EXPLANATORY MEMORANDUM TO

THE WORKING TIME (AMENDMENT) (No. 2) REGULATIONS 2009

2009 No. 2766

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

This memorandum contains information for the Joint Committee on Statutory Instruments

2. Purpose of the instrument

2.1 These regulations seek to add to the list of doctors in training for whom a derogation is made under the Working Time Regulations 1998 ("the Working Time Regulations") to provide for an average 52-hour maximum working week until 31 July 2011.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 The established convention of laying statutory instruments before Parliament for 21 days before they come into force will be breached in this instance due to the evidence gathering timetable.

3.2 In December 2008 the NHS Management Board agreed that Working Time Directive ("WTD") quality assurance monitoring would be undertaken until August 2009. Strategic Health Authorities (SHAs) were asked to provide a global position on readiness for doctors in training for all trusts including foundation trusts to meet the requirements of the WTD (it was recognised that foundation trusts were not compelled to complete the returns). Returns were made on a monthly basis until July 2009. As a result of these the Secretary of State made regulations providing for a derogation from the WTD with effect from 1 August 2009 for certain categories of doctors which had been identified as requiring such derogation by that point. Following this, the Secretary of State for Health agreed that the Strategic Health Authority Quality Assurance monitoring should remain in place to identify further specialties that may require further support following 1st August. The monitoring is to continue until December 2009 at which point the need to continue will be reviewed. Under this, the purpose of the Strategic Health Authority European Working Time Directive Quality Assurance framework for the period August to December is to concentrate on specialties that would not be able to meet their service needs without derogation. These derogations were not included in the August 2009 derogations for the reasons given at paragraph 7.3 below.

3.3 Accordingly the Strategic Health Authority (SHA) has been engaged in an exercise of collecting evidence from trusts that identifies those additional doctors requiring derogation since 1 August 2009. This has been followed by an assessment of these proposals by a scrutiny panel composed of representatives of the Royal Colleges, British Medical Association, SHA and Department of Health, which made provisional recommendations for consideration by the Secretary of State for Health on 8 October. This list was finalised on 12 October. Scrutiny panels in Scotland and

Wales have also had to consider derogations in their jurisdictions and make recommendations to their Ministers.

3.4 The approved list of doctors requiring derogation could only then be incorporated into a statutory instrument for consideration with officials in the health departments of England, Scotland and Wales and the Department of Business Innovation and Skills prior to seeking the approval of the Secretary of State. Within these constraints the instrument could not be laid before Parliament until 15 October at the earliest.

3.5 It is imperative these regulations come into effect on 2 November to coincide with the hospital rota change over from the previous 3-month rota period which commenced 1 August. If the derogations do not apply to the relevant doctors by then this will cause difficulties in meeting the needs of health service delivery that the derogations are intended to avoid. This is because it will not be possible to apply the new rota until the derogations have come into force and there would be great difficulties in establishing a transitional rota for the meantime.

3.6 The reduced period for laying the Regulations before they come into force has been due to the timetable as described above.

4. Legislative Context

4.1 These Regulations provide an additional exception from the rules on working time in EC Directive 2003/88. These Regulations apply the additional transitional period provided for in the third subparagraph (as read with the fifth subparagraph) of Article 17(5) of Directive 2003/88/EC concerning certain aspects of the organisation of working time ("the Directive"). Those subparagraphs permit Member States to derogate from the 48-hour working week limit laid down in Article 6 of the Directive, for an additional period of two years, in respect of doctors in training, where it is necessary to do so to take account of difficulties in meeting this provision of the Directive with respect to their responsibilities for the organisation and delivery of health services and medical care. A Transposition Note is annexed to this Memorandum at Annex A.

4.2 These Regulations further amend the Working Time Regulations (SI 1998/1833). The Working Time Regulations were previously amended by the Working Time (Amendment) Regulations 2009 (SI 2009/1567) to provide for the 48-hour working time limit to be increased to 52-hours for certain doctors in training with effect from 1 August until 31 July 2011. Under those amendments a new Schedule 2A was inserted into the Working Time Regulations, which listed those categories of doctors in training to whom this 52-hour working time limit applies. These Regulations make further amendments by extending the categories of doctors specified in Schedule 2A to whom the derogation applies and amending Regulation 25A so that those additional derogations have effect from the date that these Regulations come into force, on 2 November 2009, until 31 July 2011.

5. Territorial Extent and Application

5.1 This instrument applies to Great Britain.

6. European Convention on Human Rights

6.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

- ***What is being done and why***

7.1 The object of Article 6 of the Directive is to reduce the maximum number of hours in the average working week to 48. Some doctors in training may however need to work longer than 48 hours to fulfil the needs of service delivery. Where there are difficulties in complying with the 48-hour week then it is possible for Member States to choose to apply an additional transitional period and apply an average 52-hour week to doctors in training instead. A small number of services, particularly 24-hour immediate care services, have required further support after 1 August, which prompted notification of an intention to take advantage of the additional period to the European Commission in January of this year. This will allow a further two-year transitional period before the 48-hour week limit can be applied to all doctors in training. (A further additional period of one year may be sought under the fourth sub-paragraph of article 17(5), in respect of "special difficulties" in complying with the 48-hour week. If this is applicable, it will be the subject of separate legislation in due course.)

7.2 The European Commission has responded to the notification sent in January from the UK Governments about its intention to derogate from the Directive to allow a small number of health services more time to be fully compliant. The Commission has accepted that the UK needs up to two more years before it can fully implement the Working Time Directive for all doctors in training. The Commission's view is that the UK will need to apply again if it needs to take a third, and final year to implement fully the Directive. The situation will continue to be monitored and reviewed by the assurance process. The Commission's response is annexed to this Memorandum at Annex B.

7.3 The further derogations to be addressed by these Regulations were not included in the derogations made in the Working Time (Amendment) Regulations 2009 because when the original derogations were sought Trusts had plans in place which would have meant that derogations may not have been required. Plans were and are in place, however they will take time to implement, hence the requirement to derogate. It was also difficult for Trusts to predict completely the position as many were still actively trying to recruit to specialty training posts. It is only after implementing their revised (48 hour) working arrangements that the position became clearer and the need for further derogation could be determined. Some Trusts had resisted putting forward derogations in the first tranche as they felt that they could manage service provision with 48 hours. It is now apparent for a small number of specialties that derogation is required.

7.4 The services requiring the derogation are listed in the table at regulation 3 of the Regulations. They are listed by reference to employer, specialist service and grade (and, where applicable, rota). A list of the relevant NHS grades for doctors in training and an explanation of the rotas referred to in the regulations is contained in Annex C to this Memorandum.

- ***SHA Quality Assurance Process***

7.5 Rotas which have potential difficulties in meeting service needs without derogation, with plans in place to address these within the 26 week reference period were rated as amber. Where trusts felt that there were such difficulties despite having action plans in place, they were rated red as the plans would take time to implement hence would not be able to avoid such difficulties within the reference period and would require derogation. SHAs were given a deadline of 30th September to submit applications for derogation. Each application received was put through rigorous scrutiny at SHA level to ensure only applications with genuine cases for derogation were submitted.

7.6 Once received, the DH team checked that all applications were completed correctly, met the criteria (i.e. only trainee rotas are put forward), were supported by robust and detailed evidence, explaining why derogation is now required with plans to achieve compliance at the earliest opportunity. They also ensured that applications were approved by the following

- Trust Chief Executive
- Trust Medical Director
- PCT Chief Executive
- SHA Medical Director
- SHA Workforce Director

7.7 All applications received in September 2009 were for additional rotas which will experience difficulties in meeting service needs without derogation.

- ***Scrutiny Panel Process***

7.8 A list of Scrutiny Panel members is set out at Annex D. The role of the Scrutiny Panel is to:

- Provide the Secretary of State with a list of recommended derogations.
- Ensure that applications adhered to the agreed process with approval at SHA and Trust level and that the information requested to support the applications had been provided.
- Assess whether a consistent level of quality assurance had been applied to all applications.
- Take a national view of some specialties to identify whether national action was required.

7.9 The Panel have agreed the following categorisation of applications:

- Category A - Recommended, clear plan including timeframe.
- Category B - Recommended, credible plan described. Early follow up to take place to assess progress and performance manage implementation of plan.
- Category C - Recommended, serious concerns identified, other further action required with immediate follow up. Performance management with active intervention and ongoing support.
- Category D - Unable to recommend based on the information provided. Urgent information required before application can be reconsidered.

7.10 The Panel was advised that if there were serious concerns over any application an opportunity should be given for further information to be provided. Each application was categorised by the panel as above. Following scrutiny, those categorised as 'D's were followed up immediately for further information, clarification, more detailed action plans.

- ***Consolidation***

7.11 These Regulations amend the Working Time Regulations, which apply to all persons in employment in Great Britain, only in respect of certain doctors in training. Policy responsibility for doctors in training rests with the Department of Health, but overall policy responsibility for the Working Time Regulations rests with the Department for Business, Innovation and Skills. The Department of Health therefore does not propose to consolidate the Working Time Regulations.

8. Consultation

8.1 An extensive consultation process was established through the European Working Time Directive (EWTD) Reference Group co-chaired by Dr Hulf CBE, President of the Royal College of Anaesthetists and Dr Patricia Hamilton Director of Medical Education England.

8.2 Stakeholders have been consulted on the changes contained in the legislation over the course of 2009. These included the medical profession, the medical Royal Colleges, the medical Deaneries, the professional bodies, the British Medical Association, Strategic Health Authorities, Local Health Boards, hospital trusts and trainee doctors.

8.3 This consultation process informed the previous amendments (SI 2009/1567). The further changes proposed in this Amendment have been informed by the ongoing EWTD Reference Group processes, meetings with the Academy of Medical Royal Colleges, and other key partners as stated in paragraph 8.2

9. Guidance

9.1 No guidance will be needed for this legislation. There has been close collaboration with the relevant stakeholders to work out the best way of implementing the requirements of the Directive in relation to the maximum average working time and they are already familiar with the changes and what they need to do.

10. Impact

10.1 There is no impact on business, charities or the voluntary sector.

10.2 There is no impact on the public sector, other than those hospitals and doctors in training rotas that the SI identifies.

10.3 A full impact assessment has not been pursued because the cost benefit analysis has shown the costs to be under the £20M threshold.

10.4 An Equality Impact Assessment is annexed to this Memorandum at Annex E.

11. Regulating small business

11.1 The legislation does not apply to small business.

12. Monitoring & review

12.1 The changes in the maximum average working time for those doctors in training, who are affected, aim to ensure service delivery in hospitals up until 31 July 2011. The need for a 52-hours working week for those doctors in training who are affected will continue to be monitored and reviewed through the Department of Health compliance assessment processes, and the legislation may be amended accordingly.

13. Contact

Ali Enayati at the Department of Health can answer any queries regarding the instrument. Tel: 0113 254 5701 or email: Ali.Enayati@dh.gsi.gov.uk.

ANNEX A

TRANSPOSITION NOTE FOR THE WORKING TIME (AMENDMENT) (No.2) REGULATIONS 2009

Directive
Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time (OJ L 299, 18.11.2003, p. 9).

Article	**Objectives**	**Implementation**	**Responsibility**
17(5), third, fifth subparagraphs	To allow Member States an additional transitional period for applying Article 6 (maximum weekly working time) to doctors in training. An additional two year period is available, if necessary, to take account of difficulties in applying Article 6 with respect to a Member State's responsibilities for the organisation and delivery of health services and medical care.	Amendments to regulation 25A(1) and (1A) of, and Schedule 2A to, the Working Time Regulations 1998.	The Secretary of State for Health.

ANNEX B



COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 28.9.2009
C(2009) 7381 final

COMMISSION OPINION

of 28.9.2009

within the framework of Article 17(5) of Directive 2003/88/EC of the European Parliament and of the Council concerning certain aspects of the organisation of working time
('The Working Time Directive')

Extension of transitional arrangements for the working time of doctors in training in the Netherlands

COMMISSION OPINION

of 28.9.2009

within the framework of Article 17(5) of Directive 2003/88/EC of the European Parliament and of the Council concerning certain aspects of the organisation of working time
('The Working Time Directive')

Extension of transitional arrangements for the working time of doctors in training in the Netherlands

1. INTRODUCTION

This Opinion is based on Article 17(5) of Directive 2003/88/EC of the European Parliament and of the Council[1] concerning certain aspects of the organisation of working time ('The Working Time Directive'). It concerns a notification by the Netherlands, under this Article, of its wish to continue transitional arrangements until 31 July 2011 as concerns working time limits for doctors in training.

Doctors in training were excluded from the scope of the first Working Time Directive in 1993. This was changed in 2000 by an amending Directive, and doctors in training are now covered by the consolidated Working Time Directive, in the same way as other workers[2]. Normally, Article 6 of the Directive limits working time to a maximum of 48 hours per week on average[3], including any overtime. However, Article 17(5) of the Working Time Directive allows transitional arrangements for applying these limits to weekly working time in the case of doctors in training.

The relevant parts of Article 17(5) are as follows:

'...With respect to Article 6 [limit of 48 hours to average weekly working time] derogations [regarding doctors in training] shall be permitted for a transitional period of five years from 1 August 2004.

Member States may have up to two more years [from 1 August 2009], if necessary, to take account of difficulties in meeting the working time provisions with respect to their responsibilities for the organisation and delivery of health services and medical care. At least six months before the end of the transitional period, the Member State concerned shall inform the Commission giving its reasons, so that the Commission can give an opinion, after appropriate consultations, within the three months following receipt of such information. If the Member State does not follow the opinion of the Commission, it will justify its decision. The notification and justification of the Member State and the opinion of the Commission shall be

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1 *Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time*, OJ L 299, 18.11.2003, p. 9. The Directive consolidates and repeals two earlier Directives, 93/104/EC and 2000/34/EC.

2 Directive 2000/34/EC was to be transposed into national law, as regards doctors in training, by 1 August 2004.

3 Under Articles 16, 17, 18 and 19 of the Directive, the average may be calculated over a 'reference period' not exceeding 4 months (basic rule), 6 months (by legislation or collective bargaining, in specified activities which include the activities of doctors in training), or 12 months (by collective bargaining only.)

published in the Official Journal of the European Union and forwarded to the European Parliament.

Member States may have an additional period of one year, if necessary, to take account of special difficulties in meeting the responsibilities referred to in the [previous] subparagraph. They shall follow the procedure set out in that subparagraph.

Member States shall ensure that in no case will the number of weekly working hours exceed an average of 58 during the first three years of the transitional period, an average of 56 hours for the following two years, and an average of 52 for any remaining period. ...
With respect to Article 16(b) [reference period for calculating average weekly working time] *derogations* [regarding doctors in training] *shall be permitted provided that the reference period does not exceed 12 months, during the first part of the transitional period* [2004 - 2007]*, and six months thereafter.'*
Article 17(5) also provides for consultation between employers and employees' representatives about the implementation of any transitional arrangements: *'the employer shall consult the representatives of the employees in good time with a view to reaching an agreement, wherever possible, on the arrangements applying to the transitional period.*' Such an agreement must respect the limits set out in Article 17(5), but it may set out, in particular, the measures to be adopted to reduce weekly working hours to an average of 48 by the end of the transitional period.
These transitional arrangements are summarised in the table below.

Table: Summary of the transitional provisions for doctors in training, under Article 17(5)

Period	***Derogation possible***	***Conditions***
1 August 2004 – 31 July 2009	Derogation from 48-hour limit to average weekly working time	Transitional limits will apply to average weekly working time: <u>1 August 2004 - 31 July 2007:</u> **May not exceed average 58 hours/week.** The reference period* may not exceed 12 months. <u>1 August 2007 – 31 July 2009:</u> **May not exceed average 56 hours per week.** The reference period may not exceed 6 months. **The reference period is the maximum period over which average weekly working time may be calculated.*
1 August 2009- 31 July 2011	Extension of above derogation from 48-hour limit	If necessary to take account of difficulties in meeting the working time provisions, given the responsibilities for organising and delivering health services/medical care. A Member State wishing to use this derogation must notify Commission (with reasons) by 31 January 2009. The Commission gives an opinion on the notification. In any event, average weekly working time **may not exceed 52 hours per week.** The reference period may not exceed 6 months.
1 August 2011 – 31 July 2012	Possible further extension of above derogation	If necessary, to take account of special difficulties in meeting the above responsibilities. A Member State wishing to use this derogation must notify the Commission (with reasons) by 31 January 2011. The Commission gives an opinion on the notification. In any event, average weekly working time **may not exceed 52 hours per week.** The reference period may not exceed 6 months.

2. THE NOTIFICATION BY THE MEMBER STATE

By letter dated 27 January 2009, and registered 29th January 2009, the national authorities of the Netherlands notified the Commission services that they wished to use the possibility under Article 17(5) of maintaining special transitional rules in the Netherlands as regards doctors in training, for the two-year period starting on 1 August 2009. The notification makes the following points:

- Under national law[4], the average weekly working time of doctors in training is already limited to 56 hours over a six-month reference period, for the period up to 31 July 2009, consistent with Article 17(5) of the Directive.
- In addition, on-call time is fully counted when calculating the maximum possible weekly working time for doctors in training.
- However, organisations representing employers in the hospital sector[5] have informed the national authorities that it is not possible, in the short term, for them to make the necessary arrangements to organise the necessary on-call services in hospitals within a 48-hour average weekly working time. They consider that allowing a 52-hour limit for a further two years would be essential in order for them to guarantee the necessary quality and continuity of medical services.
- The national authorities consider that a phased introduction of a 48-hour working week will facilitate a change in culture – one which will take some time to become established – within this sector.
- The national authorities have agreed to the request of the hospital employers' organisations, subject to the non-negotiable condition that the employers' organisations, together with the workers' organisations, should draw up a workable plan by 1 August 2009 for reducing the average weekly working time to 48 hours by 1 August 2011.
- By mail of 22 July 2009, the Dutch authorities have informed the Commission that such an implementation plan was agreed by the relevant social partners on 22 July 2009, and that the Dutch authorities would confirm this information officially by the end of August 2009.

3. THE OUTCOME OF CONSULTATIONS ON THE NOTIFICATION

When the present Article 17(5) was adopted, the Commission made a statement that it would interpret the expression 'after appropriate consultations', in the second paragraph of this provision, as intending that the Commission should *'consult management and labour at European level and representatives of the Member States…*' before giving an Opinion regarding extended transitional arrangements for working time of doctors in training. [6]
The Commission services duly consulted all Member States and the European social partners about the notification received from the Netherlands.
Replies were received from seven Member States (Bulgaria, France, Greece, Lithuania, Luxembourg, Spain and Sweden.) No Member State indicated any objection to the Netherlands availing of the extended transitional period.

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4 The Working Hours Decree (*het Arbeidstijdenbesluit*)

5 The Netherlands Federation of University Medical Centres (*Nederlandse Federatie van Universitair medische centra / NFU)* and the Netherlands Association of Hospitals (*Nederlandse Vereniging van ziekenhuizen / NVZ)*

6 Commission statement regarding implementation of Article 1(6) of Directive 2000/34/EC, OJ L 195/41 at p. 45, 1.8.2000.

BusinessEurope indicated that its member federation, the Confederation of Netherlands Industry and Employers (VNO-NCW), supports the Netherlands' notification. It confirmed that the decision of the Dutch national authorities to make use of the transitional provisions is based on a request by the hospital sector itself; and that the Netherlands Association of Hospitals, a member of VNO-NCW, fully agrees with this approach and endorses the contents of the notification letter sent to the European Commission by the national authorities.
The ETUC, in a preliminary reply, indicated that Dutch trade unions seemed to consider that the national authorities had not sufficiently consulted the national social partners on this issue; but no further details were provided.

4. ASSESSMENT OF THE NOTIFICATION IN THE CONTEXT OF THE DIRECTIVE

The Working Time Directive was adopted by the European Parliament and the Council under Article 137(2) of the EC Treaty, which provides for Community measures to improve the working environment by protecting workers' health and safety. The Directive's main purpose is to lay down minimum safety and health requirements for the organisation of working time.
According to the information available to the Commission, the situation under national law is as follows:
- The generally applicable limit to average weekly working time is 48 hours, over a reference period not exceeding 16 weeks. Working hours are regulated within this framework by detailed collective agreements. However, under the Working Hours Act 1996, so-called 'inactive' periods of on-call time at the workplace were treated as rest time, and were not included in the calculation of weekly working time.
- After the Court of Justice ruled in the *Jaeger* case[7] that such periods must be fully counted as working time for the purposes of the Directive, this ruling was applied by national courts in several cases relating to the Dutch health and emergency sectors. Consequently, the Working Hours Decree 605/2005 amended national law in the Netherlands to define inactive on-call time at the workplace as working time. According to national law, collective agreements which predated this amendment were now void, to the extent that they did not comply with the new definition.
- As the national authorities considered that this change had considerable implications for the health and care sectors, they also introduced in 2005, as a temporary measure, a limited opt-out under Article 22 of the Directive for sectors which made extensive use of on-call time.
- Under this temporary measure, use of this opt-out is limited to situations where on-call time is required for continuity and quality of service provision, and where it cannot be avoided by organising work differently. It requires a collective agreement, as well as the individual consent of the worker concerned. It is only available where immediate compensatory rest is provided for any missed daily or weekly rests. Where these conditions are fulfilled, a worker may agree to work up to 60 hours per week, including the on-call time, averaged over a period of up to 26 weeks.
In the light of this information, the Commission is of the opinion that the protective conditions required by the Directive for the use of this derogation appear to have been correctly transposed.
In the Commission's view, it would (overall) be particularly desirable to provide flexibility for the national authorities to reorganise overall training and work systems, if that can reduce reliance on long hours by doctors who agree to use the opt-out.
In view of the responses received to the consultation, particularly from the social partners concerned, the Commission considers that the reasons put forward by the national authorities can be accepted as valid.

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7 *Jaeger* (Case C-151/02).

5. CONCLUSIONS

As a result of the above, the Commission is of the opinion that:

- it can be accepted that the Netherlands may require up to two more years from 1 August 2009, in accordance with Article 17(5) of Directive 2003/88/EC (the Working Time Directive), before it can apply the limit to working time contained in Article 6 of the Directive as regards doctors in training.
- it should be underlined that in any event, under Article 17(5) of the Directive, Member States in this situation shall ensure that weekly working hours do not in any case exceed 52 hours per week, averaged over a period not exceeding six months,
- it is noted that the notification depends on the condition, stipulated by the national authorities, that the relevant employers' and workers' organisations at national level will draw up by 1 August 2009 an agreed plan for achieving a 48-hour weekly working time in the hospital sector by 1 August 2011. It appears that such a plan was agreed on 22 July 2009.
- the employers at national level are encouraged to engage in information and consultation with representatives of doctors in training, in accordance with the sixth subparagraph of Article 17(5), with a view to reaching agreement, wherever possible, on the arrangements which will apply to the extended transitional period and on the measures to be adopted to reduce weekly working hours to an average of 48 hours generally by the end of the transitional period,
- the national authorities are requested to ensure the dissemination of this Opinion, so that it may be taken into account (where relevant) by the competent national authorities.

ANNEX C

RELEVANT NHS GRADES, SHIFTS AND ABBREVIATIONS

Relevant NHS Grades:

"F" "Foundation", and the number equates to the year of training (e.g. F1 means 1st year of Foundation training)

"CT" "Core Training", and the number equates to the year of training

"ST" "Specialty Training", and the number equates to the year of training

"FTSTA" "Fixed Term Specialty Training Appointment", and the number equates to the year of training

"CST" "Core Surgical training", and the number equates to the year of training

"SpR "Specialist Registrar"

Relevant Shifts:

"1st on call": a rota where the doctors on the rota will be called first at night in the event of an emergency.

"2nd on call": a rota where the doctors on the rota will be called if the 1st on call have already been called and are dealing with an emergency.

"Combined surgical on call rota": this rota covers a number of surgical specialties.

"Tier 2 (full shift)": a full shift rota (maximum length of duty 14hrs) where the 2nd tier of doctors are on this rota. A hospital may organise its rota cover in tiers.

"Tier 3 – (partial shift rota (24 hour service))": a partial shift rota of a 24hr service (maximum length of duty is 16 hrs) where the 3rd tier of doctors are on this rota. A hospital may organise its rota cover in tiers.

ANNEX D

SCRUTINY PANEL MEMBERS – September 2009

Judith Hulf, President, Royal College of Anaesthetists (Chair)

Ian Gilmore, President, Royal College of Physicians

David Grantham, Head of Programmes, NHS Employers

Paul Holmes, Deputy Director for Workforce, East of England SHA

Debbie Mellor, Deputy Director, Workforce Capacity, DH

Janet Monkman, Director of Workforce, East Midlands SHA

Mary Armitage, Deputy Director Medical Education England

Andrew Thornley, BMA Junior Doctors Committee

Shreelatta Datta, Chair BMA Junior Doctors Committee

Ian Wilson, Deputy Chair of BMA Central Consultants & Specialists Committee

ANNEX E

Equality Impact Assessment

The Working Time (Amendment) (No. 2) Regulations 2009

STEP 1 - IDENTIFYING THE AIMS

1. What type of policy is this?

These regulations amend the Working Time Regulations 1998, for the purpose of implementing a derogation permitted by Article 17(5) of the Working Time Directive (Directive 2003/88/EC). The Government considers the 48 hour limit set by the European Commission to be a reasonable maximum limit to ensure patient safety, provision of services, staff well being and work life balance. The Government recognised that working towards a 48 hour limit would require new ways of working within the health sector and service redesign. These amendments will allow those services that face challenges additional time to become fully compliant.

These amendments provide for a 52 hour limit on the average working week for certain doctors in training until 31 July 2011. Until 31 July 2009, the limit on the average working week for doctors in training was 56 hours. From 1 August 2009 this limit reduced to 48 hours for the majority of doctors in training. It is however necessary to apply a 52 hours limit for certain doctors in training to ensure for the continued delivery of certain health services and medical care.

2. What is the aim and purpose of the policy?

The purpose is to facilitate further derogation for certain groups of doctors in training to allow them to work a further 4 hours per week over the current 48 hr maximum. To allow those services further time (upto August 2011) to restructure and redesign services to ensure compliance with the EWTD. These further derogations represent a small proportion of the some 6600 planned to be compliant.

3. Outline of proposals being considered.

The proposed amendment to the exisiting regulations will facilitate 73 rotas covering the working paterns of certain doctors in training. This will allow those doctors in training, covered by these rotas, to work an additional 4 hours per week.

4. Why are the proposals being made - for what reason?

The Department of Health recognises that without the proposed derogation those areas of the Service affected will find difficulty in ensuring the continued delivery of certain health services and medical care thereby having a potential negative impact on patients.

5. Outcomes we want to achieve: Effective Delivery of Certain Health Services.

The object of Article 6 of the Directive is to reduce the maximum number of hours in the average working week to 48. Some doctors in training may however need to work longer than 48 hours to fulfil the needs of service delivery. Where there are difficulties in complying with the 48-hour week then it is possible for Member States to choose to apply an additional transitional period and apply an average 52-hour week to doctors in training instead. A small number of services, particularly 24-hour immediate care services, have required further support after 1 August, which prompted notification of an intention to take advantage of the additional period to the European Commission in January 2009. This will allow a further two-year transitional period before the 48-hour week limit can be applied to all doctors in training. (A further additional period of one year may be sought under the fourth sub-paragraph of article 17(5), in respect of "special difficulties" in complying with the 48-hour week. If this is applicable, it will be the subject of separate legislation in due course.)

The European Commission has responded to the notification sent in January 2009 from the UK Governments about its intention to derogate from the Directive to allow a small number of health services more time to be fully compliant. The Commission has accepted that the UK needs up to two more years before it can fully implement the European Working Time Directive (EWTD) for all doctors in training. The Commission's view is that the UK will need to apply again if it needs to take a third, and final year to implement fully the Directive. The situation will continue to be monitored and reviewed by the Department of Health's assurance process

The NHS is supported strategically and practically by key partner groups that have been established since January 2009. Membership includes the Academy of Medical Royal Colleges, the medical Royal Colleges, medical Deaneries, SHAs, NHS Employers, and British Medical Association.

An EWTD team was specifically set up as the momentum grew. This was led by Dr Wendy Reid. Key groups involved in EWTD include:

- Clinical lead and advisory group: chaired by Dr Wendy Reid, National Clinical Advisor.
- EWTD Reference Group: co–chaired by Judith Hulf, President of Royal College of Anaesthetists and Professor Patricia Hamilton, Director of Medical Education England at the Department of Health.
- EWTD Task and Finish Group: chaired by Dr Wendy Reid
- SHA and Royal College Liaison teams.
- Skills for Health – Workforce Projects National EWTD Lead. This organisation provides practical support resource and tools for NHS organisations providing practical solutions to aid compliance and hosts the SHA EWTD leads meetings.

To support the decision on seeking a derogation from the EC, SHAs, in partnership with their trusts, have been providing monthly state of readiness reports on EWTD compliance. These will be published by the Department of Health in 2009.

A scrutiny panel process was set up to consider the requests for derogation.

Scrutiny Panel Process

The role of the Scrutiny Panel is to:

- Provide the Secretary of State with a list of recommended derogations.
- Ensure that applications adhere to the agreed process with approval at SHA and Trust level and that the information requested to support the applications had been provided.
- Assess whether a consistent level of quality assurance had been applied to all applications.
- Take a national view of some specialties to identify whether national action is required.

The Panel have agreed the following categorisation of applications:

- Category A - Recommended, clear plan including timeframe.
- Category B - Recommended, credible plan described. Early follow up to take place to assess progress and performance manage implementation of plan.
- Category C - Recommended, serious concerns identified, other further action required with immediate follow up. Performance management with active intervention and ongoing support.
- Category D - Unable to recommend based on the information provided. Urgent information required before application can be reconsidered.

The Panel was advised that if there were serious concerns over any application an opportunity should be given for further information to be provided. Each application was categorised by the panel as above. Following scrutiny, those categorised as 'D's were followed up immediately for further information, clarification, more detailed action plans.

6. Who is the policy intended to help/ benefit?

The change is intended to minimise disruption to patient care within the NHS. It is not possible to establish accurately the number of junior doctors affected; the number of doctors on a rota will vary between trusts and specialties, and is dependant on the number of patients and the complexity of cases.

7. Who are the main stakeholders/ customers/ communities of interest?

Stakeholders have been consulted on the changes contained in the legislation over the course of 2009. These included the medical profession, the medical Royal Colleges, the medical Deaneries, the professional bodies, the British Medical Association, Strategic Health Authorities, Local Health Boards, hospital trusts and trainee doctors.

Engagement with a range of stakeholders clarified the level of challenge faced by certain services. By listening to concerns raised and examining the evidence collected by the SHA monthly returns on the state of readiness, the decision to seek a derogation was made that would allow continuity of services where a plan was in place to achieve full compliance in the agreed timescales. Department of Health will

publish in 2009 the evidence provided by SHA monthly returns on the state of readiness.

This consultation process informed the previous amendments (SI 2009/1567). The further changes proposed in this Amendment have been informed by the ongoing EWTD Reference Group processes, meetings with the Academy of Medical Royal Colleges, and other key partners as stated in paragraph five.

8. Does the policy have any existing aims in relation to equality, social inclusion or community cohesion?

No.

9. How is the resulting policy delivered / administered?

See step 7

STEP 2 - CONSIDERING EXISTING INFORMATION AND WHAT THIS TELLS US

It is recognised that the policy has the potential to create short term inequality in doctors in training working on rotas for which derogation applies working a 52 hour week, compared with those working a 48 hour week. However, any short term inequality that may arise will be resolved when full compliance is achieved.

10. What are the impacts or effects for communities?

Race or ethnicity

The Race Relations Act 1976 makes it unlawful to treat a person less favourably than another on racial grounds, which is defined to include grounds of race, colour, nationality (including citizenship) and national or ethnic origin.

Is there any discrimination on the grounds of race?

There is no discriminatory impact. The proposed policy will not make a distinction between the race, colour, nationality or ethnicity of doctors in training and the proposal will affect all doctors in training listed on the rotas in Table 1 equally. In addition, selection of specialisms or rotas for derogation is not dependent on any single factor and is driven by local service needs. No pattern has been found to suggest that any specialism or rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged.

Do the proposals promote equality of opportunity?

There is no impact on equality of opportunity, the proposed policy would not make a distinction between the race or ethnicity of doctors in training.

Do the proposals promote good race relations?

There is no potential for a negative impact on race relations because the amendments effect all individuals on the named rotas.

Are the changes likely to be a proportionate means of achieving a legitimate aim?

Yes. The changes apply to all individuals on the named rotas equally.

Religion or Belief

The Employment Equality (Religion or Belief) Regulations 2003 apply to women and men of any age and prohibit discrimination against Individuals because of religion or similar belief. These Regulations apply to all facets of employment – including recruitment, terms and conditions, promotions, transfers, dismissals and training.

There is no discriminatory impact. The proposed policy will not make a distinction between the religion or belief of doctors in training and the proposal will affect all doctors in training on the named rotas equally. In addition selection of specialisms or rotas for derogation is not dependent on any single factor and is driven by local service needs. No pattern has been found to suggest that any specialism or rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged.

Gender and transgender

The Sex Discrimination Act 1975 applies to women and men of any age, including children, and prohibits sex discrimination against individuals in the areas of employment, education, the provision of goods, facilities and services, and in the disposal or management of premises.

There is no discriminatory impact. The proposed policy will not make a distinction between the gender of doctors in training and the proposal will affect all doctors in training on the named rotas equally. In addition selection of specialisms or rotas for derogation is not dependent on any single factor and is driven by local service needs. No pattern has been found to suggest that any specialism or rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged.

Sexual orientation

The Employment Equality (Sexual Orientation) Regulations 2003 prohibit discrimination on grounds of sexual orientation. The regulations make it illegal to discriminate against, victimise or harass, anyone on grounds of their sexual orientation.

There is no discriminatory impact. The proposed policy will not make a distinction between the sexual orientation of doctors in training and the proposal will affect all doctors in training on the named rotas equally. In addition selection of specialisms or rotas for derogation is not dependent on any single factor and is driven by local

service needs. No pattern has been found to suggest that any specialism or rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged.

Disability

The Disability Discrimination Act 1995 prohibits discrimination against disabled people in the areas of employment, the provision goods, facilities, services and premises, and education; and enables regulations to be made to improve access to public transport.

There is no discriminatory impact. The proposed policy will not make a distinction between disabled and non-disabled doctors in training on the named rotas and the proposal will affect all doctors in training on the named rotas equally. In addition selection of specialisms or rotas for derogation is not dependent on any single factor and is driven by local service needs. No pattern has been found to suggest that any rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged.

Human Rights

The Human Rights Act, which came into force in October 2000, incorporates into domestic law the European Convention on Human Rights to which the UK has been committed since 1951. Section 6 of the Human Rights Act makes it unlawful for a public authority to act in a way which is incompatible with a Convention right

The proposed policy will not contravene human rights. This is because the proposed policy will not engage or adversely affect any of the rights guaranteed under the European Convention on Human Rights.

Age

The Employment Equality (Age) Regulations 2006 make it unlawful to discriminate on grounds of age.

There is no discriminatory impact. The proposed policy will not make a distinction on the grounds of the age of doctors in training and the proposal will affect all doctors in training on the named rotas equally. In addition selection of specialisms or rotas for derogation is not dependent on any single factor and is driven by local service needs. No pattern has been found to suggest that any specialism or rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged.

Relationships between or within communities

12. What do you know about how the proposals will impact on different communities?

The proposed policy will not have a different impact on different communities.

STEP 3 - ASSESSING THE IMPACT

13. Is there any evidence of higher or lower take-up by any group or community, and if so, how is this explained?

There is no evidence.

14. Do any of these limitations amount to unlawful discrimination?

No.

15. If No, do they amount to a differential impact, which should be addressed?

No.

16. If the impact or effects are adverse for any community or group, can they be defended in order to provide equality for another community under legislation or policy?

There is no evidence.

17. Do you have enough information to make a judgement?

Yes, the proposed policy will not make any discriminatory distinctions and the effects of the proposals apply equally to all individuals on a named rota. In addition selection of specialism or rotas for derogation is not dependent on any single factor and is driven by local service needs. No pattern has been found to suggest that any specialism or rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged.

18. Is it possible to get the information quickly and easily or is it recommended that the collection of such data be included as an action for the action plan that will be developed? Please detail below.

Not required.

STEP 4 - DEALING WITH ADVERSE OR UNLAWFUL IMPACT

19. What can be done to improve the policy or any proposals in order to reduce or remove any adverse impact or effects identified?

The proposed policy will not impact differently on people on grounds of their disability, race, gender, sexual orientation, age, religion or beliefs, human rights or on communities. The proposal will affect all doctors in training on the named rotas equally. In addition selection of specialism or rotas for derogation is not dependent on any single factor and is driven by local service needs. No pattern has been found to suggest that any specialism or rota is more likely than any other to require derogation. Therefore no particular group will be disadvantaged

20. What would be needed to be able to do this? Are the resources likely to be available?

None.

21. What other support or changes would be necessary to carry out these actions?

Nothing.

STEP 5 - CONSULTING THOSE AFFECTED FOR THEIR VIEWS

An extensive consultation process was established through the European Working Time Directive (EWTD) Reference Group co-chaired by Dr Hulf CBE, President of the Royal College of Anaesthetists and Dr Patricia Hamilton Director of Medical Education England.

Stakeholders have been consulted on the changes contained in the legislation over the course of 2009. These included the medical profession, the medical Royal Colleges, the medical Deaneries, the professional bodies, the British Medical Association, Strategic Health Authorities, Local Health Boards, hospital trusts and trainee doctors.

This consultation process informed the previous amendments (SI 2009/1567). The further changes proposed in this Amendment have been informed by the ongoing EWTD Reference Group processes, meetings with the Academy of Medical Royal Colleges, and other key partners as stated in paragraph 8.2

Postgraduate Medical Education and Training Board (PMETB) is the training regulator and their survey of trainees has raised concerns that junior doctors (in training) may be falsifying hours to specific trusts and specialties. We are writing to PMETB to ask them to work with the Deans to investigate practice locally in order to enable a better understanding of the issue, to discourage poor practice and to improve the position for next year's survey.

Medical Education England's review of training will complement the work being done by the PMETB as part of their ongoing programme of quality assurance of postgraduate medical education and training. Professor Sir Christopher Edwards is expected to announce shortly the name of the chairman who will lead the MEE review on EWTD and its impact on the quality of training.

STEP 6 – NEXT STEPS AND ACTION PLANNING

Monitoring and sharing of best practice (see below) will facilitate the EWTD Reference Group work towards achieving full compliance.

Evidence gathering will continue to inform if and when further derogations my be required.

STEP 7 – ARRANGEMENTS FOR MONITORING AND REVIEW

The NHS is supported strategically and practically by key partner groups that have been established since January 2009. Membership includes with the Academy of Medical Royal Colleges, the medical Royal Colleges, medical Deaneries, SHAs, NHS Employers, and British Medical Association

An EWTD team was specifically set up as the momentum grew this was led by Dr Wendy Reid. Key groups involved in EWTD include:

- Clinical lead and advisory group: chaired by Dr Wendy Reid, National Clinical Advisor.
- EWTD Reference Group: co–chaired by Judith Hulf, President of Royal College of Anaesthetists and Professor Patricia Hamilton, Director of Medical Education England at the Department of Health.
- EWTD Task and Finish Group: chaired by Dr Wendy Reid
- SHA and Royal College Liaison teams.
- Skills for Health – Workforce Projects National EWTD Lead. This organisation provides practical support resource and tools for NHS organisations providing practical solutions to aid compliance and hosts the SHA EWTD leads meetings.

Also In January 2009 the SHAs established a robust and rigorous quality assurance process to monitor compliance levels. This information has been shared with the Academy of Medical Royal Colleges, the EWTD Reference and Steering Groups and the SHA EWTD leads. This work in on-going until December when the situation will be reviewed.

The SHAs and medical Royal College Liaison Groups are working with trusts to support and ensure implementation of all service plans by 2011. They are monitoring on a monthly basis.

Table 1

Column 1 *Employer*	*Column 2* *Place*	*Column 3* *Specialist Services*	*Column 4* *Grade and, where applicable, Rota*
England			
East Midlands Strategic Health Authority area			
Chesterfield Royal Hospital NHS Foundation Trust([8])	Chesterfield Royal Hospital	Emergency Medicine Obstetrics and Gynaecology Paediatrics	F2, ST1 to ST7 F2, ST1 to ST7 F2, ST1 to ST8
Derby Hospitals NHS Foundation Trust([9])	Royal Derby Hospital	Oral Maxillo Facial Surgery	ST3 to ST7
Northampton General Hospital National Health Service Trust([10])	Northampton General Hospital	Emergency Medicine	ST3 to ST7
Nottingham University Hospitals National Health Service Trust([11])	Queens Medical Centre, Nottingham	Neurosurgery	ST4 to ST8
University Hospitals of Leicester National Health Service Trust([12])	Glenfield Hospital Leicester Royal Infirmary and Leicester General Hospital	Paediatric (Cardiology and Cardiac Intensive Care) Neonatology	ST3 to ST8 ST1 to ST3
East of England Strategic Health Authority area			
Cambridge University Hospitals NHS Foundation Trust([13])	Addenbrookes Hospital	Anaesthetics	ST3 to ST7 and SpR

([8]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 (c.43) with effect from 1st January 2005. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006 (c.41), by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006 (c.43).

([9]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 (c.43) with effect from 1st July 2004. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006 (c.41), by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006 (c.43).

([10]) Established by S.I. 1993/2561.

([11]) Established by S.I. 2006/782.

([12]) Established by S.I. 1999/2921, as amended by S.I. 2003/2150.

([13]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st July 2004. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

Norfolk and Norwich University Hospitals NHS Foundation Trust([14])	Norfolk and Norwich University Hospital	Obstetrics and Gynaecology Paediatric Neonatal	ST3 to ST9 and SpR– Tier 3 (partial shift rota (24 hour service)) ST3 to ST8 and SpR – Tier 2 (full shift)
Peterborough and Stamford Hospitals NHS Foundation Trust([15])	Peterborough District Hospital and Edith Cavell Hospital	General Surgery	CT1 and CT2
The Queen Elizabeth Hospital King's Lynn National Health Service Trust([16])	The Queen Elizabeth Hospital	Obstetrics and Gynaecology	ST3
London Strategic Health Authority area			
The Royal Free Hampstead National Health Service Trust([17])	The Royal Free	Neurosurgery	ST3 to ST8
The Royal Marsden NHS Foundation Trust([18])	The Royal Marsden	Otolaryngology and Plastic Surgery Urology and Gynaecology	ST3 to ST8 ST3 to ST8
North East Strategic Health Authority area			
The Newcastle Upon Tyne Hospitals NHS Foundation Trust([19])	Freeman Hospital Newcastle General Hospital	General Surgery – Hepatobiliary and Transplant Paediatric Cardiology Neurology	ST3 to ST7 and SpR ST4 to ST8 and SpR – 2nd on call F2, CT1 and CT2 - 1st on call ST3 to ST7 and SpR - 2nd on call

([14]) Authorised as an NHS foundation trust under section 35 of the National Health Service Act 2006 with effect from 1st May 2008.

([15]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st April 2004. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

([16]) Established by S.I. 1991/2363, as amended by S.I. 2005/332.

([17]) Established by S.I. 1990/2435, as amended by S.I. 1996/871.

([18]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st April 2004. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

([19]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st June 2006. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

	Royal Victoria Infirmary	Paediatric Surgery Paediatrics	ST4 to ST8 and SpR - 2nd on call ST4 to ST8 and SpR
North Tees and Hartlepool NHS Foundation Trust([20])	University Hospital of Hartlepool and University Hospital of North Tees	Paediatrics	ST3 to ST7 and SpR
North West Strategic Health Authority area			
Aintree University Hospitals NHS Foundation Trust([21])	University Hospital Aintree	Anaesthetics - Critical Care	CT1, CT2 and ST3 to ST7
North Cumbria University Hospitals National Health Service Trust([22])	Cumberland Infirmary West Cumberland Hospital	Emergency Medicine Paediatrics Emergency Medicine	F2, FTSTA1, FTSTA2 and ST1 to ST7 ST1 and ST2 F2 and ST1 to ST3
Royal Bolton Hospitals NHS Foundation Trust([23])	Royal Bolton Hospital	Paediatrics	FTSTA3 and ST4 to ST8
Tameside Hospital NHS Foundation Trust([24])	Tameside General Hospital	Trauma and Orthopaedics	F2, CT1, CT2, ST1 and ST2
Warrington and Halton Hospitals NHS Foundation Trust([25])	Warrington Hospital	Trauma and Orthopaedics	F2, ST1 and ST2
South Central Strategic Health Authority area			
Buckinghamshire Hospitals National Health Service Trust([26])	Stoke Mandeville Hospital and Wycombe Hospital	Anaesthetics	ST3 to ST5
Isle of Wight National Health Service Primary Care Trust([27])	St. Mary's Hospital	General Medicine General Medicine Emergency	F2, CT1 and CT2 ST3 and ST4 F2, ST1 and ST2

([20]) Authorised as an NHS foundation trust under section 35 of the National Health Service Act 2006 with effect from 1st December 2007.
([21]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st August 2006. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.
([22]) Established by S.I. 2001/656, as amended by S.I. 2008/1775.
([23]) Authorised as an NHS foundation trust under section 35 of the National Health Service Act 2006 with effect from 1st October 2008.
([24]) Authorised as an NHS foundation trust under section 35 of the National Health Service Act 2006 with effect from 1st February 2008.
([25]) Authorised as an NHS foundation trust under section 35 of the National Health Service Act 2006 with effect from 1st December 2008.
([26]) Established by S.I. 2002/2419.
([27]) Established by S.I. 2006/2537.

		Medicine Obstetrics and Gynaecology General Surgery General Surgery, Trauma and Orthopaedics, Obstetrics and Gynaecology	 ST3 F1 F2, ST1 and ST2 – Basic Surgical Training rota
Oxford Radcliffe Hospitals National Health Service Trust([28])	Horton General Hospital, Banbury	Obstetrics and Gynaecology	ST3 to ST5
Winchester and Eastleigh Healthcare National Health Service Trust([29])	Royal Hampshire County Hospital	Surgery	ST3 to ST5
South East Coast Strategic Health Authority area			
Ashford and St. Peter's Hospitals National Health Service Trust([30])	St. Peter's Hospital	Anaesthetics	CT2 and ST3 to ST7
Brighton and Sussex University Hospitals National Health Service Trust([31])	Princess Royal Hospital Royal Sussex County Hospital and Princess Royal Hospital Royal Sussex County Hospital	General Internal Medicine Emergency Medicine Obstetrics and Gynaecology	ST3 to ST8 ST3 to ST8 ST3 to ST8
East Kent Hospitals University NHS Foundation Trust([32])	Queen Elizabeth the Queen Mother Hospital	Anaesthetics – Intensive Care Unit and Theatres Paediatrics	CT1 and CT2 ST3 to ST7
Frimley Park Hospital NHS Foundation Trust([33])	Frimley Park Hospital	Anaesthetics – Intensive Care and Acute Care Common Stem	CT1 and CT2

([28]) Established by S.I. 1993/2544, as amended by S.I. 1998/1227 and S.I. 2000/961.
([29]) Established by S.I. 1993/2581, as amended by S.I. 2001/1915.
([30]) Established by S.I. 1998/801.
([31]) Established by S.I. 1992/2536, as amended by S.I. 2003/866 and S.I. 2004/2894.
([32]) Authorised as an NHS foundation trust under section 35 of the National Health Service Act 2006 with effect from 1st March 2009.
([33]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st April 2005. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

		Emergency Medicine Obstetrics and Gynaecology Paediatrics	ST3 to ST6 ST1 to ST7 ST4 to ST7
Royal Surrey County Hospital National Health Service Trust([34])	Royal Surrey County Hospital	Anaesthetics – Intensive Care Unit Acute Medicine Emergency Medicine	F2, CT1 and CT2 F1, F2, CT1, CT2 and ST3 to ST7 ST3 to ST7
Surrey and Sussex Healthcare National Health Service Trust([35])	East Surrey Hospital and Crawley Hospital	Paediatrics	ST3 to ST6
South West Strategic Health Authority area			
University Hospitals Bristol NHS Foundation Trust([36])	Bristol Eye Hospital, Bristol Royal Infirmary and St. Michael's Hospital Bristol Royal Hospital For Children, Frenchay Hospital, Southmead Hospital and St. Michael's Hospital	Anaesthetics Otolaryngology	ST3 and ST4 - 1st on call ST4 to ST7 – 2nd on call ST1 to ST3
West Midlands Strategic Health Authority area			
George Eliot Hospital National Health Service Trust([37])	George Eliot Hospital	Anaesthetics	ST3 to ST7
University Hospital of North Staffordshire National Health Service Trust([38])	The Royal Infirmary	Renal Neurosurgery	ST3 to ST8 F2, ST1 to ST3
Yorkshire and the Humber Strategic Health Authority area			

([34]) Established by S.I. 1990/2442, as amended by S.I. 1996/2860.
([35]) Established by S.I. 1998/651.
([36]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st February 2007. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.
([37]) Established by S.I. 1993/2551 and S.I. 2009/510.
([38]) Established by S.I. 1992/2559, as amended by S.I. 1993/713 and S.I. 2003/792.

Bradford Teaching Hospitals NHS Foundation Trust([39])	Bradford Royal Infirmary and St. Lukes Hospital	Otolaryngology/ Plastic Surgery/Oral and Maxillofacial Surgery (merged rota)	F2, CT1 and CT2
Calderdale and Huddersfield NHS Foundation Trust([40])	Calderdale Royal Hospital Huddersfield Royal Infirmary	Emergency Medicine Anaesthetics Emergency Medicine	F2, CT1, CT2, CT3, ST4, ST5 and SpR CT1, CT2, ST3 to ST5 and SpR F2, CT1, CT2, CT3, ST4, ST5 and SpR
Hull and East Yorkshire Hospitals National Health Service Trust([41])	Hull Royal Infirmary	Neurosurgery	F2, ST1 and ST2
Scarborough and North East Yorkshire Healthcare National Health Service Trust([42])	Scarborough General Hospital	Anaesthetics Acute Medicine Neurology Diabetes and Endocrinology Care of the Elderly	CT1, CT2 and ST3 to ST5 ST3 to ST5 ST3 to ST5 ST3 to ST5 ST3 to ST5
Sheffield Children's NHS Foundation Trust([43])	Sheffield Children's NHS Foundation Trust, Capitol Park, Barnsley	Paediatrics – Critical Care, Neonatal Services	ST6 to ST8 – Transport rota
The Rotherham NHS Foundation Trust([44])	Rotherham General Hospital	Obstetrics and Gynaecology	ST1 to ST7
York Hospitals NHS Foundation Trust([45])	York Hospital	Obstetrics and Gynaecology	ST3 to ST7 and SpR

([39]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st April 2004. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

([40]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st August 2006. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

([41]) Established by S.I. 1999/2675.

([42]) Established by S.I. 1991/2398.

([43]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st August 2006. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

([44]) Authorised as an NHS foundation trust under section 6 of the Health and Social Care (Community Health and Standards) Act 2003 with effect from 1st June 2005. The authorisation under the 2003 Act has effect as if given under section 35 of the National Health Service Act 2006, by virtue of paragraph 1 of Schedule 2 to the National Health Service (Consequential Provisions) Act 2006.

		Trauma and Orthopaedics	F2, CT1, CT2, ST1 and ST2
Scotland			
Ayrshire and Arran Health Board([46])	Ayr Hospital	Emergency Medicine	ST3 to ST7 and SpR
Borders Health Board([47])	Borders General Hospital	Paediatrics	ST3 to ST9 and SpR
Fife Health Board([48])	Forth Park Maternity Hospital and Victoria Hospital	Paediatrics	ST3 to ST9 and SpR
Lanarkshire Health Board([49])	Wishaw General Hospital	Emergency Medicine	ST3 to ST7 and SpR
		Neonatology	ST3 to ST9 and SpR
	Hairmyres Hospital	Emergency Medicine	ST3 to ST7 and SpR
	Monklands Hospital	Emergency Medicine	ST3 to ST7 and SpR
Wales			
Cwm Taf Local Health Board([50])	Royal Glamorgan Hospital	Ophthalmology	Junior”

([45]) Authorised as an NHS foundation trust under section 35 of the National Health Service Act 2006 with effect from 1st April 2009.
([46]) Established by S.I. 1974/267, as amended by S.S.I. 2003/217 and S.S.I. 2006/32.
([47]) Established by S.I. 1974/267, as amended by S.S.I. 2003/217 and S.S.I. 2006/32.
([48]) Established by S.I. 1974/267, as amended by S.S.I. 2003/217 and S.S.I. 2006/32.
([49]) Established by S.I. 1974/267, as amended by S.S.I. 2003/217 and S.S.I. 2006/32.
([50]) Established by S.I. 2009/778 (W. 66).