

***Guidance on  
Implementing the  
European Working Time  
Directive (EWTD) for  
Doctors in Training***

---

## Contents

Guidance content	page 3
1. What's required and by when	page 4
2. Practical guidance on achieving EWTD compliance	page 5
3. Delivering effective medical training under EWTD	page 8
4. Support for the change process	page 9
5. Who needs to do what?	page 10
6. Further guidance	page 12
 <b>Annex A</b>	
Other factors impacting on the working hours of doctors in training	page 13
 <b>Annex B</b>	
Background on relevant initiatives/publications	page 14

### **Guidance content**

This guidance sets out the key facts and relevant timescales of the EWTD as it will apply to doctors in training from August 2004. It supports the implementation process already going on in NHS Trusts following the HR Performance Framework (published by DH in 2000 under cover of HSC 2000/030). It reminds NHS Trusts, Strategic Health Authorities, Primary Care Trusts and others of their role in ensuring doctors in training comply with the EWTD while maintaining existing high standards of care and service delivery. Finally, it shows where the EWTD fits into the wider picture of improving working lives of NHS staff.

In section 6 it identifies a number of supporting sources of guidance, which include two attached documents. One is drafted jointly with the British Medical Association, NHS Confederation and the National Assembly for Wales on moving medical working patterns to achieve EWTD and New Deal compliance. The other is from the Academy of Medical Royal Colleges on the key issues of cross-cover, skill-mix, etc. Also identified is the detailed information on the DH website on the EWTD pilots and the solutions they are testing to ensure EWTD compliance for doctors in training, and 'Liberating Learning' a report from the Conference of Postgraduate Medical Deans of the UK on clinical training. Section 6 also signposts related work, such as that on configuring hospitals and the Changing Workforce Programme, giving summaries and website addresses as appropriate.

Although the EWTD will not apply to doctors in training until August 2004, the changes are so profound that it is essential that the service takes full advantage of the preceding 18 months to prepare for change. Decisions will have to be taken early in the preparation phase, and this document should be regarded as the start of a process that - if it has not done so already - must get underway immediately in all NHS organisations. NHS Trusts must also achieve full New Deal compliance for doctors in training from August 2003, which will be an essential step towards achieving EWTD compliance.

---

## **1. What's required and by when**

The key aspects of the EWTD as it will apply to doctors in training are:

### **Working hours per week**

- By **August 2004**, a reduction to overall average weekly working hours of 58 hours
- An interim 56-hour week by **August 2007**
- A further reduction to 48 hours **August 2009** (this could be extended to 2012)

### **Rest provisions from August 2004**

- 11 hours' continuous rest in every 24 hour period
- Minimum 20 minute break when shift exceeds 6 hours
- Minimum 24 hour rest in every 7 days or
- Minimum 48 hour rest in every 14 days
- Minimum 4 weeks' annual leave
- Maximum 8 hours work in 24 for night workers (if applicable)

### **Other factors impacting on the working hours of doctors in training**

The EWTD must be seen as part of a package of initiatives that will affect the hours worked by doctors in training. These initiatives are intended to support safe working practices, improving the quality of care given to patients whilst at the same time ensuring doctors obtain effective training and support from employers. These initiatives include the New Deal, Improving Working Lives (IWL), and planned flexibilities in applying the Directive's rest provisions.

The New Deal sets out a contractual limit of weekly hours worked by doctors in training of 56 hours per week from August 2003 and Trusts will need to ensure posts are compliant. NHS Trusts will also be required to provide, by April 2003, a portfolio of evidence over a wide range of policies and procedures that improve the working lives of staff as part of the IWL standard.

A recent ruling in the European Court of Justice also has significant implications for the design of posts for doctors in training. The SiMAP ruling that "***time spent on call by doctors...must be regarded in its entirety as working time...if they are required to be present at the health centre***" means that current resident on call working patterns will generally not be compatible with the EWTD from 2004.

Taken together with the other requirements of the EWTD, the implication is that current resident on call working patterns will generally not be compatible with the EWTD from 2004. Trusts will therefore need to look critically at working patterns and whether it is necessary for doctors to be resident. Where the intensity of calls requires resident cover, it is likely to be necessary to move to new patterns of working such as shifts or partial shifts.

Finally, the UK will be making changes to the rest provisions of the EWTD by derogating to allow the provision of compensatory rest where it is not possible to provide the full period of continuous rest. The effect of this will be to give individual Trusts the maximum amount of flexibility in applying this part of the Directive.

Annex A gives further details on New Deal, the SiMAP ruling and derogations and Annex B gives relevant website information.

---

## **2. Practical guidance on achieving EWTD compliance**

### ***Why we cannot simply increase the number of doctors to make all rotas compliant***

There will be increases in the medical staffing in both consultants and training grades, but it is important that these additional doctors are used to deliver increased activity or improved patient care. Recruiting additional doctors just to make all the existing on-call rotas compliant will not be an effective use of financial and human resources. The main reasons for this are:

- For many existing resident on call rotas, the intensity of calls is not sufficient to justify moving to a full shift pattern. In these cases it may be possible to provide non-resident on call cover without increasing the number of doctors.
- It is unlikely that it will be possible to recruit sufficient doctors at SHO or equivalent level to make all the existing SHO rotas compliant. Small hospitals in rural areas are likely to be particularly vulnerable in relation to recruitment problems.
- If these additional doctors are not appointed into bona fide training grades, their posts may not be able to offer satisfactory training and career development opportunities for the individuals recruited.
- Such an approach is likely to be at odds with the aims of modernising the service and medical education.

### **Recommended Process for Developing an Action Plan**

The critical issue in relation to EWTD is the provision of out of hours emergency medical cover. Solutions are likely to require a more radical approach involving the following elements:

- A thorough assessment of what activities need to be done out of hours and who could do them.
  - Who can best deliver care? Should it be a doctor or a non-medical practitioner?
  - If a doctor is needed, what level and type of doctor would be most appropriate to deliver care to the patient?
  - Are there ways of reducing the likelihood of this activity occurring out of hours?
- A clear assessment of the activities that doctors in training need to undertake to meet their training needs. Individual Learning Plans need to be developed which can effectively deliver training objectives within the new working patterns and service models (see section 3 below).
- Appraisal of service models to see if there are alternative ways of delivering the service which maintain or improve the quality of care for patients and can achieve EWTD compliance.
- Reviewing working patterns for all medical staff – Consultants, Associate Specialists, Staff Grades and Training Grades.

Trusts must ensure that the solutions they develop achieve the dual aims of EWTD compliance and service delivery. It will not be appropriate to achieve EWTD compliance for doctors in training at the cost of failing to meet delivery targets.

---

## What are the solutions?

The results of this process will produce different solutions across specialties and type of hospital but are likely to include some or all of the changes outlined below. A national programme of pilot projects has been set up covering a range of different services and approaches. Examples of some or all of the solutions described below can be found in each of the pilot projects. Details of the solutions that are being tested can be found on the EWTD web site at <http://www.doh.gov.uk/workingtime/>

- **Reduction in the number of rotas**

There will need to be fewer but more intensive resident rotas supported by on-call cover from home. This will be achieved by:

- **Cross cover**

While this may involve sharing cover between related specialties, greater benefits are likely to result from more radical approaches. A number of Trusts, including some of the pilots, are developing central emergency teams or night teams able to provide cover across the hospital. These bring together medical staff from A&E, Acute Medicine and in some cases also Anaesthetics and Surgery as well as non-medical practitioners.

- **Fewer tiers of cover**

New non-medical roles are being developed which can work alongside SHOs and PRHOs and in many cases eliminate the need for these tiers of cover. Increasingly, the main tier of out of hours medical cover will be provided by experienced doctors such as Specialist Registrars, Staff/Associate Specialist Grades or in some cases Consultants.

There are good examples of both cross cover and reduced tiers of cover in the pilots.

- **New working patterns**

Simply replacing a resident on call rota with a EWTD compliant shift rota could require an increase in the number of doctors on the rota from 5 or 6 to 8 or more. However, more creative redesign of working patterns can avoid the big increases in staffing that this implies. Examples are given in the pilot project information where, by changing the working patterns of both the Consultants and Specialist Registrars, it is possible to provide resident 24-hour cover with as few as 6 SpRs.

- **Expansion of staff numbers**

Underpinning these changes will be the planned expansion in the consultant workforce to enable a move towards a consultant delivered service. Floors and ceilings have been introduced which will allow SpR numbers to expand beyond the 1,000 increase in the NHS Plan to approximately 1,500 and further expansion is being considered. Trusts should build on these increases rather than expanding the number of 'Trust Doctors'.

Large increases in the nursing workforce and the Allied Health Professions have already been achieved and there is a commitment to maintain these levels of growth. These increases in the non-medical workforce together with up-skilling of the Health Care Assistant workforce will support the development of the non-medical practitioner roles required.

- **Team working**

Effective use of non-medical practitioners and extension of cross cover will require a move from the traditional consultant firm to multi-disciplinary team working. There are good examples in the pilot projects of night nurse practitioners and other non-medical practitioners working alongside doctors in multidisciplinary teams.

- **New service models**

---

Many of these changes will be supported by the development of new models of service delivery. In particular, this is likely to involve greater differentiation of services, for example separation of high and low acuity and day and night services, which will allow medical resources to be concentrated where they are most effective. These changes also need to be underpinned by the effective use of clinical networks.

Starting from the premise of the need to maintain local access to services wherever possible and also improve the quality of patient care, the **Department of Health advisory framework for configuring hospitals** (see section 6 below) provides guidance on developing service models that also achieve EWTD compliance. It also makes clear the importance of patient and public involvement at every stage in the process.

- **Use of IT**

The use of IT can potentially reduce the need for resident medical expertise where this is difficult to provide. Examples include video links into major trauma units to support local emergency assessment of patients, near patient testing, access from home to imaging data, etc. Several of the pilots are using IT to supplement other changes in achieving EWTD compliance.

**Section 6 sets out the supporting information and guidance that is being made available to support the required change process.**

---

### **3. Delivering effective medical training under EWTD**

The changes needed to achieve EWTD compliance will significantly affect the working patterns of doctors in training and also change the traditional one-to-one relationship between a training grade doctor and their consultant. Proposals contained in the recent consultation document *Unfinished Business* could also have a significant impact on the training experience of doctors in training (see Annex B for information on where the document can be accessed). Given these changes, maintaining quality of training will require:

- A clear identification of what training grade doctors need to do to achieve their training goals.
- Greater investment in alternative approaches to training such as web-based materials and the use of simulators etc.

NHS Trusts, through their education supervisors, will need to ensure that Individual Learning Plans are developed which can effectively deliver training objectives within the new working patterns and service models.

The Department of Health will be working with Postgraduate Deans and the medical Royal Colleges to ensure that NHS Trusts are supported in this with good advice on training models. As a first step the Conference of Postgraduate Medical Deans (COPMED) has produced a document *Liberating Learning* (see Section 6 below).

---

#### **4. Support for the change process**

The implementation of the EWTD is part of several changes affecting the NHS now and over the next few months, including the implementation of the New Deal for doctors in training, continued expansion of staff numbers, and increased flexibility within teams. It is important that these changes are viewed together. Additional support being given by the Department of Health includes:

##### **EWTD Pilot Projects**

A programme of pilot projects is being funded by the Department of Health to test a range of solutions to the implementation of the Directive. Details of these projects will be made available on the EWTD website and will be updated regularly to reflect progress.

All the pilots are being asked to fulfil a number of core functions:

- Carry out a baseline assessment of the impact of EWTD for their services and a clear action plan for implementation. The data from this will be used as the basis for a wider assessment of the impact of EWTD.
- Act as a focus of learning for the solutions they are testing, linking to other NHS Trusts within their Workforce Development Confederation and nationally.
- Where appropriate, develop training programmes for new roles that can be accessed by other Trusts.

##### **Strategic Change Fund**

To support the required changes across the whole service, a strategic change fund is to be made available and £7m has already been committed to pilot projects in the period up to August 2004. This will be available to support the following activities:

- Development of non-medical roles to reduce dependence on medical out of hours cover.
- Developing training programmes to support these new roles.
- Developing new models of service delivery and working patterns, e.g. the emergency team.
- Organisational development to facilitate the implementation of the new models.
- Other initiatives that will directly facilitate the achievement of EWTD compliance.

The aim is to develop a strategic approach to delivering the required changes across health communities, drawing on the solutions being developed within the pilot projects.

---

## **5. Who needs to do what?**

Implementation of the EWTD is a legal requirement for the NHS. However, it is only part of much wider aims to improve the work/life balance for NHS staff. These include existing initiatives such as "Improving Working Lives" and the "Changing Workforce Programme" (information is included in Annex B).

The EWTD is also much more than "just an HR issue". It will require a radical rethink of the way in which some services are provided but this needs to be done within the context of the wider modernisation agenda of providing a service that better meets the needs of NHS patients and those that care for them.

The Strategic Change Fund will be available to support some of the transitional costs of implementing EWTD but commissioners and providers will need to identify the recurrent costs within Local Delivery Plans.

### **Strategic Health Authorities**

In developing their Local Delivery Plans (LDPs), StHAs must address the workforce and service delivery implications of the EWTD. They will be supported in the production of the workforce element of these plans by the Workforce Development Confederation (WDC).

As part of their performance management, StHAs must ensure that their local Trusts have robust plans to achieve EWTD compliance for doctors in training from August 2004 and New Deal compliance from August 2003. Working through WDCs, they must also ensure that the pilot projects and other good examples of EWTD compliance are used to maximise delivery of the changes needed to achieve compliance.

### **NHS Trusts**

As part of the LDP process, each NHS Trust will need to satisfy their StHA that they have a robust plan for meeting the requirements of the New Deal and EWTD. The immediate priority will be achieving compliance with the parts of the EWTD that cover doctors in training from 2004. However, Trusts must ensure that action taken in the run-up to August 2004 also support the longer-term changes that will be needed to meet the requirements of the directive from 2009 and the wider goals of service modernisation.

The aim of the pilot programme is to support Trusts in implementing the EWTD by providing examples of solutions that can be widely applied and by establishing training programmes for Healthcare Practitioners that can be accessed by other Trusts.

Trusts, through their education supervisors and with the involvement of Deaneries and College visitors, will also need to ensure that the learning objectives of doctors in training are met within the new working patterns.

EWTD compliance is also one of the requirements for Trusts to achieve IWL accreditation.

### **Primary Care Trusts**

PCTs need to be aware that implementation of the EWTD will have implications for both staffing and service delivery models. NHS Trusts should be discussing with their commissioners the impact that EWTD compliance will have on individual departments and specialties well in advance of August 2004. In addition to their role as commissioners of services, PCTs must also ensure that, as service providers, their own staff (for example in mental health or community health services) comply with the EWTD.

---

Discussions on changes that need to be implemented to prepare for compliance should form part of the planning round for the financial year 2003/4.

### Workforce Development Confederations and Deaneries

In addition to supporting the StHAs in the workforce element of the LDP, WDCs will also need to address the training implications of the EWTD. Many of the solutions rely on the development of extended non-medical roles, and recruitment and training of these staff will need to start well in advance of August 2004. Since many of these posts are likely to be filled by staff already within Trusts, staffing plans should also address back-filling the consequential vacancies.

WDCs will be responsible for the local management of the EWTD pilots and for using these to help to facilitate the changes required to achieve compliance. WDCs will also need to ensure they make the best use of available resources, including the training budgets they hold, to support EWTD implementation.

The changes in working patterns of doctors in training will have a significant impact on their training. Deaneries need to be working with Trusts to ensure that satisfactory training arrangements are in place when the changes are introduced. Further guidance on training arrangements under EWTD is contained in the document *Liberating Learning* (see section 6 below).

### Department of Health

The Department of Health will continue to work with national stakeholders including the Royal Colleges and the BMA to facilitate successful implementation of the EWTD. We will also discuss how the best practice from the EWTD pilots and work from other Trusts on EWTD compliance can best be disseminated.

---

## **6. Further Guidance**

In order to assist with this process a range of guidance will be made available prepared by the Department of Health and other stakeholders. The Department of Health's EWTD website - <http://www.doh.gov.uk/workingtime/> - will include copies or full details of all the guidance currently available. Annex B also gives details for accessing additional supporting information.

- **Details of the pilot projects and the lessons emerging from them**

The website will provide a live source of information on the types of solution being tested within the pilots and the lessons being learned. This will be updated regularly during the pilot programme and will also link to similar work being taken forward in other NHS Trusts.

- **Details of good practice from other NHS Trusts which are not one of the pilot projects**

This section already includes some information and will be updated on a regular basis to reflect other work being done in the NHS to achieve EWTD compliance for doctors in training.

- **Guidance on working patterns for doctors**

A document jointly prepared by the BMA, DH, National Assembly for Wales and the NHS Confederation providing practical advice on moving medical working patterns to New Deal and EWTD compliance.

- **Guidance from the Academy of Royal Colleges (AoMRC)**

The AoMRC has produced a short document on key issues such as cross-cover, tiers of cover, skill-mix and service configuration. The paper also gives the AoMRC's commitment to work with Postgraduate Deans, DH and NHS managers to find ways of implementing the EWTD for doctors in training while protecting service delivery and training.

- **Department of Health advisory framework for configuring hospitals**

Guidance on developing service models, which deliver modernisation of services and which are also viable within the EWTD.

- **A Practical Guide to Liberating Learning (COPMED)**

This document is a practical, working document to be used within the context of clinical training. It consists of an introduction, which sets the context of learning within the planned implementation of the EWTD and a matrix of learning strategies that can be used to help trainers, and learners exploit and maximise the time and opportunities that are available for learning.

- **Guidance on software to support medical rostering**

A small technical group consisting of NHS managers, doctors in training, Regional Action Team representatives, DH representatives and members of NAMPS (National Association of Medical Personnel Specialists) met in 2001 to look at software packages available for monitoring New Deal/EWTD compliance. A link from the DH website to their report, which includes the monitoring guidance/criteria, will be established when the document is available.

## **Other factors affecting the working hours of doctors in training**

### **New Deal**

Under the new contract for doctors in training, from **August 2003**, overall average weekly working hours for all doctors in training should not exceed 56. This contractual limit, which has applied to pre-registration house officers since August 2001, is lower than the EWTD maximum of 58 hours.

### **SiMAP ruling**

The definition of “working time” in the Directive is as follows:

*“Any period during which the worker is working, at the employer’s disposal and carrying out his or her activity or duties, in accordance with national laws and/or practice”.*

Among other matters, in the SiMAP case the European Court of Justice was asked to pronounce on whether time spent by doctors “on call”, either at the medical centre or away from it, counted as “working time” and therefore towards the 48-hour week. The Court’s judgement was as follows:

*“The characteristic features of working time are present in the case of time spent on call by doctors...where their presence at the health centre is required. It is not disputed that during periods of duty on call under those rules, the first two conditions are fulfilled. Moreover, even if the activity actually performed varies according to the circumstances, the fact that such doctors are obliged to be present and available at the workplace with a view to providing their professional services means that they are carrying out their duties in that instance”.*

This means that:

*“Time spent on call by doctors...must be regarded in its entirety as working time...if they are required to be present at the health centre. If they must merely be contactable at all times when on call, only time linked to the actual provision of...services must be regarded as working time.”*

### **Implications of SiMAP and other factors**

The implications of the case are that, if there is a business and operational need for a health care professional to be present on-call at the premises and available for the purpose of providing continuity of service, this should be viewed as working time. Put another way, doctors resident on-call but asleep will count as working.

In effect, individual doctors who can currently cover 72 hours of the week through resident on-call rotas will only be able to cover 58 hours.

## **Background on relevant initiatives/publications/websites**

### **Care Group Workforce Teams**

These teams are set up to advise on workforce issues in relation to specific care groups. Implementing EWTD for doctors in training will have a significant impact on services within a number of care groups such as Emergency and Maternity services.

Website: <http://www.doh.gov.uk/cgwt/>

### **Changing Workforce Programme**

The Changing Workforce programme has been set up to help the NHS and associated organisations look at new ways of working to improve patient care and ensure good use of skills.

Website: <http://www.doh.gov.uk/hrinthenhs/changingworkforce.htm>

### **Configuring Hospitals Framework**

Website: <http://www.doh.gov.uk/configuringhospitals/>

### **Conference of Postgraduate Medical Deans of the United Kingdom (COPMED)**

The document "Liberating Learning" is available on the COPMED website:

<http://www.copmed.org.uk/Publications/index.html>

### **Developing key roles for midwives and nurses**

This document provides case studies of the Chief Nursing Officer's *10 key roles for nurses* from the NHS Plan, together with advice on implementation, and on the professional and legal boundaries to each of the roles. These roles will be important in developing the non-medical roles that will assist in EWTD compliance. The document is on the DH website at:

<http://www.doh.gov.uk/newrolesfornurses/>

### **Unfinished Business**

The Chief Medical Officer's report on proposals for reform of the Senior House Officer Grade. This sets out proposals for a replacement for PRHO and SHO training consisting of two stages a two year generic Foundation programme, incorporating the current PRHO, followed by time-capped Basic Specialist Training programmes aligned to broad specialty groups. The Report also recommended a review of NCCGs, which is now underway. A mailbox has been set-up for comments [NCCGReview@doh.gsi.gov.uk](mailto:NCCGReview@doh.gsi.gov.uk). The report can be downloaded from the DH website:

<http://www.doh.gov.uk/shoconsult/>

### **Human Resources Performance Framework**

The framework was published under cover of HSC 2000/030. It supports the service in measuring and maintaining progress towards the aims set out in *Working Together, Securing a Quality Workforce for the NHS*. The framework is available on the DH website:

<http://www.doh.gov.uk/hrstrat.htm>

---

## **Improvement, Expansion and Reform**

New NHS planning arrangements are described in *Improvement, Expansion and Reform - Priorities and Planning Framework 2003-2006* which sets out the vision for services over the next three years, and how national commitments translate into targets for the NHS and social services. The new system is described in more detail in accompanying guidance (*Improvement Expansion and Reform - Technical Guidance on the Planning Process*) which provides information on the roles and responsibilities of organisations under the new planning framework, and the specific contribution of workforce within the three year LDP.

Improvement, Expansion and Reform - Priorities and Planning Framework:

<http://www.doh.gov.uk/planning2003-2006/>

Improvement, Expansion and Reform - Technical Guidance on the Planning Process:

<http://www.doh.gov.uk/ldp2003-2006/>

*This website requires a password, which has been sent to Strategic Health Authorities to disseminate locally.*

## **Improving working lives**

The Improving Working Lives (IWL) initiative aims to make the NHS a better place to work and is underpinned by the IWL Standard. The latter can be viewed on the IWL website. NHS organisations will be required to achieve accreditation against the standard by April 2003, demonstrating they are improving the working lives of staff.

It summarises the expectations placed on NHS employers to support staff, promote their welfare and development, and enable a healthy and productive balance between work and life outside work.

Website: <http://www.doh.gov.uk/iwl/>

## **Skills Escalator**

The development of new roles has to be underpinned by using the skills escalator approach. The essence of this approach is that all staff are encouraged through a strategy of lifelong learning to constantly renew and extend their skills and knowledge, enabling them to move up the escalator. This guidance is available on the DH website at:

<http://www.doh.gov.uk/hrinthenhs/learning/section4b/skillsescalatorhomepage.htm>

## **Working Time Directive - DH site**

This site will have updates on EWTG issues, information on the pilots and other good practice.

<http://www.doh.gov.uk/workingtime/>

---

### **Working Together - Learning Together**

A Framework for Lifelong Learning for the NHS, published in November 2001, sets out a vision and strategy for lifelong learning to ensure NHS staff are equipped with the skills and knowledge to work flexibly in support of patients and encouraged to grow, develop and realise their potential.

<http://www.doh.gov.uk/lifelonglearning>

### **Working Together, Securing a Quality Workforce for the NHS**

This guidance is available on the DH website at:

<http://www.doh.gov.uk/newnhs/hrstrat.htm>