



# Signposting European Working Time Directive Solutions



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## Forewords

“The NHS Next Stage Review sets out a vision for excellence in quality of patient care and clinical engagement. The achievement of EWTD compliance in NHS North West, one year ahead of the national target, supports this vision in ensuring that our junior doctor workforce is appropriately rested and able to provide safe patient care. Early implementation has given NHS North West the opportunity to evaluate, monitor and realise the benefits of the changes made. Organisations are now empowered to look beyond simple compliance and to continue to improve solutions to maximise education, training and service delivery in the 48 hour week.

Clinical leadership has undoubtedly been essential. The NHS North West EWTD project was delivered by a team of seven junior doctors who engaged with junior and senior doctors in the service, royal colleges and deaneries in order to deliver the best possible solutions.

This signposting gives practical advice to overcome barriers and achieve EWTD compliance within NHS organisations.

*Dean Royles  
Director of workforce and education, NHS North West*

“As the deadline for achieving EWTD compliance for all doctors in training looms closer, the lessons that have already been learnt from across the service become a valuable resource. I believe that this signposting document provides such a resource and it will hopefully equip trusts with a range of tried and tested ways of making progress with this challenging agenda.

*Stephen Welfare  
Chair, EWTD Steering Group and director of workforce, NHS East of England*

“Signposting EWTD Solutions is a practical guide to helping NHS services to overcome the 10 main blockers to successful EWTD 2009 implementation. The EWTD and medical workforce teams in NHS East of England, NHS North West and the Workforce Projects Team have vast experience of helping trusts across the NHS make huge strides towards 2009 compliance. This collaboration shows our collective determination to support the quality of patient care, clinical training and work/life balance of staff across the NHS by signposting readers to tried and tested solutions.

*Sue Dean  
Director, Skills for Health - Workforce Projects Team*

## Glossary

<b>A&amp;E:</b> Accident and Emergency	<b>MPET:</b> Multi Professional Education and Training
<b>AHP:</b> Allied Health Professional	<b>MTAS:</b> NHS Medical Training Application Service
<b>AoMRC:</b> Academy of Medical Royal Colleges	<b>NHS:</b> National Health Service
<b>DH:</b> Department of Health	<b>PCT:</b> Primary Care Trust
<b>EWTD:</b> European Working Time Directive	<b>PDA:</b> Personal digital assistants
<b>HaN:</b> Hospital at Night	<b>PMETB:</b> Postgraduate Medical Education and Training Board
<b>HR:</b> Human Resources	<b>SHA:</b> Strategic Health Authority
<b>JIF:</b> Joint Investment Framework	
<b>MMC:</b> Modernising Medical Careers	

## Introduction

This report has been produced by NHS East of England, NHS North West and Skills for Health - Workforce Projects Team. It is based on experiences of working with more than 100 trusts on implementing the 2009 European Working Time Directive requirements.

Readers are signposted to a range of good practice solutions that have been implemented across parts of the NHS to overcome obstacles to EWTD 2009 compliance.

## Background and Concept

The concept came from the work done by NHS North West on known barriers and is linked to NHS East of England's work on EWTD enablers. The concept was used successfully in the Hospital at Night conference in 2008 and modified for the NHS Employers event where over 100 participants found the approach very useful. At that event the barriers were broken down by a) barrier, b) solution, c) opportunity and allocated to individuals with sufficient experience, skills and knowledge to present the abc in three minutes.

## Audience

The audience for this report is NHS trusts who employ junior doctors and are responsible for delivering the EWTD. It can also inform and guide commissioners who have a role in supporting solutions.

## Service Delivery Needs

*Gerry Bolger*

### Barrier:

'We cannot deliver the service needs in a 48 hour week'.

### Response:

Yes you can.

### Solution:

- Eliminate waste and make the most of the hours available
- Match medical workforce cover to medical workload by:
  1. Assigning non medical specific tasks to skilled/advanced nurse practitioners and other assistant nurse practitioners (AHPs)
  2. Considering implementing New Ways of Working with assistant and advanced practitioner roles which can take workload away from medical staff, which in turn will develop and retain other staff groups.
  3. Extending the use of phlebotomy staff and others to reduce unnecessary routine tasks which can be safely delivered, as implemented at Royal Surrey Hospital.
- Implement or extend HaN to 24:7:
  1. Use the HaN principles of effective teams
  2. Working to support your out of hours/weekend and nights:
    - » HaN has been implemented in over 130 NHS Trusts across the UK
  3. Take the model further by supporting teamwork solutions across a 24:7 period for example:
    - » Homerton University Hospital NHS Foundation Trust
    - » Guys' and St Thomas' NHS Foundation Trust
    - » South Devon Healthcare NHS Foundation Trust.



**Signposting good practice and reference documents:**

EWTD 2009 pilots programme at:  
[www.healthcareworkforce.nhs.uk/pilotprojects](http://www.healthcareworkforce.nhs.uk/pilotprojects) ►

**Opportunities:**

Gives you the chance to develop a more efficient system which:

- Pays for itself over time
- Supports medical education
- Supports 48 hour compliance. ■

**Number of Doctors and the EWTD**

Dr Deborah Kendall

**Barrier:**

Implementing EWTD requires more doctors on expanded rotas to meet service needs within the 48 hour week to prevent impaired training.

**Solution:**

It is important to recognise that each speciality has individual challenges. There are those specialties where 24 hour clinician care is an absolute requirement, for example obstetrics and gynaecology. A&E and acute medicine must accommodate an unpredictable patient flow. There are also specialties where only certain clinicians have the specific skills required such as surgery and anaesthesia.



However it is equally important to recognise where clinician resource can be better utilised and supported by staff with a different range of skills. These resources should be managed to ensure the right person reaches the right patient at the right time. Consideration of a trained doctor delivered service is currently a favourable model in 24 hour service specialties such as obstetrics and in line with Clinical Negligence Scheme for Trusts (CNST) requirements for labour ward cover (referred to in 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' at: [www.rcog.org.uk/index.asp?PageID=1168](http://www.rcog.org.uk/index.asp?PageID=1168))

To assess the feasibility of alternative working models other than increased medical staff it is important to ask certain questions of the current service provision model.

- **Can the task only be completed by a doctor?**

Doctors time is a valuable commodity. Activity analysis of the trainee's daily routine can highlight repetitive tasks that could or should be performed by another professional, for example phlebotomy for venepuncture. The analysis might identify administrative practices that can be streamlined to increase trainee availability. This not only enhances training but streamlines service. Some trusts have employed the use of LEAN methodology to assess service, including Bolton NHS Primary Care Trust and Stockport NHS Foundation Trust, with a view to improving quality through efficiency. ►



- **What are these other roles?**

There are traditional nursing and service roles that support the doctor which can be reintroduced or extended eg phlebotomy. In addition a number of newer opportunities are currently in use across the North West, as listed below:

- Pharmacy transcribers
- Pharmacy prescribers
- Theatre assistants
- Anaesthetic assistants
- Trauma nurse specialists
- Acute nurse specialists.

These roles are attractive to the post holder as they offer personal and professional development.

August 2009 should not be seen as a deadline for implementing these roles because they can contribute to sustainable solutions over time.

- **Does a clinician need to be on site continuously out of hours?**

A non resident on call model at middle grade level has been successfully implemented in many of the surgical specialties. This allows the trainee to maximise daytime availability, which would otherwise be limited by full shift working. Crucial to this model is the need for a robust multidisciplinary handover.

- **Do we make the best use of our medical staff out of hours?**

Handover is vital for patient safety and can be managed most effectively by a centralised multidisciplinary approach. Current models for HaN use night coordinator role(s) to allocate tasks received from wards to both medical and nursing staff to ensure each patient sees the right person at the right time. To assist with the allocation of tasks, a number of electronic systems are in current analysis, in the North West this is predominately HaNBleep. Each doctor and night coordinator carries a PDA in order to receive tasks and communicate with the overnight team as a whole without being disturbed by a conventional bleep which might interrupt an episode of care or otherwise go immediately unanswered. The emphasis of HaN should be on teamwork where a core skills knowledge base can be utilised and cross cover when required.

**Signposting good practice and reference documents:**

The Case for Hospital at Night: The Search for Evidence:  
[www.healthcareworkforce.nhs.uk/hospitalatnightpublications](http://www.healthcareworkforce.nhs.uk/hospitalatnightpublications)

Hospital at Night Activity Database and Analysis Packs:  
[www.healthcareworkforce.nhs.uk/hospitalatnightresourcepacks](http://www.healthcareworkforce.nhs.uk/hospitalatnightresourcepacks)

A comprehensive guide to implementation and a library of best practice can be found at: [www.healthcareworkforce.nhs.uk/hospitalatnightresources](http://www.healthcareworkforce.nhs.uk/hospitalatnightresources)

- **How can we increase doctors' efficiency?**

Where the doctor is the most appropriate person to provide care and to gain from training experience it is vital to ensure the time is used efficiently. Current forms of assistance for repetitive tasks for trainees include the use of digital dictation for discharge summaries and electronic label production for tissue sample bottles. All areas of the doctors' responsibilities should be assessed for efficiency and ease of practice.

**Opportunities:**

- Implementation of EWTD compliant rotas should be completed in tandem with an assessment of current training. Current ways of working may not be best practice.
- EWTD provides opportunity to consider service realignment in order to improve efficiency and safety as well as to achieve compliance. When considering new rotas that meet with EWTD it is best practice to perform an activity analysis to showcase how the department is currently run and to highlight areas for improvement. Long term sustainability should be the mainstay of any investigation into service redesign and this is not solely reliant on medical staff expansion.

**Summary:**

In summary, there is reason to re-examine whole service to ensure current best use of resource and to evaluate where additional resource is necessary and whether this is reliant on clinical staff or not. ■



## Junior Doctor Engagement

*Dr Rishiraj Hazarika*

### Barrier:

The implementation of the 48 hour week by 2009 is one of the most significant changes to occur in recent times affecting junior doctors. Previously several initiatives such as MMC and MTAS have led to some extent to a demoralisation of the junior doctor workforce who have seen prescriptive and autocratic changes which affect their working lives.

The historical disconnect between junior doctors and management does not mean that this very important workforce is not concerned with issues which affect them. As was seen by the large demonstration which took place in London regarding the MTAS computerised application system, junior doctors do want to engage and take ownership of their working practices. They just need an avenue to do so.

### Solutions:

The Next Stage Review by Lord Darzi, has highlighted the importance of engaging clinicians in management issues and roles. Frontline staff who implement change increase the likelihood of sustained positive transformation, improving the quality of patient care.

Within the North West we have recognised these issues and have sought to fully engage junior doctors in designing their working conditions and looking at means of removing non clinical work pressures. We have strived to achieve a balance between service provision and maintaining high standards of training and education.

Fundamentally the EWTD Medical Workforce Development Team has used several strategies to fully engage all 6,500 junior doctors working in the 38 NHS trusts within the North West. Following best practice we have used a three step process to reband rotas to make sure they are EWTD and New Deal compliant.

Junior doctors have had the opportunity to consult directly with EWTD project managers within trusts in order to design their working patterns and accept new working practices. The key to success within the North West has been giving junior doctors ownership of their working conditions and empowering them with the ability to take part in their rota design.

Within the deanery we also used an information campaign, emailing junior doctors directly regarding the importance of junior doctor monitoring and rewarding the trusts and doctors who contributed to high monitoring response rates.

As part of the information campaign, we also designed posters and postcards which highlighted the importance of the EWTD and monitoring junior doctor hours. With the recent developments in social networking this also provided an alternative messaging stream, such as using Facebook™ and Myspace™. Within trusts we have also highlighted the importance of creating steering groups which have the opportunity for junior doctor engagement/representation and where those doctors can act as clinical champions when interacting with their colleagues. For the August 2008 intake of doctors, the deanery created an induction DVD citing the importance of the New Deal Contract, EWTD implementation and junior hours monitoring.

Providing areas of information distribution and explaining to junior doctors the (actual) 'bigger picture' of the rebanding process has helped to increase levels of engagement. We have communicated information about pay protection and explained that the implementation of the EWTD is not just localised to one particular region but will be occurring nationally.

The creation of EWTD compliant rotas in the North West has been achieved through managed change, which is transparent and auditable.

### Signposting good practice and reference documents:

North West EWTD Medical Workforce Development Team website:  
[www.nwpgmd.nhs.uk/hospmed/ewtd](http://www.nwpgmd.nhs.uk/hospmed/ewtd)

Junior doctors involved in management of rotas  
British Medical Journal Careers, 17 November 2007: 179-180  
Najim, O., Clough, D., Cousins, D., Johnston, M., Sunderland, H., Tan, K. and Ahmed-Little, Y. (2007)

Engaging Doctors: Can doctors influence organizational performance?  
NHS Institute for Innovation and Improvement  
Hamilton, P., Spurgeon, P., Clark, J., Dent, J., Armit, K.

Engaging Doctors in Leadership: What we can learn from international experience and research evidence?  
NHS Institute for Innovation and Improvement  
Ham, C., Dickinson, H.

Workforce Projects Team support a national junior doctors' forum and are establishing an online forum at [www.healthcareworkforce.nhs.uk](http://www.healthcareworkforce.nhs.uk). ►

## Example of a monitoring campaign poster:



**NHS**  
North West

# Are You a Junior Doctor?

## Resuscitate your mess with a Plasma TV and a Wii!

Hours monitoring is coming this September 2008  
Wii can only get your pay right...  
If you monitor your hours right!

Most Rotas have changed in the North West to comply with EWTD, and will be monitored this September.

**The Trust with the most valid returns will win a 42" Plasma TV and a Wii!**

### Why monitor?

Due to the EWTD and New Deal most rotas have changed in the North West. The EWTD is a health and safety regulation and the New Deal addresses your hours worked and working conditions.

Monitoring is a contractual requirement for all junior doctors. It measures your post's intensity and the hours you have worked. It's a way to address any concerns around your training, pay, working conditions and health and safety.

**How you should do it**

- You will be sent a diary card by your medical staffing department.
- The card will be delivered to your pigeon hole, departmental secretary, email address or in person.
- You need to fill it in accurately and promptly as recommended by the GMC's guidance for good medical practice. The longer you leave it the more difficult it will be.

If you want to know more, contact your medical staffing department or your EWTD Medical Advisor at NHS NW, or visit [www.nwpgmd.nhs.uk/hospmed/ewtd](http://www.nwpgmd.nhs.uk/hospmed/ewtd)

**NHS NW EWTD Medical Workforce Development Team**  
Project Director  
Debbie Kendall  
[d.kendall@nwpgmd.nhs.uk](mailto:d.kendall@nwpgmd.nhs.uk)  
Deputy Director  
Omar Najim  
[o.najim@nwpgmd.nhs.uk](mailto:o.najim@nwpgmd.nhs.uk)

**Greater Manchester**  
Maria Breslin  
[m.breslin@nwpgmd.nhs.uk](mailto:m.breslin@nwpgmd.nhs.uk)  
**Cheshire and Mersey**  
Jenny Harrop  
[j.harrop@nwpgmd.nhs.uk](mailto:j.harrop@nwpgmd.nhs.uk)  
**Cumbria and Lancashire**  
Rishi Hazarika  
[r.hazarika@nwpgmd.nhs.uk](mailto:r.hazarika@nwpgmd.nhs.uk)

Win a Wii!

Please note the first hospital which returns the most valid monitoring data within the set deadline will win the above prizes. Terms and conditions available on EWTD NW Deaneary website.

**EWTD Medical Workforce Development Team**  
NHS North West

## Opportunities:

Involving junior doctors and other clinicians in rota design leads to a happier workforce who consequently provide better patient care. They have ownership of a change which may not be initially perceived as beneficial, due to a reduction in hours leading to a consequent impact on pay and training opportunities.

Doctors at a ground level know which parts of the day/week consist of the highest work load intensity. This knowledge can be used to design rotas which take into account busy working periods throughout the day/week.

The changes are not a 'one size fits all' approach. Junior doctor engagement provides the opportunity to tailor rotas individually to their needs, maximising training potential and taking into account clinical duties. ■



## Education and Training

Dr Maria Breslin

### Barrier:

We cannot deliver education and training in a 48 hour week.

### Solutions:

The effect that the EWTD will have on junior doctors' training is a common concern amongst trainees and trainers, however there are ways to ensure training is maximised within the 48 hour week.

It is important to try to maximise the normal working day availability. This is when junior doctors have the most training opportunities, for example during ward rounds, clinics and theatre lists, where they can learn from senior colleagues. In the North West we looked at using a rota of 11 doctors for 48 hour full shift rotas, which matched the normal working day availability of the eight doctor model for 56 hour rotas. This ensures adequate working day availability for training.



It is also important to consider the most appropriate type of working pattern for particular specialties, for example surgery SpRs may be able to work non resident on call rather than full shifts. This then increases their working day availability so that they can attend theatre lists and clinics.

Nights do not tend to be good for training opportunities. HaN is a model used by many trusts in the North West where bleeps are filtered through a night nurse coordinator. This filters out inappropriate duties which do not provide training

opportunities, for example excessive venepuncture. It also incorporates a structured handover which can be used as a learning opportunity for the junior doctors.

It is important to align training opportunities with service needs, for example junior doctors clerking patients admitted during the night will learn a lot more if they are able to attend the post take ward round within their shift. Handover could also be used for informal teaching from senior colleagues.

Inappropriate duties should be minimised, for example excessive cannulation and venepuncture which could be undertaken by phlebotomists and trained nursing staff. This leaves more time for junior doctors to spend on tasks which have training value.

Technology can be used to support training, for example digital dictation can make completing discharge summaries more efficient and less time consuming. This can be another way of maximising the time junior doctors have for training opportunities. HaNBleep is used to support Hospital at Night and involves the night coordinator allocating jobs to the appropriate person via hand held PDAs.

It is important to protect training time as much as possible. Sometimes it will be inevitable that trainees will miss teaching sessions due to night duties or annual leave but efforts should be made for teaching sessions to be incorporated into the rota.

### Signposting good practice and reference documents:

Hospital at Night and the extended Taking Care 24:7 services can be found via the healthcare workforce portal at:

[www.healthcareworkforce.nhs.uk/hospitalatnight](http://www.healthcareworkforce.nhs.uk/hospitalatnight)

*Working Time Directive 2009: Meeting the Challenge in Surgery.*

Royal College of Surgeons of England. June 2008. [www.rcseng.ac.uk](http://www.rcseng.ac.uk)

Nicholas Horrocks MSc and Roy Pounder MD, DSc, FRCP.

*Designing safer rotas for junior doctors in the 48 hour week.* Royal College of Physicians, September 2006. [www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)

*Royal College of Anaesthetists. Working Time Directive 2009 and shift working: Way forward for anaesthetic services, training, doctor and patient safety.*

Royal College of Anaesthetists, June 2007.

Ahmed-Little, Y, Bluck, M (2006)

*The European Working Time Directive 2009.*

British Journal of Healthcare Management. 2006;12(12):373-376.

### Opportunities:

The limits on junior doctors' hours imposed by the European Working Time Directive can be used as an opportunity to address current issues with training and improve and maximise learning opportunities for trainees.

There may also be the opportunity to look at using personalised rotas where trainees could be matched to specific learning opportunities or trainers relevant to their individual training needs. ■



## Leadership

*Dr Deborah Kendall*

### Barrier:

The introduction of a 48 hour working week for junior doctors in NHS trusts by August 2009 is a challenging and significant task and as such requires leadership for the change to be successful. In addition, there may be other changes needed within trusts that are viewed as more important than EWTD and given priority. The impact of EWTD implementation can be far reaching and without clear and structured leadership the wider implications and benefits of proposed changes may not be realised.

### Solutions:

Leadership from both the hospital management team and clinical leadership from senior and junior doctors is recommended in order to implement the EWTD successfully. Senior level management endorsement is required to ensure that it is given priority at board level and that this is communicated throughout the trust. Trusts which have used EWTD as an opportunity to redesign services whilst also considering training and education of junior doctors are likely to have more success in developing sustainable solutions that are accepted by the junior doctors themselves. Leadership is key in developing this visionary approach and appointment of an enthusiastic clinical champion (with specific time built into their job description) can be instrumental in ensuring that the changes are both credible and appropriate.

Knowledge of EWTD and New Deal is desirable and the ability to negotiate, support and motivate the changes is essential. This approach is demonstrated at the Homerton University Hospitals NHS Foundation Trust where the changes to an elective/acute split were championed by the medical director, John Coakley. The development of a EWTD steering group within trusts ensures that the project is managed with a whole systems approach and appropriate medical leadership. Suggested membership includes the medical director, clinical directors, consultants from each speciality, clinical tutors, HR director, finance director, IT manager, medical staffing manager, junior doctor representatives, senior nursing representative, HaN representative and divisional managers.

Regular meetings are required to coordinate the project and ensure that the changes are aligned, planned and implemented according to schedule. Furthermore it is possible to involve junior doctors themselves in leading the changes both at trust and SHA level. In NHS North West, a team of seven junior doctors was appointed to implement the EWTD within the local health economy, one year ahead

of the national target, demonstrating appreciation of the leadership potential of junior doctors in training by the Strategic Health Authority and postgraduate deaneries.

### Signposting good practice and reference documents:

NHS North West has published a project report (EWTD the North West Way) detailing how the project was implemented by a team of junior doctors across 38 trusts and 6500 junior doctors.

The AoMRC has produced a publication entitled 'Engaging Doctors: Can doctors influence organisational performance?' This discusses how clinical leadership can transform healthcare to achieve high levels of excellence.

The Homerton and Guy's and St Thomas' EWTD 2009 pilot projects demonstrate excellent examples of clinical leadership:

[www.healthcareworkforce.nhs.uk/pilotprojects.html](http://www.healthcareworkforce.nhs.uk/pilotprojects.html)

The Countess of Chester established a leadership programme for doctors:

[www.healthcareworkforce.nhs.uk/chesterpilot](http://www.healthcareworkforce.nhs.uk/chesterpilot)

The North West team won the national HSJ Workforce Development Award. Skills for Health Workforce Projects Team were highly commended by the HSJ in the patient safety category and have been short-listed for the BMJ's Excellence in Learning and Education award (both for the Hospital at Night and Taking Care 24:7).

### Opportunities:

The management of the EWTD project itself at trust or SHA level can be viewed as a real opportunity for involving both junior and senior doctors in clinical leadership and management.

The Darzi review (DH 2008) encourages the development of future clinical leaders, and the experience of working on a project such as EWTD can be an opportunity for junior and senior doctors to develop operational management experience. The unique opportunity to lead a significant service improvement project, develop a strategic overview and engage with all key stakeholders in a trust or SHA can enhance doctors' roles as future clinical leaders. The Medical Leadership Competency Framework (Clarke 2008), developed by the NHS Institute for Improvement and Innovation, describes the competencies in leadership required for all doctors in postgraduate medical education.

The opportunity to work on a project such as EWTD gives a wealth of opportunities for achieving these leadership competencies. Furthermore there is the possibility to create real enthusiasm for medical leadership and management that can outlive EWTD and drive future service improvements and excellence in healthcare. ■

## Board Level Commitment

Jacky Beaumont

### Barrier:

There is no local board level commitment.

### Solutions:

- Raise awareness and create board level engagement by presenting the facts to them
- Make sure they understand the legal requirements and their responsibilities as an employer
- Make them aware of the enforcement framework and penalties the trust will face
- Indicate the junior doctor hours that will be lost each week and ask them to consider the impact that this will have on other trust objectives and targets
- Make them aware of the potential release of funding through banding changes that could be reinvested to support the transition.



### Signposting good practice and reference documents:

Doncaster and Bassetlaw Hospitals NHS Foundation Trust makes sure that progress with WTD 2009 is a standing item for their executive meetings.

The Pennine Acute Hospitals NHS Trust has undertaken a full risk assessment of the impact of changes for EWTD 2009 on other trust objectives and targets eg the 18 week wait, so that it is fully integrated with the business agenda.

Mike Farrar's support (NHS North West's chief executive) for achieving early EWTD 2009 compliance.

David Sowden's championing of EWTD solutions when NHS director of medical education.

Alistair Flowerdew (medical director at Salisbury) leading the development of an electronic handover tool.

### Opportunity:

A proactive approach to engaging the board may give the opportunity to develop a whole systems approach, eg raising awareness with the director of nursing, director of finance and others. ■

## HR Capacity

Nicole Callaghan

### Barrier:

We do not have enough staff to deliver on this agenda.

### Solutions:

- Put together a clear business case of the resources you require and ensure the right number of staff is released to deal with this work from now until beyond August 2009
- Identify clear internal clinical leadership to work in partnership with HR to deliver on this agenda
- Give local ownership to directorates/divisions where considered appropriate keeping firm overall project leadership and accountability
- Advertise as an internal development opportunity for someone to take on as a project; perhaps someone in HR working towards their Chartered Institute of Personal Development (CIPD) qualification or a junior doctor who would like some management experience
- Utilise national or local pump priming monies to appoint a project manager.

### Signposting good practice and reference documents:

- Portsmouth Hospitals NHS Trust has a junior doctor working as part of their medical personnel team on a six month rotation
- Buckinghamshire Hospitals NHS Trust amongst others has devolved responsibility for achieving EWTD 2009 compliance to its five clinical divisions. This is supported by an overarching small EWTD team consisting of a clinical lead and representatives from medical personnel
- Sheffield Teaching Hospitals NHS Foundation Trust has a dedicated EWTD 2009 project manager



### Opportunity:

By devolving responsibility to directorates/divisions this encourages greater ownership of EWTD 2009 and improves links with other key deliverables eg 18 weeks, MMC. ■

## Political Will

Dr Yasmin Ahmed-Little

### Barrier:

National and local political will to support this agenda can at times be lacking or appears very late. This can influence local support and engagement for implementation.

### Solution:

Don't lose hope, there are solutions. Momentum is growing around EWTD implementation that is now discussed regularly at the NHS Management Board and the AoMRC. The SHAs and the DH have commenced bimonthly quality assurance monitoring and the Recovery and Support Unit might become involved. Reflection on the 2004 experience of local implementation is also helpful in raising interest.

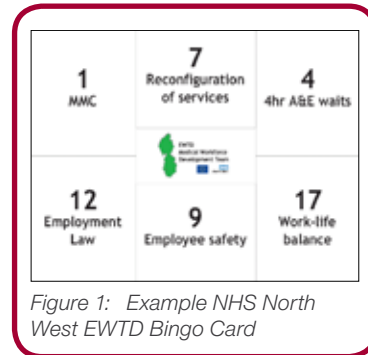


Figure 1: Example NHS North West EWTD Bingo Card

### Signposting good practice and reference documents:

The DH has sponsored the EWTD pilots programme since 2002/3.

The leadership of NHS North West committed to implementing the EWTD 2009 requirements early.

### Opportunity:

Try to link EWTD to broader NHS agendas eg four hour A&E access targets, 18 week pathways, corporate manslaughter etc. Not only will this help raise the profile of EWTD locally but such a whole system approach will lead the way to more sustainable, future-proof solutions. NHS North West used 'EWTD Bingo' as a concept to demonstrate that EWTD implementation and compliant solutions do not stand in isolation and *do* impact many other work streams. ■





## Time

Omar Najim

### Barrier:

There is not enough time for effective implementation.

The EWTD legislation came into affect for nearly all workers within the European Union in 1998, however junior doctors were exempt from immediate compliance. EWTD for junior doctor in training is being introduced in stages. In 2004, all junior doctors should have been working less than 56 hours a week and as it is well known they should be working a maximum of 48 hours per week from August 2009. There are less than six months left until the August 2009 deadline.

Many of the teams, trusts and organisations, which are trying to implement EWTD, might feel that there is little time left to tackle the many rotas that need redesigning, balanced with getting the training and service requirements right. This barrier was apparent at the time of implementing the 2004 deadline. The subsequent 'last minute solutions' exercise that most went through, left many with the determination not to repeat the same mistakes again.



### Solutions:

Time and a sense of urgency can act as a driver to introducing EWTD solutions in your organisation. The alternative, of not achieving full compliance with the directive, could have further reaching consequences than the 2004 exercise. This is in view of the recent introduction of the corporate manslaughter law and the attachment of PMETB training post requirements to EWTD compliance. The fact that EWTD is featuring highly in the many discussions of strategic bodies at the DH, royal colleges and in healthcare publications, means that the majority of the

stakeholders are prepared to be engaged around its solutions. This added to the money allocated for EWTD within the 2009-2010 operational framework, all help to place EWTD high up on your organisation's agendas for this year.

Any service needing to implement interim solutions should try to ensure these are a stepping stone to sustainable compliance.

### Signposting good practice and reference documents:

North West found that most of the work involved engaging and communicating the importance of EWTD to stakeholders. By having board and stakeholders' engagement (including trainees; consultants; nurses; managers; and medical staffing), most of ground work has been done. The Royal Liverpool and Broadgreen 2009 pilot is a good example of effective staff engagement:  
[www.healthcareworkforce.nhs.uk/liverpoolbroadgreenpilot](http://www.healthcareworkforce.nhs.uk/liverpoolbroadgreenpilot)

### Opportunities:

In the North West of England, the NW SHA and the North West and Mersey deaneries were committed to full implementation of EWTD one year ahead the August 2009 deadline. This project had the resources and backing of all North West trusts' chief executives. The project started in August 2007, with absence of a national momentum, with an average EWTD compliance of 38% across the whole of the 38 trusts in the North West. By August 2008, the compliance was 95%, almost a two fold increase. This was achieved by engaging junior doctors, who led the project to produce the solutions that addressed EWTD, service and training. In summary, communicating what the EWTD is about, engaging junior doctors and innovating are the key to lasting success. Finally, it is better to make a start than not to start at all. ■





## Finance

Neil Sellen

### Barrier:

All the solutions we can identify seem to cost more money. Where are we going to find it from?

### Solutions:

- Some of the costs can be released from the current New Deal bandings which you are paying. Maximise these savings by considering how to move rotas to 1B or even 1C if your options appraisal has shown that this is supportable
- When designing rotas look for innovative ways of ensuring that the unsocial hours element is minimised to ensure that 1B is achieved. The use of non resident on call patterns can be used effectively, subject to workload intensity reviews
- To prevent subsequent rebanding claims ensure that proper documentation of the process of rota development has taken place
- Be clear about the role of clinicians and managers in ensuring that the working pattern is not breached and have good HR monitoring systems in place to minimise potential future banding appeals.



Funding for new and extended role development is often supported by MPET funds, available from your multiprofessional deanery. Targeted skills training for staff in bands one to four is available through JIF, again via your deanery. Approach them with your plans:

- Service redesign which supports the Darzi Next Stage Review care pathway models in your area will be a priority area for investment from your commissioners. There is a particular emphasis on network solutions and improvements in patient safety and experience. Good EWTD compliance solutions can support these aims
- Substantial additional funding has been made available, through tariff to support the extra costs of providers in ensuring compliance. Identify the costs of all realistic options and demonstrate the cost benefit of your preferred approach. Unavoidable costs associated with a robustly assessed solution are more likely to be supported than a case based on personal preference or anecdote.

### Signposting good practice and reference documents:

The Countess of Chester and East Midlands pilots achieved pay band savings that were reinvested in frontline services.

[www.healthcareworkforce.nhs.uk/chesterpilot](http://www.healthcareworkforce.nhs.uk/chesterpilot)

### Opportunities:

Consider how the solution you have identified supports other trust strategic initiatives. For example the establishment of an acute assessment/care unit will support access targets and the introduction of Hospital at Night has been shown to improve the quality of patient care.

Link EWTD compliance to your own service priorities and your case for pump priming or recurrent funding will be enhanced. ■



## Biographies

### Dr Yasmin Ahmed-Little

CMO clinical adviser, NHS North West

Yasmin Ahmed-Little is currently CMO clinical adviser to NHS North West, and led a team of seven junior doctors on an ambitious project (awarded NHS North West Project of the Year 2008 and 2008 HSJ award for workforce development) to implement EWTD targets one year ahead across NHS North West, North West and Mersey Deaneries. She graduated from Manchester Medical School in June 2000 and joined the North West Regional Action Team shortly after completing her house-jobs. She has since led on issues relating to junior doctors' hours and working lives, implementing New Deal and WTD 2004, and now working towards full EWTD 48 hour compliance. Yasmin is a member of the Working Time Directive Programme Delivery Board and was recently elected to the BAMMbio Board. She has completed a Masters in Health Services Management, and is due to start her ST1 in Public Health in August 2009.

### Jacky Beaumont

Jacky Beaumont is a qualified HR professional with an MA in Management Learning and over 25 years' experience in the NHS in Senior HR Management and Workforce Consultancy. This experience includes working at SHA and acute and teaching hospital levels, as well as contributing to national and regional projects.

Jacky has a strong track record in project management, strategic planning, managing organisational change, and operational management and policy development; particularly in relation to issues and challenges associated with the medical workforce and nursing and midwifery workforce.

Jacky is currently a senior workforce consultant with leadership responsibility for the Programmes team at the East of England Strategic Health Authority, involved in delivering a number of projects associated with the National Working Time Directive 2009 Project.

### Gerry Bolger

Gerry Bolger was recently appointed as project lead - Quality in Nursing, in the Chief Nursing Officer's Professional Leadership Team.

Gerry was the senior project manager with Workforce Projects Team, leading the programme across England and project director for Hospital at Night with the London Deanery.

Gerry is a registered nurse with over 20 years' experience and has a expansive career ranging from frontline clinical, management, NHS trust board and more recently SHA experience in London. His clinical background includes working in emergency care and he has worked for almost five years as a clinical night nurse practitioner 'doing the HaN job'. He is also a qualified in-flight nurse. He holds a range of qualifications including a Masters in Health Management from City University, London, as well as a number of postgraduate certificates. Gerry is also an accredited project management practitioner with the National School of Government, UK.

He has worked on the HaN project since 2005. Professionally he is active within the Royal College of Nursing (RCN) of the UK as one of the two London council members on the RCN's UK national governing council.

In his spare time he holds a UK private pilot's licence and regularly flies in both the UK and France.

### Nicole Callaghan

BSc (Hons) MCIPD

Nicole Callaghan is a workforce consultant within the Workforce Programmes Team at NHS East of England. Nicole has 17 years public sector experience in general management and human resources/workforce development. She joined the HR department of her local NHS trust in 2001 where she gained valuable experience of temporary staffing issues successfully managing the trust's in house bank service.

At regional level, Nicole led on the future profiling of the healthcare workforce across the East of England. She also led and contributed to the development of a number of workforce modernisation initiatives, most notably the emergency care practitioner role in Essex which received national recognition at the 2004 HR in the NHS Conference.

For the past three years Nicole has been working on the national European Working Time Directive 2009 Project.

### Dr Rishiraj Hazarika

MBBS BSc (Hons)

Dr Rishiraj Hazarika is a graduate from St Bartholomew's and The Royal London Medical School, having previously trained as a surgeon. He now works as a EWTD medical advisor for NHS Northwest facilitating the implementation of the EWTD in NHS trusts based upon a triad of maintaining service provision, health and safety and ensuring good quality training for junior doctors and culminating in improved patient care and engagement from all stakeholders. He is also involved in international recruitment mechanisms and the resident consultant model in Greater Manchester.

### Dr Deborah Kendall

BSc (Hons) MBChB MRCPCH

Deborah is the project director for the European Working Time Development Team at NHS North West. Previously she was a medical advisor for the team that implemented EWTD in the North West one year ahead of the national target. The team won the 2008 HSJ award for workforce development.

Deborah's clinical background is as a paediatric endocrinologist with an interest in childhood obesity. She is currently registered for a postgraduate degree at the University of Manchester and is leading a multicentre paediatric obesity drug trial.

### Omar Najim

MBChB DOHNS MRCS

Omar Najim is currently working as a seconded fixed term fellow with the NHS Institute for Innovation and Improvement. In that, he is working on developing a nationally available tool that will improve patient safety and quality of care through engaging frontline staff, mainly junior doctors. Until recently, he was the associate director for the 2008 HSJ award winner and Secretary of State Award for Excellence in Healthcare Management shortlisted, EWTD and Medical Workforce Development Team in NHS North West.

He qualified as a doctor in 1999 and did most of his basic surgical training in the North East of England. He is a member of the Royal College of Surgeons of Edinburgh and currently in his final year MSc in Surgical Technology at Imperial. While doing his basic surgical training in the North East of England, he was a member of national Junior Doctors' Committee of the BMA and in 2007, he became an exec member of its sub-committee. He published and presented extensively on issues related to junior doctors.

### Neil Sellen

Neil has 17 years NHS experience, 10 years at trust board level. He has worked in a variety of strategic and operational roles in acute, primary care, mental health and intermediate tier settings. His background is in human resources management and he is skilled in organisational change and development; implementing major system projects; group problem resolution and research based reports. He is also an enthusiastic and highly effective presenter and facilitator of groups and conferences large and small.

He has been involved in developing EWTD solutions in one form or another from 2001. Since 2006 he has been combining his role at an SHA with membership of the East of England Workforce Programmes team, delivering intensive and streamlined support to trusts across England. He is also accountable for achieving 100% compliance with EWTD 2009 within the East of England.



Skills for Health - *Workforce Projects Team*  
1st Floor, 3000 Manchester Business Park  
Aviator Way  
Manchester  
M22 5TG

**Tel:** 0161 266 2300  
**Fax:** 0161 266 1001  
**Email:** [workforceprojectsteam@skillsforhealth.org.uk](mailto:workforceprojectsteam@skillsforhealth.org.uk)  
**Website:** [www.healthcareworkforce.nhs.uk](http://www.healthcareworkforce.nhs.uk)

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