



The Barbados Plan: a paper for Consultation

Background:

Historically, doctors in training have worked excessive hours. There is increasing evidence that excessive hours are detrimental for both doctors and patients¹². The hours that doctors can work is now limited by the combined effects of the New Deal and the European Working Time Directive.

1. The New Deal for Junior Doctors (1991)

This sets a limit of **56 hrs/week** on the number of hours doctors in training can work. Although agreed in 1991, little progress was made in reducing junior doctors' hours until the New Contract was agreed in 2000, which set financial incentives for employers to meet the targets.

2. The European Working Time Directive (EWTD)

This is a directive from the Council of Europe (93/104/EC) that lays down minimum requirements in relation to working hours, rest periods and annual leave. The EWTD is a Health and Safety legislation. Working Time Regulations (WTR) enacted the EWTD into British Law in 1998. Although doctors in training were specifically excluded from the initial EWTD and WTR, the EWTD was extended to cover doctors in training from August 2004 (Table 1). Under the EWTD, doctors' hours must be reduced to a maximum of **48 hrs/wk by August 2009**.

¹ [N Engl J Med](#). 2004 Oct 28;351(18):1829-37.

² *Jt Comm J Qual Patient Saf*. 2007 Nov;33(11 Suppl):7-18.

Date	EWTD Limits
August 2004	58 hour week & rest requirements
August 2007	56 hour working week
August 2009	48 hour working week

Table 1: The phased implementation of the EWTD for doctors in training

Case law from the European Court of Justice has significantly affected the implementation of the EWTD, and hence medical working patterns in the UK. The **SiMAP case** defined all time when the worker was *required to be present at the place of work* as actual work. The **Jaeger Judgment** confirmed this finding, and further states that time spent asleep while on call in the hospital is also defined as work.

Historically, doctors worked an ‘on-call’ rota requiring them to be available for work for extended periods (up to 56 hours), but not necessarily working. For example, a doctor might be “resident on call” in the hospital from 5pm until 9am the following day, but might be asleep from 2-4am. The SiMAP and Jaeger judgments have put an end to on-call where doctors are required to be resident in the hospital.

The effect of the EWTD on service and training

There is increasing concern that implementation of the EWTD for doctors will adversely affect both doctors’ training and patient care. Since a hospital requires doctors to be present at all times, a 48 hr/wk rota will generally mean that doctors spend less time in the hospital between the hours of 9am and 5pm. However, it is during these hours that clinics, operating lists, Consultant ward rounds, etc, take place. Doctors working a 48hr/week rota will have less exposure to these activities and will have less clinical experience than their counterparts who worked in 56 hr/wk rotas. This is of particular concern in surgical specialties, where surgeons will spend less time operating. The move from 56 to

48 hrs/wk equates to an overall reduction of 2080 hours over a 5 year Specialty Training programme³. In his report “Aspiring to Excellence”, Sir John Tooke stated that:

“...the current interpretation in UK legislation impedes the acquisition of experience, of confidence and the ability to shoulder responsibility. This promotes further the 'trainee mentality' over and above a recognition of the trainee's service contribution. In the interest of patient safety, no one would wish to see a return to hours of duty that impact on adequate rest and relaxation, but few other professions in the UK, nor medical career structures in Europe embrace the Directive in the same way that it has been embraced in the UK...

The Panel recommends that urgent attention should address whether there are ways in which a more flexible approach to EWTD could be legitimately embraced”

The Opt Out

Under Article 22 of the EWTD (2003/88/EC), the Member State can opt not to apply the limits of weekly hours of work (Article 6), providing that :

- ... [the employer] obtains the workers' agreement to perform such work
- no worker is subject to any detriment by his employer because he is not willing to give his agreement to perform such work
- the employer keeps up to date records of all workers who carry out such work

In May 2005 the European Parliament amended a proposal from the European Commission and suggested revisions to the consolidated working time directive. This proposal calls for an end to the individual opt out and details consideration of “on call work”, specifically introduced in response to the SiMAP and Jaeger Judgments.

³ 8hrs/wk x52 wks x 5yrs

While removal of the individual opt out has been supported by some nations and organizations⁴, the move has been resisted by the UK in Europe. The European Parliament proposals remain held up at the European Council, will no political solution agreed in the last 2 years.

RemedyUK proposals:

RemedyUK propose the following:

- 1) That the Government apply for an extension to full implementation of the EWTD under Article 17
- 2) That use is made of the individual opt out to allow doctors to work up to 56 hrs/wk (The Barbados Plan)
- 3) That the Government actively oppose removal of the opt out, and seek a solution to the SiMAP and Jaeger Judgments

1. The Government can apply for an extension of the transitional period for doctors in training under article 17 (e, 5). This provision:

- allows an extension of 2 years (with a possible further year) ‘to take account of difficulties in meeting the working time provisions with respect to ... the organization and delivery of health services and medical care’
- requires the member state to inform the Commission, before 1st Feb 2009 that they seek an extension and giving reasons.

2. The Barbados Plan

As detailed above, Article 22 of the EWTD allows individuals to opt out of the EWTD. However, no employer can insist that a worker opt out, nor must a worker be subject to any detriment if they do not wish to opt out. Thus:

⁴ Website of the European Trade Union Confederation: <http://www.etuc.org/a/504>

- EWTD compliant rotas (48 hrs/wk) must be designed and put in place by August 2009
- Doctors must be offered jobs which are EWTD compliant
- *After* doctors have accepted the post, they will be given the opportunity to “opt out”
- Doctors opting out would still be covered by the New Deal limits of 56 hours. Opting out of the EWTD would allow them to work up to 56 hours, which generates an additional 8 hrs of work per week
- The incentive for doctors to opt out is that the additional 8hrs/wk worked will be spent between the hours of 9am-5pm, giving them greater exposure to patients and training opportunities, and increasing the staff present at clinics, on ward rounds, or in the operating theatre, which also benefits patients
- Doctors who do **not** opt out will work the 48hr/wk rota. Therefore, in the event that all doctors choose to remain EWTD compliant, the bare minimum 48hr/wk rota is maintained

3. RemedyUK calls up on the UK Government to:

- 1) Oppose the removal of the individual opt out
- 2) Actively seek amendments to the EWTD that would allow doctors to be resident on call in hospitals

Potential difficulties and solutions:

By working above 48 hours, doctors will fall into the higher Band 2 pay bracket. Employers may find financial planning more difficult since they will not be able to plan how many doctors will opt out, and which may attract a higher banding supplement.

It is not the case that all doctors opting out would automatically receive a higher banding payment. The new contract for junior doctors stratified pay on the basis of hours of work. Therefore doctors opting out of the EWTD limit of 48 hours *may* attract a higher banding

supplement. However, were this to occur the difference in overall salary budgets will be relatively small. A doctor working a 1A rota attracts a 50% salary multiplier, while a doctor working a 2A rota attracts an 80% salary multiplier. The over all difference in salary is 20%⁵.

Implementation of the EWTD in Trusts can be a costly exercise. One Trust in the UK spent £120,000 on locum doctors in 3 months and saw average length of patient stay increase as a result of implementing EWTD compliant rotas. The strain placed on the service and training cannot be underestimated. Any increase in salary budget would generally be offset by the cost of implementing the EWTD.

Consultation

This proposal is released for consultation. The deadline for responses is 5pm on Friday 2nd May 2008

Please send your comments to :

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Thank you

The RemedyUK Team

⁵ $(1.5-1.3)/1.5 = 0.2$ or 20%