

Working Time Directive

Frequently Asked Questions for trust implementation teams

June 2009

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Introduction

These FAQs have been produced by NHS Employers to address some of NHS organisations' most frequently asked questions about the Working Time Directive and the implementation of the 48-hour working week by 1 August 2009.

The FAQs have been reviewed by members of the NHS Employers Medical Workforce Forum and other stakeholders. Periodic updates to these FAQs will be made to ensure that you are kept up to date with current news and policies. When we update these FAQs we will notify you through the [NHS Employers website](#) and the weekly [Workforce Bulletin](#).

FAQs

1. What is the Working Time Directive?

The Working Time Directive (WTD) is EU legislation intended to support the health and safety of workers by setting minimum requirements for working hours, rest periods and annual leave. The Directive was enacted into UK law as the Working Time Regulations from 1 October 1998.

The main features are:

- an average of 48 hours working time each week, measured over a reference period of 26 weeks for doctors (unless an individual chooses to 'opt out' of this requirement)
- 11 hours continuous rest in 24 hours
- 24 hours continuous rest in 7 days (or 48 hrs in 14 days)
- a 20 minute break in work periods of over 6 hours
- 5.6¹ weeks annual leave (pro-rata for part-time staff)
- (for night workers) an average of no more than 8 hours work in 24 over the reference period.

If a rest break has to be interrupted or delayed (e.g. to ensure continuity of care or in an emergency), compensatory rest must be taken immediately after the end of the working period, except in very exceptional circumstances. An individual may exercise the right to 'opt out' of the

¹ The original EWTD requirements of 4 weeks annual leave was increased from 1 April 2009 to 5.6 weeks to include bank and public holidays, or equivalent time off. This equates to 28 days (4 weeks plus eight bank and public holidays) for someone working five days a week.

average 48 hours working week but the rest and leave requirements must be met – there is no 'opt-out' from the minimum rest and leave required.

2. Who does the WTD cover?

The WTD has applied to the vast majority of employees in EU member states since 1998, with a few exceptions including doctors in training. Consultants, doctors outside training and most other NHS staff have been subject to the WTD since 1998. Details of the general implementation of the WTD in the NHS, and the national collective agreements reached, are set out in HSC 1998/204, which can be found on the Department of Health (DH) website at: www.dh.gov.uk/en/Publicationsandstatistics/Letterandcirculars/Healthservicecirculars/DH_4003843

In 2004, the WTD provisions extended to junior doctors, whose maximum working hours had to be reduced to 56 by August 2007 and now to 48 hours from August 2009.

3. Can WTD be ignored?

No. The WTD cannot be ignored. It is a legal requirement under EU and domestic UK legislation (the Working Time Regulations 1998, as amended). Employers are obliged to comply with all of its requirements, and employees entitled to the protection it affords.

4. How is compliance with WTD measured?

Measurement and monitoring of the 48 hour working week should be over a 26 week reference period for doctors (17 weeks for most other workers). Employers need to take reasonable steps to ensure that the working hours of all medical staff are compliant over this period of time.

It is generally accepted that continuous monitoring is not an achievable method of assessing compliance, except for individual cases. Employers already take snapshot data to measure both WTD and New Deal compliance for doctors in training, by diary-carding over a two week period twice a year. This should measure not only hours worked but that rest breaks are being achieved, and/or adequate compensatory rest provided.

Further advice on employers' general responsibilities for monitoring WTD compliance can be found on the BusinessLink website at: www.businesslink.gov.uk/Employing_People_files/working_time_flow_chart_august_2008.pdf

5. What about on-call time – is this work? The impact of the SiMAP and Jaeger cases.

Two cases before the European Court of Justice (ECJ) have clarified that time spent 'resident on-call' counts as work. The SiMAP and Jaeger Cases were brought by a Spanish medical union and a German doctor. In both cases, the ECJ ruled that on-call time, when a doctor is obliged to be resident in a hospital or health centre, counts as working time. For example, a doctor who is required to be resident on-call within the workplace, but is actually asleep, counts as working because they are required to be on-site.

In Jaeger, the ECJ also ruled that, in all but exceptional circumstances, compensatory rest for missed rest must be taken immediately after the end of the working period, rather than aggregated and taken at a later time. Although the judgments applied to particular cases, the assumption has to be that the same interpretations would apply to any UK doctors working similar patterns.

You can find further advice on these cases on the DH website at:

www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingworkforceplanninghome/Europeanworkingtimedirective/DH_4068970

Advice on what might constitute 'exceptional circumstances' for delaying the provision of compensatory rest, where WTD required rest breaks have been missed, can be found on the Skills for Health healthcare workforce portal at: www.healthcareworkforce.nhs.uk/working_time_directive/wtd_resources/dh-information_note.html

6. Does all on-call time count as work?

Only on-call time where a doctor is working or (following the SiMAP and Jaeger rulings) required by the employer to be resident or present within the workplace counts as work. For doctors on-call from home, or simply required to be contactable and able to return to work, work would start when they are called by the workplace either to return or

to offer advice over the telephone, and ceases when that episode of work is completed.

Similarly for doctors voluntarily resident at or near the workplace, as long as there is no requirement to be present (only to be contactable and able to return), only time spent responding to calls or returning to work and working will count as working time.

7. What are the consequences for employers of failing to achieve compliance for junior doctors by August 2009?

Individual employers (e.g. Trusts, PCTs and GP practices) are responsible for ensuring that junior medical staff can work in compliance with WTD requirements from 1 August 2009. The penalties for non-compliance are, as for other staff, possible Employment Tribunal proceedings by employees, orders for compliance from the Health and Safety Executive in respect of night worker health assessments and fines. The Department of Health may also be at risk of enforcement proceedings by the European Commission. It is possible in the case of junior doctor training posts that these may in future be de-recognised for training where they remain non-compliant.

8. In which areas do the biggest challenges exist?

It is expected that a number of hospital services delivering 24-hour immediate patient care, some supra-specialist services and small, remote and rural units will have some difficulties in delivering an average working week for doctors in training of 48 hours or less by 1 August 2009. The overall aim is to ensure that, consistent with patient safety, the maximum number of services where doctors have emergency, acute responsibilities is supported to achieve compliance. For the small number that may require additional support, DH intends to allow 'derogation'.

9. What is a derogation?

A derogation allows an EU member state more time and flexibility to implement the WTD for junior doctors for up to two years (2011) and, exceptionally, three years (2012), where there are specific problems. There is no derogation in respect of the rest and leave provisions of WTD.

The UK has sought a derogation that can be applied to doctors in training who have duties in services that are delivering 24-hour immediate patient care, in some supra-specialist areas or in small, remote or rural units. These services will be enabled, through amendments to the UK Working Time Regulations, to plan services with up to a 52 hour week for up to two years and, exceptionally, three years. During this period, employers must continue to work to achieve 48 hour compliance. Employers seeking permission to operate a 52 hour week under the derogation had until 29 May 2009 to make application to DH, via their SHAs. The arrangements were set out in a letter to Chief Executives, available on the DH website: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093940

10. What are the implications if an employer is granted derogation?

Specific services needing to take advantage of the derogation had to notify DH via their SHA by 29 May 2009. Subject to scrutiny of the reasons given and plans to achieve compliance in the future in these requests by the WTD Programme Board, these services will be enabled, through amendments to the UK Working Time Regulations, to plan services with up to a 52 hour week for junior doctors for a period of up to two years and, exceptionally, three years. These services will have to achieve full compliance with 48 hours for junior doctors by August 2012 at the very latest.

11. Is there extra funding support for WTD?

In 2008/09, £110m was included in PCT allocations to support WTD compliance. This was increased to £310m in 2009/10. To support employers, the tariff uplift for 2009/10 reflected £150m funding for WTD. As some specialties face particular challenges, a further £50m was allocated to PCTs to support changes needed in the 24/7 specialties for trained doctor solutions, particularly in paediatrics and obstetric services. SHAs have been asked to report on how this money is spent.

12. What is the implication of WTD for the number of junior doctor training posts?

There are no plans to change the number of junior doctor training posts in the light of WTD. Approved training post numbers are based on the UK's future anticipated need for trained doctors.

13. If the number of approved training posts is not increasing what are the implications for the number of consultants?

There is no plan to increase the number of approved training posts simply to meet WTD requirements. The workforce planning around the needs of the service is based on ensuring there are the appropriate numbers of approved training posts in the different medical specialties to provide sufficient trained doctors in the future. The implication for consultants and other doctors is that services may need to be redesigned. Consultants and other doctors may have to get more involved in work previously undertaken by juniors, particularly out-of-hours. To support this, the number of doctors in the NHS, including consultant and other grades, has continued to grow, increasing by 4.3 per cent in 2008. Hospital@Night, new and extended roles and other service changes are essential to managing services within each employer's resources and number of doctors.

14. What is the implication of WTD for time spent training?

The NHS has been steadily changing the way that junior doctors work and train so that their expertise is applied where needed, and that more of the work they do contributes to their training, rather than simply being on-call. Better-structured and managed training programmes for doctors go hand-in-hand with the WTD in ensuring both quality of care for patients and quality of training for junior doctors. Ensuring that NHS doctors are well rested is critical to assuring patient safety and providing quality care. These are primary objectives of WTD.

Medical education and training has undergone significant modernisation in the last decade with new competency based curricula and greater use of e-learning, simulation, and the introduction of skills laboratories. These developments have enabled doctors in training to acquire skills in reduced training hours whilst enhancing their practice under supervision. The challenge is to ensure all training opportunities are maximised and trainees supported to reach the required standards.

To ensure that training standards are maintained for the future the Secretary of State has asked Medical Education England (MEE), an independent advisory body, to commission a

study on WTD and training, and advise on any issues arising. An earlier report from the Medical Programme Board discussing issues and possible solutions can be downloaded from the MMC website at:

www.mmc.nhs.uk/default.aspx?page=510

15. What will happen to junior doctors' pay?

There will be no changes to basic pay for doctors in training. However, introduction of the 48 hour working week will mean that any supplementary banding payment should be no higher than 50 per cent of actual salary, reflecting hours that are above 40 but below 48 per week on average, provided that the New Deal hours limits and rest requirements are adhered to. Junior doctors working in posts to which a derogation has been applied, and who are required to work more than 48 hours per week, will need to receive an appropriate banding based on the hours contracted (up to an average of 52 hours per week).

16. What is pay protection and when can it be applied?

For junior doctors receiving a banding payment, pay protection only applies when a new rota is implemented with a changed band during an existing period of employment, or where a doctor had been formally offered and accepted a contract of employment with a new employer at a higher band, prior to a change in that rota's banding. In these circumstances a doctor will continue to be paid at the rate of the previous banding, as contractually agreed, until the end of their contract with that particular employer. For more information see the NHS Employers guidance on pay protection on our website at:

www.nhsemployers.org/SiteCollectionDocuments/pay_protection.pdf

17. How are junior doctor rotas re-banded and who checks them?

There is a formal process for re-banding junior doctors' rotas, which is laid out in the Terms and Conditions of Service for doctors in training. As part of this a third party, the Regional Action Team or their successor bodies, should provide the final approval for all changed rota bandings to confirm that the rotas are both New Deal and WTD compliant. The Terms and Conditions can be found on our website at:

www.nhsemployers.org/PayAndContracts/JuniorDoctorsDentistsGPRreg/Pages/DoctorsInTraining-JuniorDoctorsTermsAndConditions150908.aspx

18. Can junior doctors 'opt-out' of the 48 hour requirement?

As with other employees, all doctors can 'opt-out' of the maximum 48 hour working week, including doctors in training. However this must be agreed in writing and no employee can be forced to work more than 48 hours, except in the case of posts to which derogation has been applied, where the limit is 52 hours. Employers must keep a record of employees who have exercised their right to 'opt-out'.

Employers will also need to consider if it is desirable for an employee to 'opt-out', and whether there is a service need they can safely meet. It has to be remembered that WTD is intended to protect the health and safety of workers and because of this there can be no 'opt-out' from the rest and leave provisions. Even if they 'opt-out' junior doctors' contracts also expressly limit them to a maximum 56 hours work a week under the New Deal.

19. Should services be planned on junior doctors working no more than 48 hours a week?

Employees, including junior doctors cannot be required to work more than an average of 48 hours a week over the reference period (26 weeks for doctors). They can 'opt-out' of this limit if they wish but if they do so they must be able 'opt-in' again, with notice. As junior doctors change posts frequently, (recruitment must not be influenced by whether a doctor is prepared to 'opt-out') it is safest for planning purposes to assume that incoming junior doctors will want the 48 hour limit applied and to plan services and rotas on that basis. The exception would be where a derogation has been applied in which case services and rotas may be planned on the basis of a 52 hour week.

Where doctors are willing to opt-out any extra hours they offer might be used, up to the limits of the New Deal for junior doctors, to provide occasional cover rather than a regular commitment. Employers may also wish to be mindful of the impact of extra hours on a junior doctor's banding.

20. Are 'internal locums' allowed?

While junior and other doctors are expected to be able to cover brief absences of colleagues under their normal duties, where this is not possible it is the employer's responsibility to make alternative arrangements, or seek the engagement of a locum. Internal cover by juniors and other doctors acting as 'internal locums' is allowed, subject to them agreeing to 'opt-out' of the WTD 48 hour limit, if necessary, to undertake the locum work available and, for junior doctors, that they only work up to the overall 56 hour New Deal contractual limit. The WTD rest requirements must still be met and both doctor and employer must be in agreement that the arrangement is safe and appropriate.

It is also important to remember that employees, including junior doctors, have no right to work additional hours just because they 'opt-out'. Any extra work offered has to be because an employer has a genuine work requirement that the employee can fulfil.

21. How do WTD limits affect work for locum agencies or other employers?

It is very clear under WTD that no single employment can exceed the average 48 hours work per week, unless an individual enters into a written agreement to 'opt-out'. The only exceptions are posts to which a derogation has been applied, in which case a maximum of 52 hours work per week is then allowed.

What is not clear under WTD is whether the 48 hour average working week, or 52 for derogated posts, applies to an individual employment contract or, where an individual has more than one job, across all of their employments. This is one issue that EU member states were negotiating in order to clarify the rules, but without reaching agreement. However, it is advisable for an employer to take reasonable steps to ensure that employees are aware of the limit and able to achieve compliance by enquiring about any other employments (see HSC 1998/204).

For junior doctors the model contract includes (at paragraph 10) a requirement not to breach the New Deal limit of 56 hours per week across all employments, including locum work.

Within the NHS junior doctors can therefore 'opt-out' of the average 48 hours per week WTD requirement but, where they do, must work no more than 56 hours per week under all their contracts, including any additional work they do.

The model contract can be found on the NHS Employers website at:

www.nhsemployers.org/SiteCollectionDocuments/Doctors_training_model_contract_2007_cd_160209.doc

22. Where can I find examples of best practice and advice?

There is a wealth of best practice material and information on the Skills for Health healthcare workforce portal website:

www.healthcareworkforce.nhs.uk

This includes details of Hospital @ Night schemes, rota management, new ways of working, approaches to managing change and top tips. However circumstances will vary between organisations and employers will need to tailor approaches to local requirements.

23. What other support is available?

Every SHA has a named WTD lead who can advise on support available locally. See:

www.healthcareworkforce.nhs.uk/working_time_directive/general/working_time_directive_faqs.html

Further information

For further information and updates see: www.nhsemployers.org/medicalworkforce or email medicalworkforce@nhsemployers.org.

NHS Employers

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NHS Employers represents trusts in England on workforce issues and helps employers to ensure the NHS is a place where people want to work. The NHS workforce is at the heart of quality patient care and we believe that employers must drive the workforce agenda. We work with employers to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

NHS Employers is part of the NHS Confederation.

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