I beg to move,

That leave be given to bring in a Bill to require the Secretary of State to conduct an assessment of the impact of the European Union Working Time Directive on NHS acute medical and surgical services; to require the Secretary of State to make provision to exempt NHS acute medical and surgical services from the European Union Working Time Directive in the light of that assessment if certain conditions are met; and for connected purposes.

Before I start, I must declare an interest. My father has been a consultant orthopaedic surgeon in Bristol for more than 30 years and has just retired. If growing up in a medical family has taught me anything—I have seen the NHS under a succession of Conservative and Labour Governments—it is that politicians must listen to the professionals who know the most about the NHS, medicine and patients: the doctors. If politics is to serve the place outside these four walls, it has to get real. It has to listen to real people and get lessons from the real professionals working in our hospitals today.

I bring the Bill before the House for one reason: the people who know best about patient care—the doctors—have been raising the alarm to say that the 48-hour European working time directive is endangering patient safety. That is serious, and it is not what the directive was ever intended to do. The directive was designed to ensure that workers were not subjected to overlong working hours and were entitled to reasonable pay and conditions, time off and paid leave. In reality, that well-meaning directive is endangering patient safety in four key ways. I will expand on those four factors in the brief time that I have, because I believe that they speak for themselves. First, continuity of care is being eroded. Secondly, trainee doctors are being denied the training that they need. Thirdly, appropriate clinical expertise is not available to patients when they need it, and fourthly, I add with a certain grim irony that junior and senior doctors are more exhausted by the shift rota that the directive imposes than they were before.

I shall elaborate. Continuity of care is sometimes an overlooked factor of medical health care, but it is absolutely key. It is what allows professionals to use their professional expertise on a patient. That link between the patient and the person caring for them is vital, but the shift rota system that has been imposed under the European working time directive has meant that there are far more handovers of patients to a new doctor. At those handover points, complications arise because crucial information can be missed out and not passed on. Handovers did occur under the old system, but they were far less frequent.

From the patient's point of view, the shift system has meant that instead of having one or two doctors whom they know and begin to trust, and who have seen them from the beginning to the end of their treatment, patients are subjected to a seemingly never-ending conveyor belt of doctors. From the doctor's point of view, there is a kind of patient pass the parcel. That absolutely must stop. It is no good for the patient's care, no good for their
experience of their treatment and it is clinically risky. In fact, a third of all doctors have said that since the European working time directive was implemented, they have seen significant deterioration in patients over the handover period.

The training of our doctors for the future is also suffering. The Royal College of Surgeons has estimated that 400,000 hours of surgical time are lost every single month. It does not take a genius to work out that if the trainees are not getting the hours in, they cannot get the training that they need. Two thirds of trainees have said that they have seen significant deterioration in their training in the short time that the working time directive has been fully implemented. The irony is that the directive was supposed to alleviate the exhaustion of junior doctors, but because all their hours are clumped together in one go, it has actually led to more exhaustion. More exhausted doctors are getting less training, and it does not need me to expand on that for all Members to see that it is madness.

Particularly worrying from a patient’s point of view is that clinical expertise is not there when it is needed. If there are fewer people available, there are fewer specialist doctors when they are needed. For example, a doctor has told me that whereas before there would have been an orthopaedic senior house officer, a urology junior doctor and a general surgery SHO on duty at night in case any complications arose, under the working time directive, there might be only the general surgery SHO. If a complication arises with a patient’s treatment, they will not have the specialist doctor available to them that they would have had before the directive was imposed.

Attempts to solve the problem are very expensive, and I do not just mean the human cost, which is obviously the key issue. There is also the economic cost. The attempts to patch up the gaps left in the provision of health care professionals and doctors has led to an explosion in the number of NHS hospital locums being employed. The cost of that to the public purse has doubled in the past two years to a staggering £700 million, and the cost of surgical NHS locums has also doubled.

This cannot be allowed to continue. No one is advocating a situation in which junior doctors work too long to be able to perform their job, and the RCS has mentioned a 65-hour working limit. However, under the current arrangements, doctors are more exhausted, there is less training and patient safety is being compromised. That was never the intention behind the directive, and there are ways in which the Government can act. The police and armed forces already have an exemption from the directive. My Bill calls for the reality of the European working time directive to be assessed properly and for appropriate action to be taken to allow doctors to look after their patients in the way that they intended when they went into the profession.

We all have constituents who are patients and those who are junior doctors. No Member would seek to put their constituents’ safety at risk, and no Member would seek to stifle junior doctors’ desire and ability to perform the job that they went into the profession to do. That is why I seek to bring the Bill before the House.

Bill read the First time; to be read a Second time on Friday 10 June and to be printed (Bill 140).

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