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Compliance with the European Working Time Directive for junior doctors across NHS Wales

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I have prepared this report for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006.

The Wales Audit Office study team that assisted me in preparing this report comprised Gillian Body and Matthew Mortlock.

Jeremy Colman
Auditor General for Wales
Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

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Source: Image by Ross Brown

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Summary

1 The European Commission introduced the European Working Time Directive (the Directive) in 1993 as a measure to help protect the health and safety of workers. The Directive was embedded into UK law in 1998 through the Working Time Regulations and includes the limit of an average 48 hours a week (measured over a 26 week period) which workers can be required to work (see Appendix 2). In 2000, the scope of the Directive was extended to cover junior doctors in training but with a phasing in of the average weekly working time limit, as follows:

- 58 hours from 1 August 2004 to 31 July 2007;
- 56 hours from 1 August 2007 to 31 July 2009; and
- 48 hours from 1 August 2009.

2 Failure to comply with the Directive puts NHS trusts at risk of legal action from junior doctors and/or intervention by the Health and Safety Executive. Trusts could face fines and their Chief Executives could, potentially, face imprisonment. The European Commission also has the power to impose fines of up to £5,000 a week for each breach of the Directive. In addition, it would be difficult for trusts to defend clinical negligence or corporate manslaughter issues that may arise if any staff involved were not complying with the Directive.

3 However, there is also the risk that reductions in junior doctors' working time come at the expense of service delivery and quality of care, or limit the scope of their professional training. Financial constraints are also likely to mean that trusts cannot comply with the Directive simply by employing more doctors which may, in any case, not be the most appropriate solution.

4 In July 2006, the Assembly Government published *Designed to Comply*[1] which provided an initial assessment of the progress being made by the NHS in Wales towards full compliance with the Directive for junior doctors. In July 2007, *Designed to Comply – A Year On*[2] reported that 33 per cent of junior doctors were working 48 hours a week or less, as at the end of 2006. However, the vast majority (98.5 per cent) of junior doctors were reported to be working 56 hours or less at the same point in time, thereby mostly complying with the interim target well ahead of the August 2007 deadline.

5 The 2006 *Designed to Comply* report emphasised the importance of trusts exploring new ways of working to support compliance with the Directive. Trusts were encouraged to:

- improve rota management;
- implement the Hospital at Night model, which is intended to reduce the reliance on junior doctors to provide out of hours care (see paragraph 1.15); and

1 *Designed to Comply – Working Towards 2009*, Welsh Assembly Government, July 2006, http://wales.gov.uk/topics/health/publications/health/strategies/designedtocomply?lang=en

2 *Designed to Comply – A Year On*, Welsh Assembly Government, July 2007, http://www.wales.nhs.uk/sites3/Documents/481/Designed%20to%20Comply%20-%20A%20Year%20On.pdf

- look more widely at the way in which all staff are utilised, through workforce remodelling, to reduce the demands on junior doctors.

These activities are also integral to the *Designed to Work* workforce strategy for NHS Wales. *Designed to Work*[3] is itself intended to support delivery of the Assembly Government's ten-year strategy for health and social care in Wales, *Designed for Life*[4]. The Assembly Government has therefore expected NHS trusts to make progress in these areas regardless of the need to comply with the Directive. Service reconfiguration was also identified in *Designed to Comply* as a further means to compliance. However, the Assembly Government recognised that the timetable for reconfiguration would extend beyond August 2009.

6 This report considers whether the NHS in Wales is making good progress towards achieving full compliance with the Directive for junior doctors by August 2009[5]. Based on the rate of progress over the past two years and the challenges that still lie ahead, we conclude that the 48-hour target is unlikely to be met on time across NHS Wales as a whole without either a substantial investment of effort and resources or, in some areas, the possible temporary extension of the August 2009 deadline. We have reached this conclusion because:

- **Despite some progress, at July 2008 many trusts had not made adequate preparation to comply with the Directive by August 2009.** At July 2008, still fewer than half (47 per cent) of all junior doctors were reported to be working less than 48 hours a week. However, there had been some overall improvement from the rate of 33 per cent at the end of 2006 and 41 per cent at the end of 2007. In Velindre NHS Trust, Powys Local Health Board and the former Ceredigion and Mid Wales NHS Trust (now part of Hywel Dda NHS Trust) all junior doctors were already reported to be working less than 48 hours a week, but many trusts were far from this position. Most trusts lacked any clear overall plan to achieve compliance. Trusts had also made variable progress in making the type of changes that could support a reduction in junior doctors' hours, for example through the implementation of Hospital at Night. With the deadline for compliance fast approaching, trusts needed to work together more closely and with other partners, including the Assembly Government, to agree what should be done to support compliance.

- **The Assembly Government's current forecast that no more than 12 per cent of junior doctors will still be working more than 48 hours a week by August 2009 is optimistic.** This forecast assumes that trusts will deliver in full the plans for compliance that they have submitted to the Assembly Government since July 2008. However, planned changes may prove difficult to implement and sustain in practice and, as at January 2009, still only 50 per cent of junior doctors were reported to be working 48 hours a week or less. Any reactive short-term fixes may not necessarily represent the best long-term solution and potential barriers to the delivery of trusts' plans include a lack of funding, problems with the recruitment of junior doctors and staff resistance to change. Even if reported rota patterns

3 *Designed to Work: a workforce strategy to deliver Designed for Life*, Welsh Assembly Government, July 2006, http://www.wales.nhs.uk/sites3/Documents/433/D2W%20Strategy%20English.pdf

4 *Designed for Life: creating world class health and social care for Wales in the 21st century*, Welsh Assembly Government, May 2005, http://www.wales.nhs.uk/documents/designed-for-life-e.pdf

5 The findings and conclusions presented in this report are based on local fieldwork during the first half of 2008 (see Appendix 1), and evidence provided by the Assembly Government about developments since that time. We focus in this report on the achievement of the 48-hour week target.

comply, in principle, with the Directive, there is still the risk that junior doctors may regularly be being required to work longer hours in order to meet the demands of the job.

- **The UK Government is seeking an extension of the deadline for achieving the 48-hour week target in certain areas, but trusts still need to do everything possible to comply by August 2009.** This possible extension of the deadline is still to be approved by the European Commission. The extension would only apply to junior doctors working in certain areas where it can be demonstrated that all reasonable steps have been taken to achieve compliance. Even if trusts were granted an extension of the deadline for achieving the 48-hour week target, they would still be required to reduce these junior doctors' working time to 52 hours or less by August 2009. The NHS trusts in Wales have identified 31 separate junior doctor rotas which they feel should be considered for an extension. However, Assembly Government officials have indicated that robust evidence will be required to support any extension of the deadline. The process of assessing this evidence is currently ongoing.

Recommendations

7 In reporting our local audit findings to individual NHS trusts we made a number of recommendations for action. These recommendations tended to focus on trusts' overall planning arrangements for achieving the required reduction in working time (see Appendix 1).

8 In this summary report we have not made any additional recommendations directed at the Assembly Government. However, the Assembly Government's Department for Health and Social Services has indicated that it intends to take forward the following action to support compliance with the Directive over the next five months:

- the Director of Human Resources for NHS Wales and the Deputy Chief Medical Officer will be meeting Trust Chief Executives and Medical Directors to discuss the implementation of their plans for compliance;
- providing targeted support for those trusts who have identified difficulties in achieving compliance, in particular in specialities that have common problems, such as obstetrics and gynaecology, surgery and paediatrics;
- convening a working group as part of the Modernising Medical Careers (Wales) Programme Board, to make recommendations and produce guidance to ensure that the quality of junior doctors' training is maintained in the context of achieving compliance;
- hosting a day event on the subject of maximising junior doctors' training opportunities within the 48-hour week;
- working with the Department of Health to discuss criteria for assessing any possible future exemptions from the Directive;
- regular monitoring of trusts' rates of compliance with the 48-hour week target and reporting of this information through to the Human Resource Directors Group for Wales and on a quarterly basis to the Minister for Health and Social Services; and
- considering the recommendations of the recent UK-wide Hospital at Night audit, undertaken by the Department of Health's 'Skills for Health – Workforce Projects Team', in consultation with the NHS trusts' Hospital at Night leads.

Part 1 – Despite some progress, at July 2008 many trusts had not made adequate preparation to comply with the Directive by August 2009

There had been some overall improvement but many trusts still had a long way to go to achieve compliance

At July 2008, just over half of all junior doctors were still reported to be working more than 48 hours a week

1.1 Junior doctors' working time has been monitored by the Assembly Government based on information provided by NHS trusts. This information has been submitted around every six months alongside the returns that trusts are required to provide in relation to the New Deal contractual agreement for junior doctors (see Appendix 2).

1.2 Some Trust staff questioned the accuracy of the information that had been submitted to the Assembly Government[6]. This information about junior doctors' rota patterns has, in any case, only ever been a snapshot in time. Rota patterns can fluctuate regularly in response to local circumstances. Even then there is the risk that agreed rotas do not reflect actual working patterns (see paragraph 2.5). What the information does indicate is a slow but steady increase in the average percentage of junior doctors working 48 hours a week or less, from 33 to 47 per cent between the end of 2006 and July 2008 (see Figure 1). Of those junior doctors working more than 48 hours a week in July 2008, around one third were working more than 52 hours.

Figure 1 – NHS Wales compliance with the 48-hour week target

	Percentage of junior doctors working 48 hours a week or less	Reduction in hours needed for all junior doctors to be working 48 hours a week or less
End of 2006	33	7824
End of 2007	41	6273
July 2008	47	5848

Note

The total hours needed to achieve compliance are based on the excess time beyond the 48-hour limit for each participant on a non-compliant rota, rounded up in each case to the nearest full hour. We have used this calculation for consistency with the *Designed to Comply – A Year On* report. Without rounding up to the nearest full hour there would still have been, at July 2008, a reduction of around 5,112 hours required to achieve full compliance.

Source: Figures for the end of 2006 are taken from the Designed to Comply – A Year On report, published in July 2007. Figures for the end of 2007 and July 2008 are based on the information submitted by trusts to the Assembly Government.

6 There has been a UK-wide debate about how best to monitor and report average weekly working time. For example, some NHS organisations have calculated the average working time over the life-cycle of the individual rota (the approach used for New Deal monitoring) rather than over the 26-week period stipulated by the Directive.

1.3 Overall, the 5,848 hours required to comply with the 48-hour target was equivalent to just under four hours for each junior doctor still working on a non-compliant rota. Alternatively, the required reduction in hours would be equivalent to 122 additional doctors working a 48-hour week.

1.4 There were also still three junior doctor rotas that were operating at an average weekly working time of more than 56 hours (trusts should have achieved a reduction to 56 hours or less by August 2007). These three rotas involved, at the time, a total of 24 doctors, and were located as follows:

- a neurosurgery rota at Morriston Hospital (Abertawe Bro Morgannwg University NHS Trust), running at an average weekly working time of 58 hours and 28 minutes;
- an ophthalmology rota at West Wales General Hospital (Hywel Dda NHS Trust), running at an average weekly working time of 56 hours and 15 minutes[7]; and
- an anaesthetics rota at the Royal Gwent Hospital (Gwent Healthcare NHS Trust), running at an average weekly working time of 57 and a half hours[8].

Although two trusts were already fully compliant, many were far from this position

1.5 At Velindre NHS Trust and Powys Local Health Board all junior doctors were reported to be working an average of 48 hours a week or less. At Powys Local Health Board the four junior doctor posts in psychiatry had become compliant following the introduction of an additional staff grade post. However, the Board had had problems recruiting junior doctors to these posts and had been forced to employ more costly locum cover.

1.6 There were substantial differences in the other trusts' rates of compliance with the 48-hour week target, ranging from 31 to 73 per cent (see Figure 2). For some of the new organisations, created following the recent Trust mergers from 1 April or 1 July 2008, the aggregated position of the new organisation masks substantial differences in the compliance rate at each predecessor Trust:

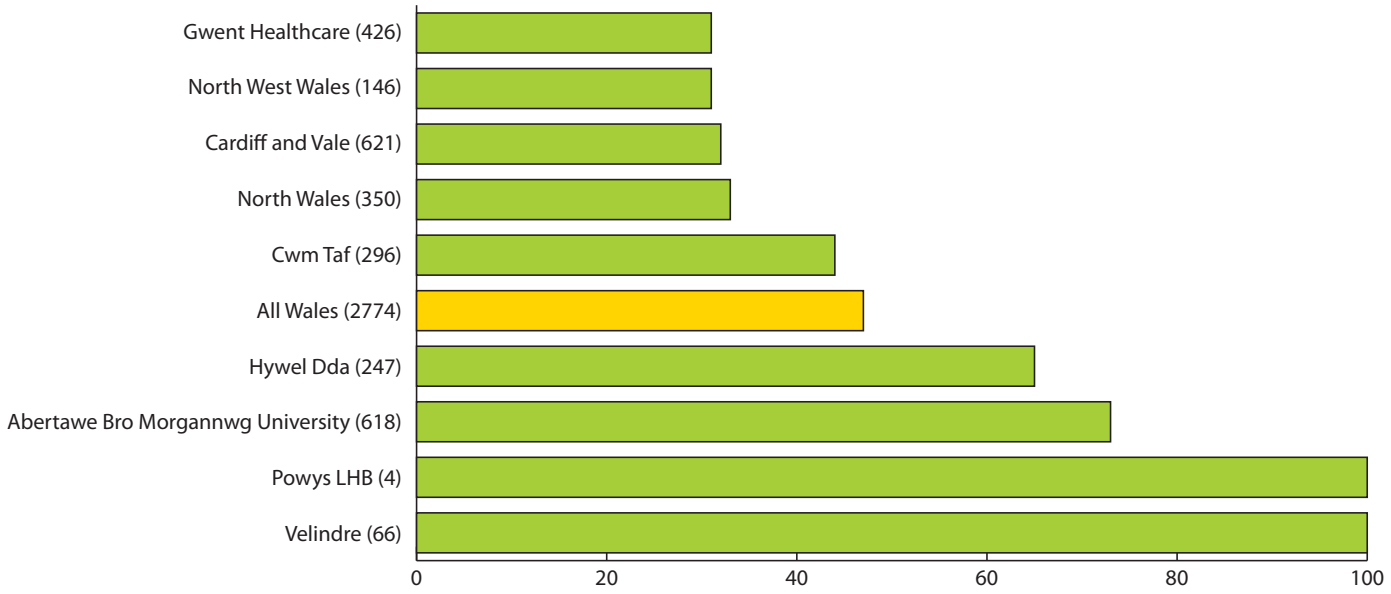
- North Wales NHS Trust: less than 20 per cent compliance across the former North East Wales NHS Trust, compared with 47 per cent compliance across Conwy and Denbighshire NHS Trust;
- Abertawe Bro Morgannwg University NHS Trust: 82 per cent compliance across the former Swansea NHS Trust and 51 per cent compliance across Bro Morgannwg NHS Trust[9];
- Hywel Dda NHS Trust: 100 per cent compliance across the former Ceredigion and Mid Wales NHS Trust, 50 per cent compliance across Carmarthenshire NHS Trust, and 68 per cent compliance across Pembrokeshire and Derwen NHS Trust; and
- Cwm Taf NHS Trust: 48 per cent compliance across the former North Glamorgan NHS Trust and 40 per cent compliance across Pontypridd and Rhondda NHS Trust.

7 This rota is now compliant with the 48-hour week limit following changes introduced in November 2008.

8 To achieve compliance, the Trust plans to change the working pattern of this rota and revise the time allocated within the working pattern to education and training, which currently exceeds recommended requirements.

9 The two predecessor trusts had reported similar levels of compliance at the end of 2007 but subsequent changes at Swansea NHS Trust had improved the rate of compliance significantly (up from 52 per cent at the end of 2007).

Figure 2 – Trust-specific compliance with the 48-hour week target, as at July 2008



Note

Figures in brackets represent the number of participants reported to be working on the junior doctor rotas at each Trust.

Source: These figures for July 2008 are based on the information submitted by trusts to the Assembly Government. As noted in paragraph 1.2, some Trust staff have questioned the accuracy of this baseline information which is, at best, a snapshot in time. In particular, North West Wales NHS Trust reported to us a considerably higher compliance rate in May 2008 than the rate of 31 per cent shown above for July 2008. We have not been able to resolve retrospectively the reason for this difference.

Trusts needed to prepare more carefully and quickly to be able to comply with the 48-hour target by August 2009

Most trusts lacked any clear overall plan to achieve compliance

1.7 The *Designed to Work* strategy stated that, 'all health care organisations will plan for the impact of the 48-hour working limit to be achieved by 2009 to meet the requirements of the European Working Time Directive'. In *Designed to Comply - A Year On*, the Assembly Government had encouraged trusts in 2007 to work towards compliance with the 48-hour limit by August 2008, thereby allowing contingency time for any problems to be overcome.

1.8 By the time of our local fieldwork, in the first half of 2008, trusts had responded, where they deemed it appropriate, to many but not all of the recommendations made to them by the Assembly Government in early 2007 (Appendix 1). However, most trusts were still to develop, in any formal or coherent way, firm plans to achieve full compliance with the Directive by August 2009. Internal responsibilities and accountabilities for achieving compliance were also sometimes unclear, either in terms of the lead executive responsibility and/or the overlapping interests of various internal working groups.

1.9 We were also concerned that the challenges associated with achieving compliance had sometimes not been given sufficient prominence. For example, although the subject featured in a Clinical and Risk Governance report presented to the final

North Glamorgan NHS Trust Board meeting in March 2008, that report referred to the good progress being made towards compliance. Given the lack of firm plans to address areas of non-compliance, we felt that the former Trust's assessment of its progress was too optimistic.

1.10 Some trusts were able to demonstrate more robust planning arrangements. At Bro Morgannwg NHS Trust, regularly updated action plans had provided a focus for improvement and the management responsibilities for achieving compliance appeared to be clearly understood. At Swansea NHS Trust, compliance with the Directive was also seen as an integral part of the Trust's overall modernisation strategy and the Trust was able to provide evidence of a detailed action plan for compliance. However, the Trust had still found it difficult to encourage lead clinicians to take ownership of this issue. Elsewhere, some trusts were just beginning to focus more attention on this issue. In March 2008, Gwent Healthcare NHS Trust established a European Working Time Directive Implementation Steering Group which was specifically tasked with responsibility for delivering compliance. Aside from the responsibilities of this group, the Trust has since submitted a number of position papers to the executive team and the board to ensure a wider corporate understanding of the issues associated with achieving compliance. Cwm Taf NHS Trust established a similar Steering Group shortly following our fieldwork.

Trusts had made variable progress in making the type of changes that could support a reduction in junior doctors' hours

Rota management

1.11 Key components of effective rota management include:

- considering the appropriate number of doctors operating on the rota and ensuring that the supply of doctors matches the demands of the service;
- providing adequate patient and consultant contact time to contribute to junior doctors' professional training; and
- seeking to mitigate any negative impact of shift patterns on junior doctors' well-being, in particular to avoid the risk of fatigue which could, in turn, lead to clinical errors.

1.12 Many of the recommendations made by the Assembly Government to individual trusts in early 2007 related to potential rota management solutions. Problems with recruitment or staff resistance meant that some trusts had not been able to implement all of these recommendations. But these recommendations did at least demonstrate that, given due attention and a willingness to consider different ways of working, rota management can be effective in reducing doctors' working hours.

1.13 The Assembly Government has funded a single electronic rota management system for NHS Wales[10]. Enhancements to the system mean that live rota information can now be input and analysed over the internet. The Assembly Government is also now able to access this information centrally as required, rather than relying on trusts to submit this information (see paragraphs 1.1-1.2).

10 Although there were some teething problems, this system had been well received generally, although Cardiff and Vale NHS Trust had still been experiencing some difficulties in its use of the system because of the way its rotas were constructed. The Trust has recently had an on-site visit from the system supplier, resulting in the rollout of an upgrade to the system which has addressed most of these problems.

1.14 The Assembly Government recently commissioned the company responsible for developing the rota management software to undertake a review of all of those rotas that still exceeded the 48-hour limit. This work was commissioned with a view to identifying options for alternative rota patterns to help achieve compliance. The emerging findings from this work were reported back to the Assembly Government at the end of January 2009 and are being passed on to trusts to consider. The Assembly Government is still to calculate the overall cost and the extent of the benefit of the proposals as this work is completed.

Hospital at Night and wider workforce remodelling

1.15 The 2006 *Designed to Comply* report describes how the introduction of Hospital at Night should spell the end to traditional silo-based team working. However, Hospital at Night is not a one size fits all approach and needs tailoring to suit local circumstances.

Hospital at Night

The Hospital at Night concept redefines the provision of medical cover out of hours and should reduce trusts' reliance on junior doctors during this period. The concept is based on the notion of only having in work those who need to be at work by introducing generic multi-professional teams. These teams would have the competences required to meet patients' immediate needs. Hospital at Night was first piloted in the UK in 2003-04 and has since been embraced by an increasing number of NHS organisations.

More information on Hospital at Night, including the results of a UK-wide survey of its implementation in 2008, can be found at http://www.healthcareworkforce.nhs.uk/hospitalatnight.html

1.16 Having made good progress with the implementation of Hospital at Night, Cardiff and Vale NHS Trust had begun to look at extending the principles of the model to its daytime and weekend work, drawing on the experience of Homerton University Hospital NHS Foundation Trust in England. However, only 32 per cent of junior doctors at Cardiff and Vale Trust were working 48 hours a week or less at July 2008, emphasising that Hospital at Night is not, by itself, a means to full compliance with the Directive. Nevertheless, the introduction of Hospital at Night had been important in helping the Trust to achieve an overall reduction in junior doctors' working hours. Bro Morgannwg and North West Wales NHS Trusts had also made relatively good progress with Hospital at Night.

1.17 However, across NHS Wales as a whole, there were clear differences in the extent to which the Hospital at Night concept had been accepted and/or fully implemented, both between or in some cases within individual trusts. For example, at Gwent Healthcare NHS Trust, Hospital at Night arrangements were not sufficiently developed at the Royal Gwent Hospital despite their more successful introduction at Caerphilly District Miners and Nevill Hall Hospitals. And Swansea NHS Trust had made less progress with Hospital at Night at Singleton Hospital than at Morriston Hospital. Some of the common constraints on the implementation of Hospital at Night included:

- cultural resistance among staff and a lack of acceptance of the model of generic working, coupled with some ongoing concerns about whether the staff working at night had the necessary competences to deliver good-quality and safe services;
- insufficient staffing resources to project manage the introduction of the model or a lack of clear senior leadership on this issue; and
- ongoing problems in terms of trusts' ability to do the 'day work' during the day,

meaning that more work was spilling over into the evening and night shifts, lengthening the handover period between shifts.

1.18 Looking beyond Hospital at Night, there is still a long way to go in terms of trusts maximising opportunities to remodel and modernise the wider workforce to reduce junior doctors' workloads. There are examples of existing or emerging good practice in workforce redesign, including the introduction of new advanced nurse practitioner roles or extension of the level of consultant cover. However, these changes tended to have been introduced on an ad hoc basis rather than as part of a clear strategic approach to workforce modernisation.

1.19 In early 2008, Cardiff and Vale NHS Trust commenced a review of its specialist and advanced nursing workforce. This work was being rolled out on a phased basis with the aim of:

- identifying the specialist and advanced practice nursing resource available within the Trust;
- understanding the current contribution made by these nurses to patient care; and
- identifying the actions required to support the development and shape of this part of the workforce to meet future healthcare and professional regulation requirements.

The outcomes from this review were intended to influence the future development of this part of the Trust's workforce, potentially facilitating a reduction in junior doctors' hours. However, we noted in our report to the Trust that this work would need to move forward quickly if it was to support compliance with the Directive by August 2009.

Service reconfiguration

1.20 In the 2006 *Designed to Work* report the Assembly Government indicated that it was unacceptable to delay new ways of working on the basis that the future provision of services was unknown. However, some local service leads had clearly been reluctant to develop firm plans to achieve compliance with the Directive ahead of wider corporate decisions on service reconfiguration. Some Trust staff were also concerned about the impact that the mergers affecting their trusts would have on the pace of change, for example in terms of the implementation of new models of unscheduled care.

1.21 While some trusts were waiting on political support for large-scale service reconfiguration, there were other opportunities for service reconfiguration, either internally or working with neighbouring trusts, that were still to be fully explored, especially where trusts had recently merged. However, there were some emerging developments, for example:

- Cwm Taf NHS Trust had begun to consider opportunities to restructure service delivery between its main hospital sites. The recommendations made by Professor Mansel Aylward in his review of health services in the Merthyr Tydfil area had also provided the Trust with a clear steer against which to revisit and revise its wider reconfiguration plans.
- Gwent Healthcare NHS Trust had clearly recognised the relationship between the health community's Clinical Futures modernisation strategy and the issue of compliance with the Directive, although the proposed timeframe for the Clinical Futures programme extends well beyond the deadline for compliance. Projects underway as part of the Clinical Futures programme which were expected to impact

on junior doctors' working patterns include the development of an integrated unscheduled care service involving NHS Direct and the Gwent Out of Hours service.

- Plans for the restructuring of unscheduled care services in North West Wales NHS Trust presented a possible opportunity to bring together the Trust's Accident and Emergency and Acute Medical rotas. The Trust has also worked with North Wales NHS Trust to implement a partial rota between Ysbyty Gwynedd and Ysbyty Glan Clwyd to share out-of-hours cover for vascular surgery. Similar arrangements are being considered in terms of ear, nose and throat and ophthalmology services.

Trusts, Local Health Boards, the Assembly Government and other partners needed to work together more closely to agree what should be done to support compliance

1.22 Some Trust staff were disappointed at the general level of support and guidance that had been offered by the Assembly Government, compared with their perception of the support available to the NHS in England. There has certainly been a wide range of activity in England relating to the Directive generally and Hospital at Night specifically, supported by the Department of Health's 'Skills for Health – Workforce Projects Team'[11]. However, trusts in Wales have also been able to access the range of guidance, shared learning and case studies that have been developed from this work.

1.23 Although fluctuating over time the Assembly Government's own staff resources to support compliance with the Directive have been relatively limited. At January 2009, the Department for Health and Social Services employed a full-time project manager with responsibility for overseeing the New Deal and the Directive, as well as a part-time junior doctor co-ordinator (four hours a week), and a part-time Hospital at Night project manager (one day a week). All three of these staff are on secondment to the Assembly Government. The secondments of the part-time junior doctor co-ordinator and Hospital at Night project manager are due to finish at the end of March 2009. At present there are no plans to reappoint to these posts. The secondment of the full-time project manager is due to finish in August 2009, beyond which the future of this post is still to be determined. The Department also uses 50 per cent of the time of a civil service executive officer to support the full-time project manager.

1.24 These posts, along with other central initiatives have been funded from the Assembly Government's own junior doctors' budget[12]. However, as the deadline for compliance with the Directive has approached, the size of this budget has decreased, from £1.4 million in 2003-04 to only £0.5 million in 2008-09. Part of this reduction in budget (£256,000) reflects the fact that monies which were used previously to support some posts within trusts had been transferred from the Assembly Government's central budget into the relevant Local Health Board allocation. Nevertheless, Assembly Government officials have also explained that another reason for the reduction in this budget was because the monies had not previously been spent in full. This underspend seems surprising given the challenges faced by NHS trusts in achieving compliance.

1.25 For the 2004-05 financial year, the discretionary revenue allocation to Local Health Boards for hospital, community and health services included an uplift of just under 6.3 per cent to account for inflation and other

11 See http://www.healthcareworkforce.nhs.uk/

12 These monies have been used previously to fund pilot projects relating to Hospital at Night or compliance with the Directive, bids by trusts for measures to improve the working lives of junior doctors, for example, improved facilities and accommodation, or to fund the provision of rota management software (see paragraph 1.13).

specific cost pressures. Of this uplift, one per cent was in recognition of cost pressures associated with junior doctors' compliance with the Directive and/or the New Deal. This one per cent uplift was equivalent to £19.7 million at 2004-05 prices[13]. The then Chief Executive of NHS Wales also wrote to NHS trusts in early 2004 explaining that additional future funding relating to the Consultant Contract and Agenda for Change should, along with the one per cent uplift for 2004-05, together help to resolve any funding issues relating to the Directive.

1.26 The one per cent increase in discretionary funding for 2004-05 has subsequently been consolidated in Local Health Boards' annual allocations. This funding may have supported early efforts to reduce junior doctors' hours to 58 hours per week or less by August 2004 and to sustain that position. However, no new central monies have since been added to Local Health Boards' allocations specifically to support further progress towards the 48-hour limit. We also found there had been relatively little recent dialogue between NHS trusts and their respective Local Health Boards as regards the changes that might have been needed to achieve full compliance with the Directive and the potential service delivery and/or financial implications of these changes.

1.27 In England, the Department of Health included £110 million in its allocations to Primary Care Trusts in 2008-09 to support compliance with the Directive. As with the funding provided previously to the NHS in Wales, we have not examined whether or not these monies have actually been directed specifically at measures to support compliance. However, the Department of Health also intends to include a further £150 million of support to Primary Care Trusts in 2009-10, as well as making available £50 million to Strategic Health Authorities to support change. The Department of Health has indicated that the funding earmarked for 2009-10 is likely to be repeated in 2010-11 to help sustain compliance.

1.28 Some Welsh trusts also expressed concern at the fact that the work of the all-Wales SAFER[14] taskforce for doctors in training had slowed down over the previous year. This taskforce was established in 2001, originally with the purpose of overseeing the implementation of the New Deal. The taskforce's work then expanded to include issues relating to the Directive and Hospital at Night. Membership of the taskforce included the British Medical Association, the Postgraduate Deanery, the Assembly Government and service representatives.

1.29 The all-Wales Medical Personnel Managers Group recommended to the all Wales Human Resource Directors Group at the end of the 2007 that the SAFER taskforce should be re-invigorated to help tackle some of the strategic issues and common problems involved in working towards compliance. The Assembly Government indicated to us in mid 2008 that it was looking to reconstitute the taskforce. But, as at January 2009, the taskforce had still not re-formed because of difficulties in getting all parties to sign up to the revised remit of the group. The Assembly Government has stressed that the project manager responsible for overseeing the New Deal and the Directive has still been continuing with the general work of the taskforce and reporting progress to the Director of Human Resources for NHS Wales. Nevertheless, the fact that the taskforce meetings have stalled, when the deadline for full compliance with the Directive has been fast approaching, is extremely disappointing.

13 Before applying this overall uplift, the Local Health Board baseline allocation from 2003-04 had already been adjusted and increased by £362,000 to meet the recurring costs of new or expanded posts created in 2003-04 to support a reduction in junior doctors' hours.

14 SAFER stands for Security, Accommodation, Facilities, Education and Rest.

Part 2 – The Assembly Government's current forecast that no more than 12 per cent of junior doctors will still be working more than 48 hours a week by August 2009 is optimistic

The Assembly Government's forecast assumes that trusts will deliver in full their current plans for compliance

2.1 Reflecting some of the concerns identified in our own local audit work, the then Chief Executive of NHS Wales (and head of the Assembly Government's Department for Health and Social Services) wrote to Trust and Local Health Board Chief Executives in mid-June 2008 expressing her own disappointment at the rate of progress towards full compliance with the Directive. That letter also requested, where required, the submission of definitive action plans to support compliance. Assembly Government officials have since visited trusts to discuss these plans in more detail[15].

2.2 On the basis of the plans discussed with each individual Trust, Assembly Government officials prepared a 'state of readiness' report. That report was approved in January 2009 by the Minister for Health and Social Services and forwarded to the Department of Health to inform the UK-wide position. In the report the Assembly Government estimated that 88 per cent of junior doctors will be working an average of 48 hours a week or less by August 2009. The Assembly Government highlighted some working patterns within Cardiff and Vale, Gwent Healthcare and North West Wales NHS trusts that were not expected, on the basis of the plans developed at the time, to be fully compliant by August 2009, along with some working patterns at Cwm Taf NHS Trust (pending that Trust's submission of its own detailed action plan[16]). Across Wales the specialties of surgery, obstetrics and gynaecology, paediatrics and anaesthetics present the most significant challenge in terms of achieving full compliance.

Planned changes may prove difficult to implement and sustain in practice

2.3 We have not challenged for ourselves the robustness of the compliance plans submitted by trusts to the Assembly Government. However, Assembly Government officials have indicated that they are, in principle, content with the plans. The state of readiness paper also concludes that, above and beyond these existing plans, 'there may still be further opportunities to increase compliance that are yet to be maximised'. In fact, such opportunities have been proven to exist through the rota design consultancy work commissioned recently by the Assembly Government (see paragraph 1.14). Assembly Government officials have indicated that this exercise appears to have produced a potential solution for every non-compliant rota. However, these solutions still have to be considered and tested by trusts, taking account of local service requirements.

15 As at the end of January 2009, Cwm Taf NHS Trust was still to submit an action plan to the Assembly Government. The Trust had, however, been working to develop an integrated plan covering its two predecessor trusts and had constituted a new Steering Group to lead on this work, as well as appointing a project manager to take forward Hospital at Night.

16 Despite the absence of a definitive action plan from Cwm Taf NHS Trust, the Assembly Government assumed that those rotas at the Trust that were already operating at between 48 and 50 hours a week should be able to be made compliant by improvements in rota management. Taking that into account, the state of readiness paper estimated that the Trust would be at least 62 per cent compliant by August 2009, compared with the 44 per cent compliance reported for July 2008.

2.4 Nevertheless, the forecast level of compliance by August 2009 is inherently optimistic. As at January 2009, the overall compliance rate across Wales still stood at only 50 per cent, demonstrating that most of the planned changes identified by trusts to achieve compliance were yet to take effect[17]. It remains to be seen whether all of these changes can actually be implemented by August 2009, and any reactive short-term fixes may not necessarily represent the best longer-term solution[18].

2.5 Potential barriers to the delivery of these plans and general compliance with the Directive include:

- **A lack of funding for extra staff or problems recruiting doctors could affect the viability of some of the planned changes.** Some of the solutions proposed by trusts to achieve compliance with the Directive are based on the introduction of new posts. However, the funds to support these posts have not yet been agreed in all cases and cannot be assumed given the wider financial constraints on the service. Even then, there are still live concerns about the recruitment of junior doctors for August 2009. Any problems filling posts are likely to impact upon trusts' ability to implement and sustain planned changes in working practices to support compliance.

- **Staff may be resistant to planned changes.** Staff resistance in some quarters has already hindered trusts' efforts to implement proposed changes to rota patterns or new ways of working, such as Hospital at Night. Underpinning some of this resistance is the wider concern about the impact of the reduction in junior doctors' hours on their professional training. However, the Assembly Government's state of readiness report also stated that 'there is little evidence that the delivery of training has been looked at creatively along with improving the trainees' understanding of what the training experience is, with little reflective learning taking place in some areas'. Nevertheless, the issue of training time is still a source of contention and something that trusts need to consider carefully when implementing their plans for compliance with the Directive.

- **Reported rota patterns may comply with the Directive but these rotas may not reflect actual working patterns.** As at July 2008, of those junior doctors working on compliant rotas, just over a quarter were working between 47 and 48 hours and six per cent were working on rotas of exactly 48 hours. These rotas leave little or no slack to account for any additional work pressures that may contribute to longer hours of work, for example where staff may provide cover for other absent staff. Ideally, trusts need to be building in some contingency to allow for additional hours being worked without this automatically breaching the Directive, either in terms of rest requirements or average weekly working time. Some trusts were more confident than others in the integrity of their agreed rotas and pointed to the fact that it is in the financial interest of junior doctors to indicate if they are working longer hours as this could affect their pay banding. Nevertheless, we did identify evidence to suggest that at least some junior doctors regularly had to work longer hours than indicated by their assumed rota patterns. Longer hours working may, from

17 This latest 50 per cent compliance figure has been reported by the Assembly Government based on the live rota information on trusts' web-based rota management software, and may therefore not be entirely consistent with the previous compliance rate figures based on the rota information submitted by trusts (see paragraphs 1.1-1.2).

18 North Wales NHS Trust plans to trial some new rotas prior to the August 2009 junior doctor intake by temporarily reducing hours or, where necessary, appointing locums to cover any additional workloads.

time to time, be unavoidable to cope with service pressures. However, in calculating average weekly working time over an average 26 week period, trusts have the opportunity to smooth out the impact of these peaks in demand on junior doctors' working patterns to ensure compliance with the Directive.

Part 3 – The UK Government is seeking an extension of the deadline for achieving the 48-hour week target in certain areas, but trusts still need to do everything possible to comply by August 2009

3.1 On 30 January 2009, the UK Department of Health published notification of its intention to seek a limited exemption (derogation) of the Directive for up to three years (through to August 2012)[19]. This derogation is subject to approval by the European Commission, which is due to respond by 1 May 2009. The decision to seek this derogation follows work undertaken by the Department of Health, in discussion with each of the devolved administrations in Wales, Scotland and Northern Ireland, to assess the likelihood of achieving full compliance with the 48-hour limit by August 2009.

3.2 The Department of Health has indicated that the derogation would apply, in principle, to those junior doctors who have duties in services that are delivering 24-hour immediate patient care, in highly specialised (supra-specialist) areas, or in small, remote, or rural units. However, trusts seeking to take advantage of the derogation would have to demonstrate that they had taken all reasonable steps to achieve compliance and that there were specific and unavoidable reasons why they would not be able to do so. Even those areas covered by the possible derogation would still have to reduce the average weekly working time of junior doctors to less than 52 hours which, in some cases, is still a challenge in itself (see paragraph 1.2).

3.3 The new Chief Executive of NHS Wales (and Head of the Assembly Government's Department for Health and Social Services) wrote to NHS Trust Chief Executives in early February 2009 to explain the implications of the possible derogation of the Directive. There are 31 separate junior doctor rotas in Wales, around seven per cent of all rotas, where trusts have identified that they would like to seek a derogation. Assembly Government officials have indicated that robust evidence is required for these working patterns to be considered for derogation. The process of assessing this evidence is ongoing[20].

19 *The European Working Time Directive – UK notification of derogation for doctors in training*, Department of Health, January 2009, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093940

20 The final assessment of whether individual rotas are eligible for derogation, assuming that the principle of derogation is approved by the European Commission, will be made by the UK Department of Health but taking advice from the Assembly Government. Rotas that are approved for derogation would then need to be written into the UK Working Time Regulations.

Appendix 1 – Methodology

1 In the first half of 2008 we undertook local fieldwork to examine the progress that the NHS trusts in Wales (excluding the Welsh Ambulance Services NHS Trust) and Powys Local Health Board were making towards achieving compliance with the Directive for junior doctors. We focused on the requirement to reduce junior doctors' average weekly working time to 48 hours or less[21].

2 We started our fieldwork prior to the mergers that have since affected a number of trusts[22]. However, we planned our work so that we were able to compare and contrast in the newly formed trusts, the progress made by each of their predecessor organisations. Because all of the junior doctors employed by Velindre NHS Trust and Powys Local Health Board were already working less than 48 hours a week, we did not undertake detailed fieldwork or reporting at these sites.

3 We were particularly interested in the progress that trusts had made since the beginning of 2007. This timeframe reflected the fact that Assembly Government officials had visited each trust in late 2006, work which then informed the *Designed to Comply – A Year On* report. In conducting our own work we considered the extent to which trusts had acted upon the recommendations made to them by the Assembly Government in early 2007, based on these visits.

4 During the development of our local work we liaised closely with Assembly Government officials. In early June 2008, we also briefed officials on the key themes that were emerging from our work. This feedback has helped to inform some of the action taken subsequently by the Assembly Government.

5 Our own local recommendations to individual NHS trusts tended to focus on:

- where needed, promoting the urgent development and delivery of plans designed to help achieve the 48-hour target, including, where trusts had recently merged, taking forward learning and any good practice from each of the predecessor trusts;
- clarifying management responsibilities and accountabilities for achieving compliance with the Directive;
- encouraging trusts to engage in a clear dialogue with their relevant Local Health Board(s), the Assembly Government, and other trusts, as regards the measures that might have been required locally and nationally to achieve compliance with the Directive and their potential financial and service delivery implications; or

21 The Assembly Government has funded the provision of rota management software (see paragraph 1.13) which should ensure that rotas are, in principle, designed to comply with the Directive's other working time related requirements (see Appendix 2).

22 On 1 April 2008, North Glamorgan and Pontypridd and Rhondda NHS trusts merged to form Cwm Taf NHS Trust; Swansea and Bro Morgannwg NHS trusts merged to form Abertawe Bro Morgannwg University NHS Trust; and Carmarthenshire, Pembrokeshire and Derwen, and Ceredigion and Mid Wales NHS trusts merged to form Hywel Dda NHS Trust. In addition, North East Wales and Conwy and Denbighshire NHS trusts merged to form North Wales NHS Trust on 1 July 2008.

- emphasising the importance of keeping Trust Boards and other relevant fora fully appraised of emerging plans and progress in light of the challenging timescale and the risks associated with achieving, or not achieving, the 48-hour target.

Appendix 2 – The European Working Time Directive

1 The basic rights and provisions provided for under the Directive are:

- a limit of an average of 48 hours a week which a worker can be required to work (the UK Government has previously agreed an opt-out whereby workers can choose to work more hours if they want to)[23];
- a limit of an average of eight hours' work in 24 which night-workers[24] can be required to work;
- a right for night workers to receive free health assessments (and a general obligation on employers to provide these assessments before they start working nights and on a regular basis thereafter – once a year being appropriate as a minimum);
- a right to 11 hours' rest a day and an in-work rest break if the working day is longer than six hours; and
- a right to a day off each week and four weeks' paid leave a year.

2 The provisions of the Directive were first embedded into UK law in 1998 through the Working Time Regulations[25]. In May 2000 the scope of the Directive was extended to cover junior doctors in training but with a phasing in of the average weekly working limit of 48 hours, as follows:

- 58 hours from 1 August 2004 to 31 July 2007;
- 56 hours from 1 August 2007 to 31 July 2009; and
- 48 hours from 1 August 2009.

3 In 1991 the UK Government, the NHS and the British Medical Association agreed a package of measures on working hours, pay and conditions for junior doctors, referred to as the New Deal. One of the key features of the New Deal was the agreement to establish maximum contracted weekly hours for different working patterns. These were agreed in 1996 as 72 hours a week for on-call rotas, 64 hours a week for partial shifts and 56 hours a week for full shifts. The New Deal was refined in 1999 in terms of shift patterns and rest requirements along with a new pay structure for doctors. From August 2003 it has been a contractual obligation for trusts to ensure all junior doctors in training comply with the New Deal. Because the New Deal is a contractual agreement the provisions of the Working Time Regulations, as statutory law, take precedence.

4 Rulings by the European Court of Justice (known as the SiMAP and Jaegar rulings) have determined previously that any time spent resident on-call counts towards the average weekly working time, making achievement of Directive even more difficult, and superseding the provisions for on-call rotas within the New Deal agreement. The way in which on-call time is calculated within the average weekly working time, as well as the right of Member States to present

23 For most occupations, the provisions of the regulations measure the average working week over a 17-week reference period. However, for doctors in training this reference period is 26 weeks.

24 Night workers are classed as those who normally work an average of at least three hours at night (night time being classified as between 11pm and 6pm).

25 See http://www.berr.gov.uk/whatwedo/employment/employment-legislation/working-time-regs/index.html

individuals with the opportunity to opt out from the Directive have been the subject of recent debate at European level. However, any subsequent changes to the Directive, and following that to the UK working time regulations, are unlikely to take place before the August 2009 deadline for achieving a reduction in junior doctors' working time to 48 hours a week or less.