey of junior doctors,[8] 30 per cent of respondents indicated that compliance with a maximum 48 hour week had had a positive effect on their personal health and safety, compared to 18.3 per cent who indicated it had had a negative effect.

However, as the GMC report also notes, different working patterns may have introduced other risks. For example, long hours have not been eliminated entirely. Working hours for doctors working on shifts is dependent on how the rota is organised and averaging 48 hours over a reference period of 26 weeks does not preclude doctors from working long hours in short sustained bursts followed by a period where they are

5 http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/77N84N5KQ1LVMF7XR5FUI6MQNG287F.pdf
6 http://www.gmc-uk.org/about/research/14413.asp
7 http://www.gmc-uk.org/about/research/14413.asp – page 24
8 BMA Junior Doctors Committee (2010) *BMA Survey of junior doctors' working arrangements 2010.* London: British Medical Association

relatively inactive. Because of this, many junior doctors still report that the fatigue that comes from long working hours is a problem, particularly when working multiple night shifts. For example, in 2013 one junior doctor told the BMA:[9]

"Night working needs more controls in order to keep doctors safe. I can manage a run of intense 13 hour night shifts in a busy tertiary centre but I am terrified about falling asleep on the 37 mile drive home."

Recent years have seen the introduction of much more complex and intense rotas in secondary care as employers strive to balance the requirements of the WTR with a need to ensure that hospitals are adequately staffed and junior doctors receive adequate training opportunities. Doctors have reported that this has led to other problems. Poor rota design, the increased number of handovers and an increased focus on service provision were cited by junior doctors responding to the BMA's 2010 survey.

Impact on training

In 2010, 50 per cent of respondents to the BMA 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.

These percentages change dramatically dependent on specialty, with those in specialties which require experiential learning of practical procedures markedly less likely to believe that training can be delivered within a 48 hour week. For example, around 70% of psychiatry and emergency medicine trainees believe it is possible to train in their specialty within a 48 hour week, but only 33% believe this is possible in surgical training.

Over half of respondents said that the length of training should be increased to enable the required competencies to be reached within a maximum average of 48 hours per week.

It is pertinent to note that, although some doctors have expressed concerns about the quality of their training, there is a distinct lack of empirical evidence to support the premise that their training has been negatively affected by the WTR. This is partly because it is difficult to study the impact of a change that has only been fully in place since 2010, and partly due to the introduction of other changes to postgraduate medical training which took place in parallel and make it difficult to isolate the impact of just one factor.

To the best of the BMA's knowledge, no link has been demonstrated between the introduction of the WTR and the proportion of doctors who are awarded a Certificate of Completion of Training or Certificate of Eligibility for Specialist Registration – both of which require candidates to demonstrate that they have met pre-defined criteria for training, qualifications and experience.

9 http://bma.org.uk/-/media/Files/PDFs/Working%20for%20change/Negotiating%20for%20the%20profession/BMA%20Junior%20Doctors%20Report%20220713.pdf

2. What have you or your organisation been able to do to solve these problems?

The WTR is just one of a number of factors that have an impact on patient and doctor safety, and the quality of training. The BMA seeks to address all of these factors through a variety of approaches. With specific reference to the WTR, the BMA takes the following broad approach to addressing problems with WTR implementation:

- Publication of guidance
- Support for individual members who encounter difficulties
- Negotiations with NHS Employers to ensure the development of an effective contract for doctors in training

Publication of Guidance

The BMA regularly produces guidance on the WTR and related issues. This guidance is primarily aimed at an audience of clinicians, but we know that it is also widely used by NHS managers.

As well as general guidance about the impact of WTR on each of the main groups of doctors, we have produced more comprehensive guidance in a number of areas, including:

- **Rota Design** – Good rota design is a critical if the WTR are to be properly and safely implemented and fatigue is to be avoided. Although rota design in secondary care is more complex than it used to be, this does not mean that it is too difficult to do well. Our guidance outlines the basic principles that we believe must be used to organise rotas that comply with the law and keep patients and doctors safe. It recommends that doctors should be involved in rota design.[10]
- **Monitoring** – Junior doctors have a responsibility to ensure that they are working safely. To help with this, the BMA has also produced guidance on monitoring, which we hope will help doctors to ensure that their working hours are safe and in compliance with the WTR.[11]
- **Handover** – Shorter rotas can mean more handovers and, together with the NHS Modernisation Agency and National Patient Safety Agency, we have produced guidance to support clinicians and managers in developing safe handover procedures.[12]

A more comprehensive list of guidance produced by the BMA can be found in section 4 of this paper.

10 http://bma.org.uk/practical-support-at-work/contracts/juniors-contracts/rotas-and-working-patterns
11 http://bma.org.uk/practical-support-at-work/contracts/juniors-contracts/monitoring-guide/what-is-monitoring
12 http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Contracts/safe%20handover%20safe%20patients.pdf

Support for individual members

The BMA provides tailored support to individual members on request. This includes contract checking, supporting members to engage in rota design and to challenge poor (and sometimes illegal) rota design.

We flag up concerns in advance or as early as possible so that they can be addressed by employers before they become a problem. We have also agreed WTR policies with many employers, via Local Negotiating Committees (LNCs).

BMA staff provide support to individual members and groups of members in their efforts to monitor their working hours' compliance with the WTR and support them in resolving these problems. We also ensure that reports are circulated to LNCs so that concerns can be addressed across the whole Trust.

We also advise members when they approach us for information about how to opt-out of WTR regulations.

Junior Doctors Contract Negotiations

The BMA, NHS Employers, and representatives from Scotland, Wales and Northern Ireland are currently negotiating a new contract for doctors in training, and working hours will form a large part of our joint work. We expect that negotiations will continue until late 2014, with a view to introducing a new contract in 2015.

The contract will be a complete revision of the current contract, and will have a strong emphasis on simplicity, safety and training. As a baseline, we have agreed that any new contract should:

- comply with relevant legislation
- be safe for patients and for doctors in training
- recognise that both service delivery and training will continue to take place throughout the seven day week.

In acknowledging that some doctors in training may wish to work longer hours, we have agreed that 'where it is possible to opt out of all or part of statutory working hours limits, the employment contract will enable doctors in training who wish to opt out to do so, but they will not be required by employers to opt out.'

And, in recognition of the risks that can come from working too many hours in a single week, we have also agreed to 'investigate limiting the number of actual working hours (as defined by statute) in a defined (in days) period."

Outside major contract negotiations, the BMA meets regularly with NHS Employers to negotiate minor necessary changes to existing contracts.

Consultant Contract Negotiations

Similarly, the BMA is currently involved in negotiations over potentially the most significant changes to the consultant contract for at least a decade and one aspect being discussed is how to increase consultant presence across the whole of the 7 day week. Any change to working patterns and hours should always be considered in the context of its possible impact on the health and safety of those directly and indirectly affected and it is vital that strong health and safety legislation is in place and regularly reviewed to ensure that consultants and their patients are not at risk as a result of changes to working practices.

3. What more could be done to solve these problems?

When 'Time for Training: A Review of the impact of the European Working Time Directive on the quality of training'[13] was released in 2010, the BMA called for[14]:

- A clear commitment to implementing the recommendations by the Department of Health, employers and deaneries
- A coordinated response by all key stakeholders in ensuring the recommendations are implemented locally as best appropriate
- A review of whether the recommendations have been implemented
- A clear understanding of the prioritisation of the recommendations
- Clarification of the relevance of the report to the devolved nations
- An annual review of training outcomes for trainees following the introduction of the EWTD in order to follow the impact of EWTD on training
- Clear consultation and involvement of consultants and trainees in changes at local and regional level to ensure that training opportunities are optimised with the 48 hour working week.

We are disappointed that many of the review's recommendations, and many of the changes the BMA called for in 2010, have not been effectively implemented. As noted in section 4, there is a wealth of literature in this area and a great deal of excellent guidance. Instead of more of the same, what is needed now is strong leadership from key stakeholders and a sustained commitment to implementing the good practice that already exists.

In particular, we believe that:

- greater focus should be placed on ensuring that rotas are designed appropriately. As well as placing an emphasis on safety by balancing working hours to limit unnecessary fatigue, a good rota will also ensure that trainees receive sufficient training opportunities during their placements
- some use could be made of increased working hours, through use of the individual opt-out which is available under the current WTR. The BMA supports the use of the opt-out in principle, although we do not believe it should be used to address problems of poor training as these should be addressed through other channels. Doctors should not, under any circumstances, be pressured to opt-out against their wishes. There is a risk that increasing usage of the opt-out could cause additional fatigue. It is also likely that employers will incur additional salary costs if they ask doctors to work longer hours
- consideration could be given to extending training programmes in specialties where it can be clearly demonstrated that trainees are not receiving sufficient training to be awarded a CCT / CESR. This could allow an increase in training time without an increase of fatigue if combined with good rota design and a commitment to increasing training opportunities instead of simply increasing the level of service provision. Extending training programmes would require a significant restructuring of training and should not be done to address problems of poor training, which again should be addressed through other channels.

13 http://www.mee.nhs.uk/PDF/JCEWTD_Final%20report.pdf
14 http://bma.org.uk/working-for-change/negotiating-for-the-profession/european-priorities/ewtd

4. Is there specific evidence (such as publications or studies) you would like to highlight to the taskforce?

There is a wealth of research into the impact that the WTR has had on the NHS. Key areas of focus include the impact on patient safety, the impact on training and the wellbeing of doctors and training. This research is well summarised in the literature review that was published alongside the GMC's 2012 report into 'The Impact of the Working Time Regulations on Medical Education and Training'.[15]

There are a number of research and resource documents which we would like to highlight, and we have listed them below. We have also listed some key BMA publications.

BMA publications

- BMA survey of members views on the European Working Time Directive – Final Report – 2008 – Click here to read.
- BMA survey of junior doctors' working arrangements 2010 – Click here to read.
- BMA cohort study: 2006 medical graduates (Fifth report, 2011) – http://bma.org.uk/working-for-change/negotiating-for-the-profession/workforce/cohort-study
- Health effects of working unsocial hours and shift work – A briefing from the BMA Board of Science – http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/77N84N5KQ1LVMF7XR5FUI6MQNG287F.pdf
- Shift-work, Rest and Sleep: Minimising the Risks – Discussion paper by the BMA Scottish Junior Doctors Committee, February 2010 – http://www.bma.org.uk/sc/employmentandcontracts/working_arrangements/work_patterns/shiftwork.jsp?page=1
- Safe Handover Safe Patients (jointly with NHSMA and NHS NPSA) – http://bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Contracts/safe%20handover%20safe%20patients.pdf
- Draft heads of terms for negotiations to achieve a new contract for doctors and dentists in training (BMA/NHSE, June 2013) – http://bma.org.uk/-/media/Files/PDFs/News%20views%20analysis/In%20depth/Junior%20consultant%20contracts/juniorscontract_headsofterms.pdf
- Doctors in Training – Contract Proposals: Feedback from Doctors (Ipsos MORI, July 2013) – http://bma.org.uk/-/media/Files/PDFs/Working%20for%20change/Negotiating%20for%20the%20profession/BMA%20Junior%20Doctors%20Report%20220713.pdf
- BMA Guidance on Rotas and Working Patterns – http://bma.org.uk/practical-support-at-work/contracts/juniors-contracts/rotas-and-working-patterns
- BMA Guidance on Monitoring – http://bma.org.uk/practical-support-at-work/contracts/juniors-contracts/monitoring-guide/what-is-monitoring

15 http://www.gmc-uk.org/The_Impact_of_the_Working_Time_Regulations_on_Medical_Education_and_Training___Literature_Review.pdf_51155615.pdf

Other publications of note

- The Impact of Working Time Regulations on Medical Education and Training (GMC/Durham University report 2012) – http://www.gmc-uk.org/about/research/14413.asp
- Time for Training – A Review of the impact of the European Working Time Directive on the quality of training (Professor Sir John Temple for MEE/DH, May 2010) – http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf
- A Compendium of Solutions for Implementing the Working Time Directive for Doctors in Training from August 2009 (Skills for Health) – http://www.rcoa.ac.uk/system/files/TRG-WTR-Compendium.pdf
- The implementation and impact of Hospital at Night pilot projects – An evaluation report (DH, 2005) - http://collections.europarchive.org/tna/20081008124422/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4117968
- Working the night shift: preparation, survival and recovery: A Guide for Junior Doctors (RCP 2006) – http://www.rcplondon.ac.uk/sites/default/files/documents/working-the-nightshift-booklet.pdf
- Working Time Directive 2009: Meeting the challenge in surgery (RCS 2009) – http://www.rcseng.ac.uk/publications/docs/working-time-directive-2009-meeting-the-challenge-in-surgery-1
- Rota planning: Guidance from the Working Time Directive working party (RCS 2007) – http://www.rcseng.ac.uk/publications/docs/rotaplanning.html
- Optimising Working Hours to Provide Quality in Training and Patient Safety – (AsiT, January 2009) – http://www.asit.org/assets/documents/ASiT_EWTD_Position_Statement.pdf
- MMC Programme Board Task & Finish Group on Quality – Maintaining Quality of Training in a Reduced Training Opportunity Environment – http://www.mee.nhs.uk/PDF/Quality%20of%20Training%20FINAL.pdf

5. Are there any examples of ways in which the Working Time Directive has been successfully implemented that you would like to highlight?

The BMA has not undertaken any primary research in this area, but we have been impressed by some of the work that has been done by others.

In particular, we would like to highlight the work of the Hospital at Night[16] project, which emphasises the role of multidisciplinary teams in the provision of hospital care at night at the same time as reducing dependence on junior doctors to provide cover at night.

When evaluated,[17] the Hospital at Night pilot projects were reported to have positively impacted on patient safety, to have reduced fatigue among doctors, and to have improved opportunities for training.

A variety of other interesting models have been developed. Many are referenced in the recent GMC report on The Impact of the Working Time Regulations on Medical Education and Training. Another which has recently come to our attention is the 'sliding scale of intensity' rota which has been introduced at Birmingham Children's Hospital.[18]

16 http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59820
17 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4117968
18 http://www.cfwi.org.uk/publications/what-does-24-7-working-mean-for-the-workforce