UPDATE ON WORKING TIME DIRECTIVE

Background

1. Junior doctors now fall within the Working Time Regulations (which implemented the EWTD in the UK). These limit average hours to 48 over a reference period of 26 weeks, unless an individual ‘opts out’, and establish minimum rest periods (which cannot be subject to an ‘opt-out’). The New Deal contractual limit of 56 hours per week, and rest breaks, continue to apply.

2. NHS Employers supports the need for controls on hours for doctors (including doctors in training). This helps ensure safe working and a decent work-life balance – as for other staff and in line with the NHS staff pledges.

3. Skills for Health/National Workforce Projects has had the lead role supporting implementation of the WTD for junior doctors. NHS Employers has sought to promote and signpost solutions and offer advice and guidance on issues related to interpretation of contracts and the Regulations.

Derogation

4. There are a small number of specific services or rotas where compliance was not achievable by the deadline. In such cases the government sought permission to derogate. These rotas have two years, and exceptionally up to three, to operate at 52 hours per week, until they comply with 48 hours.

5. Of 6,646 rotas operating across 247 trusts in England, 200 were covered by derogation in the statutory instrument published on 23 June 2009. A further 100 were allowed derogation in October 2009 following a second round of applications.

Rota gaps and use of internal cover

6. There have been suggestions that ‘gaps’ in trust rotas mean unsafe levels of staff are being seen in some areas, and criticism that hospitals are employing their own doctors as locum cover and/or pressuring trainees to falsely report their working hours. The PMETB trainee survey indicated that some doctors felt they were asked to report hours that differed from those they actually worked.

7. It is normal practice for employers to agree with staff, including junior doctors, that, if needed, they can work additional hours to cover absent colleagues – provided the employee is willing and is not forced or bullied into doing so. Both employee and employer must be satisfied the arrangement is safe and WTD and contractual rest breaks must be maintained.
8. WTD allows opt out of the 48-hour week only if agreed by the employee - but it requires compliance with rest breaks at all times. WTD ensures doctors should work no more than an average of 48 hours unless both they, and their employer, agree that they should – a sensible ‘safety check’ on their hours. Junior doctors who ‘opt out’ can only work up to 56 hours a week under their New Deal contract.

Use of external locums

9. The use of external locums has attracted publicity of late. The shortage of locum doctors has caused rates to escalate and increased pressure to make use of non-framework agencies, with the attendant need for employers to ensure pre-employment checks are completed.

10. The quality of doctors supplied has also been criticised. The case of Dr Ubani, a GP locum who had flown to the UK to work weekend shifts in an out of hours service and who administered a fatal 100mg rather than 10mg dose of morphine to a patient has, in particular, focussed attention on the differing language testing requirements for EEA and non-EEA doctors seeking a license to practice and admission to the GMC register. It has also highlighted variation in the approaches of PCTs towards their scrutiny of applications to join the GP performers list. Dr Ubani’s application to a previous PCT had been rejected.

11. In response NHS Employers has drafted some advice for NHS organisations setting out their responsibilities and those of the regulator in relation to the appointment and use of locum doctors. The draft advice is at Appendix 1 and comments are invited.

Reviews of WTD impact on training

12. The standards for specialty training in the UK are set by PMETB. It is responsible for assuring the quality of UK training and that the required standards are met before doctors can qualify for registration as a specialist capable of independent practice (with a CCT or via an equivalence route).

13. Curricula are competency based and where there is evidence that the competencies required are not being achieved action can be taken. This may include lengthening the training for individual trainees. PMETB has established a national (UK) WTD panel to examine whether there has been an impact upon the quality of training delivered this will work in tandem with a review of the impact of WTD by Medical Education England.

14. MEE has announced that Professor Sir John Temple will conduct the independent examination of the impact of WTD on training commissioned by the Secretary of State, and make any recommendations. He has previously been the Postgraduate Dean in the West Midlands, Chair of the UK Committee of Postgraduate Medical Deans (COPMeD) and led the implementation of the Calman higher specialist reforms. MEE has yet to decide the membership of any reference group or panel to support Professor Temple.

15. The MMC working group report on maximising training within the 48-hour week has been publicised and this, and the resources available on the SfH/National Workforce Projects website, identify solutions and suggestions to applying WTD in order maximising training locally.
Readiness and monitoring

16. The national WTD reference group, with the engagement and support of the royal colleges including RCS, deaneries, BMA, SHAs, NHS Employers and others, has continued to meet and coordinate and advise on activity.

17. Trusts are currently submitting data from the latest New Deal monitoring. Previous monitoring in September 2008 indicated some two thirds of juniors were then compliant with 48 hours. The data from March 2009 that three quarter of juniors were compliant.

18. Regional support teams of experts have been established by some of the medical royal colleges and have been working with SHAs and employers to support implementation and new ways of working. These are now increasingly focusing on areas of difficulty.

Pandemic and WTD

19. If necessary, doctors can ‘opt-out’ to support the NHS during pandemic or other emergency. GMC advice is that they put patients first as professional. There is no reason to believe they would behave otherwise in any emergency. A model ‘opt-out’ is on the NHS Employers website.

European developments

20. There have been some developments in Europe, prompted by reported difficulties in some countries achieving compliance and the possibility of infraction proceedings (currently proceedings are underway against Greece for failure to implement the directive adequately).

21. The European Commission has indicated a willingness to consider and consult on a comprehensive revision of the WTD in 2010. This follows the failure of the original conciliation between the European Employment Ministers and the European Parliament to reconcile their diametrically opposed positions (particularly on the opt-out). The European Commission wants a future revision of the directive to marry the legal aspects with economic and social dimension and particularly to account for new working practices.

22. At the stage this is taken forward there will be a social partner consultation and NHS Employers will be in a position to input views through its European Office and links.

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DRAFT LOCUM ADVICE FOR COMMENT

1. Use of locum doctors advice

The quality, competence and communications skills of locum doctors, and the checks made upon them before engagement by organisations providing NHS care is an important concern. Patient safety requires that locum doctors are appropriately trained and qualified for the work they undertake. This paper is intended to summarise the current standards governing the appointment and use of locum doctors. **Ultimately it is the organisation engaging a locum doctor that carries the responsibility for ensuring that doctor is a suitable appointee for the role.**

2. 1997 locum guidance and Code of Practice

A Code of Practice on the use of locum doctors was published by the Department of Health in August 1997 (Appendix 1). The observations, recommendations and requirements it set out remain appropriate for today.


3. Mandatory NHS employment check standards

The mandatory employment check standards (published by NHS Employers) apply to all staff engaged within the NHS, including those working as locums.

There is a set of standards covering:

- Verification of identity
- Right to work
- Registration and qualifications
- Employment history and references
- Criminal record checks
- Occupational health

These standards are mandatory and apply to all staff including locums, volunteers, students, researchers etc. They also apply in primary care and to admissions to the GP performers list held by PCTs (admission to a performers list is necessary, in addition to GMC registration, to work in NHS general practice in the UK).

Details of each of these standards is available at [http://www.nhsemployers.org/RecruitmentAndRetention/Employment-checks/Employment-Check-Standards/Pages/Employment-Check-Standards.aspx](http://www.nhsemployers.org/RecruitmentAndRetention/Employment-checks/Employment-Check-Standards/Pages/Employment-Check-Standards.aspx)
The Care Quality Commission as part of its annual health check, and NHS Litigation Authority as part of its annual risk assessment, will examine that NHS organisations are complying with these standards and requiring and checking that their contractors and locum agencies to do likewise.

4. Communication skills

It is important that organisations using locums and agencies are aware of distinctions between the GMC language testing requirements for the registration and licensing of doctors who trained and qualified in the EEA and those from outside the EEA.

Within the EEA the GMC recognises equivalent medical qualifications and is not expected to test for language competency or communication skills before registering and licensing a doctor for UK practice if they are:

- Nationals of members states of the European Economic Area (EEA) other than the UK
- Swiss nationals who since 1 June 2002 benefit under European law
- UK nationals who are exercising their European Community (EC) rights of free movement within the EEA. Generally speaking this means someone who has worked as a doctor in another EEA member state and is returning to the UK to work.
- UK nationals and non-EEA nationals who are married to EEA nationals who are exercising their EC rights of free movement within the EEA. Generally speaking this means someone accompanying a spouse coming to the UK to work.

For all other International Medical Graduates (IMGs) seeking registration and a license to practice from the GMC they must evidence a satisfactory standard of English, usually through the International English Language Testing (IELTs) and PLAB tests.

Further information on the GMC’s requirements is at http://www.gmc-uk.org/doctors/register/registration_information.asp#englang

Details of IELTs and PLAB are at http://www.gmc-uk.org/doctors/registration_applications/language_proficiency.asp

Organisations engaging locum doctors therefore need to establish for themselves that appointees have appropriate communication and language skills, bearing in mind the different registration and licensing arrangements for EEA and non EEA doctors. This might be done by testing communication skills at interview or using an assessment process.

5. Hours

Doctors are under a professional obligation not work when their ability or competence is impaired through working excess hours.

Agencies and employing organisations must ensure that the Working Time Regulations on hours and rest breaks are applied to the doctors working for them. To do this they should make enquiries of hours across all employments and assignments.
For junior doctors in training there is a maximum contractual limit of 56 hours per week across all employments. For further information on this and ‘opt-out’ see http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/EWTD/Pages/FAQs-September2009.aspx

6. Use of locum agencies

Where organisations use locums who are employed or engaged via an agency they must ensure that the agency is satisfying the same level of employment check standard as the NHS.

Agencies that are engaged under the Buying Solutions - Health (formerly NHS Purchasing and Supply Agency, PaSA) framework are contractually obliged to meet these standards, and their compliance is audited by the national Buying Solutions - Health team.

Any ‘off framework’ agencies are not being covered, and any organisation using them must make its own arrangements for ensuring compliance.

Details of the agencies operating under the national framework can be found at http://www.pasa.nhs.uk/PASAWeb/Productsandservices/Agencystaffandoutsourcedservices/Agencyandtemporarystaff/Medicallocums/LandingPage.htm

7. Induction

Locum doctors should be offered appropriate induction for their role and appropriate supervision. There is a handbook and suggested mandatory training published by NHS Professionals at: http://www.nhsprofessionals.nhs.uk/flexible/doctors/mandatory-info.aspx

Organisations will also have their own policies and procedures appropriate for their services.

8. Feedback on performance

Locums, and any agency they have been supplied through, must be given feedback on their performance after every assignment. A model report form was included in the 1997 Code of Practice, although agencies may use their own.

Many agencies and locum doctors report that such feedback is not being provided. The provision of feedback will become increasingly important as revalidation of doctors is introduced – it will be part of the evidence base a locum doctor will need to re-validate and retain their license to practice.

In addition, any serious issue or concern where potential risk to patients is identified should be reported to the GMC, and where appropriate under the alert letters system.

Organisations need to ensure that the appropriate doctor (usually the supervising consultant) completes and returns feedback on a locum doctor’s assignment when it concludes.

9. Length of locum appointment
Locum employment should be for limited duration while substantive recruitment takes place or other arrangements are made. In the case of locum consultants the NHS Appointment of Consultant Regulations require appointments should normally be for not more than 6 months initially, with possibility for extension up to 12 months maximum. Guidance and the regulations are at http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Morestaff/Nationalrecruitmentcampaign/DH_4082973

10. Avoiding locum usage

Workforce planning and recruitment can help avoid the use of locum staff. NHS Employers has published guidance on managing medical vacancies at http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/Medical_Education_and_training/Specialty-and-GP-training/Managing-medical-vacancies/Pages/Managing-medical-vacancies.aspx

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