Consultation on new suite of guides for the Train Driving Licences and Certificates Regulations 2010 February 2019

Responses from:
Aslef
Directrail
Dr D.B. Shackleton
Dr P Davies
GTR Health
Health management
mtrcrossrail
northern
RPS OH
RSSB
southeastern
Trinity

ASLEF
the train drivers' union

By e-mail

Dear Sue,

Please find below ASLEF's response to the ORR Consultation on new suite of guides for the TDLCR 2010.

TDLCR 2010, Key facts for train drivers' leaflet.

- Bad wording on the leaflet with age stipulated as over 20, it would be better to state 21.

TDLCR 2010, A guide for train operators, February 2019.

- Page 6, clause 10, clarification is needed on what this clause means and how it will operate.
- Page 8, clause 1.3, the minimum age at the moment to obtain a licence is 21 but the age shown is 20.
- Page 16, clause 4.1, typo in first line "to the drivers they of drivers" presumable this should read "to their drivers".

TDLCR 2010, A guide to the medical and occupational psychological fitness requirements, February 2019.

- Page 6, clause 1.3, typo "increse" should be increase and "examinationjs" should be examinations.
- Page 7, clause 1.6, mentions that "Employers of train drivers may decide to include other tests as they see necessary" for consistency this needs removing it should not be down to individual employers to determine what tests can be included.
- Page 8, clause 1.9, what is the difference between bullet point 1 and bullet point 4, do they not have the same meaning?
- Page 9, clause 1.15, "Medical assessors must also have suitable experience and qualifications to carry out the examination" What exactly are the qualifications and experience that is required?
- Page 10, clause 1.22, In addition to the results been communicated to the driver's employer the driver needs to be advised so that the outcome is known.
- Page 12, clause 2.1, is this clause factually correct? Pre 3rd October 1988-drivers will not have had any occupational psychological fitness examination.
- Page 16, clause 4.1, "must demonstrate independence, competence and impartiality" how are these criteria measured?

- Page 18, clause 4.11, can a doctor or psychologist be removed from the register for failing clause 4.1 regarding “demonstrate independence, competence and impartiality”?
- Page 18, clause 4.13, typo “annex C” should read annex A.

TDLCR 2010, Guide to training and examination requirements, February 2019.

- Page 4, clause 2.2, clarification is required about who gets recognition and when it would apply e.g. short-term training.
- Page 4, clause 2.2, bullet point one, is this the same as clause 2.6?
- Page 5, clause 2.7, Is “Someone” a typo?
- Page 5, clause 2.8, are the competent persons registered and recognised by the ORR?
- Page 5, clause 2.11, “out” needs inserting on line four between “carried” and “to”.
- Page 7, clause 3.1, bullet point seven, “a driver holding the certificate for that infrastructure/rolling stock must be present” What does this mean?
- Page 9, clause 4.1, bullet point three, “a driver holding the certificate for that infrastructure/rolling stock must be present” What does this mean?

Regards
Vincent
Vincent Borg
ASLEF Health & Safety Department

Direct Rail Services

By e-mail

Good Afternoon Sue,

Please accept the information contained within this email as Direct Rail Services formal response to the consultation on the new suite of guides for the Train Driving Licences and Certificates Regulations 2010.

DRS support in principle the content of the draft guidance documents, however have observation/questions as detailed below.

A Guide to the medical and Occupational Psychological fitness requirements

1.9 A train driver has been on sick leave for at least 30 days – Does this depend on the nature of the illness/sickness and to what level of detail would be required?

Following an occupational accident or absence involving other people – Does this include trauma?

Guide to Training and Examination Requirements

2.13 A unique registration number must be provided on all driving licence application forms where they have carried out the training or assessment of that driver – Currently DRS use employee number is this acceptable and will this require a change to a more unique registration number?

4.1 Examination centres criteria – Bullet point 1, examiners have minimum train driving experience of 4 years, this is different to trainers who require 3 years' experience in train driving experience can this be clarified?

Please contact myself if any additional information is required or clarification needed thanks.

Regards
Dougie Hill
Head of National Freight Strategy & Policy
Direct Rail Services

Dr D B Shackleton MRCP MFOM
Specialist in Occupational Medicine

The Tower House
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By e-mail

Train Driving Licences and Certificate Regulations 2010 - Consultation

Train Driving Licences and Certificates Regulations 2010: A guide to the medical and occupational psychological fitness requirements

Draft guidance for consultation February 2019

Overall comment. The draft guidance is a welcome development however:

A. There is a serious omission of specific guidance on the medical meaning of the requirements in Schedule 1. Due to the way that the original directive was drafted, UK doctors cannot consistently interpret the medical requirements without supporting medical guidance.

B. There are some parts of the guidance that go beyond the remit of ORR under TDLCR and/or are already covered by other legal requirements, for example mandated by the General Medical Council.

Section 1 – Medical Examinations
1.6
Comment: RIS 3451 TOM is an RSSB document that is likely to become obsolete and be withdrawn now that there are no circumstances where the old 3451 standard will apply to drivers on Network Rail controlled infrastructure.

The guidance that RIS 3451 TOM contains in regard to the medical interpretation of Schedule 1 TDLCR should be duplicated in or moved to this guidance produced by ORR, who are the enforcing authority for TDLCR.

1.17
Comment: This section is a statement of the obvious and covers many areas that are fundamental to medical practice and governed by the GMC. As a general principle this guidance should be confined to areas that ORR enforces as a consequence of TDLCR and should not duplicate requirements that are mandated elsewhere and relate to fitness to practice generally.

Not all equipment can be calibrated, for example a patella hammer or a stethoscope.

1.18
Comment: SEQOHS is a voluntary quality assurance scheme run by the Faculty of Occupational Medicine. Although it has been widely promoted and may well be a significant source of income for the Faculty it has no legal or regulatory status. It is not clear whether

SEQOHS have ever published any evidence to show that participating providers are safer, more effective or better quality than those who use different schemes, in-house schemes or do not participate at all. Other QA schemes are also available. For ORR to "strongly recommend" i.e. *promote* this particular scheme is disproportionate, lacks balance and oversteps their regulatory role, placing a burden on providers that may not be necessary in every case.

Appropriately qualified and licensed specialist doctors are legally free to practice in the field of Occupational Medicine without participation in SEQOHS. The revalidation process linked to licensing by the GMC ensures that doctors are fit to practice.

1.21
Comment: Many doctors do not use these terms and they are not standard "current industry practice". The medical practitioner must issue a certificate or statement indicating that the driver did or did not "pass the required medical examination" (Reg. 8(d)), "in accordance with TDLCR Schedule 1"

1.22
Comment: What is the "correct medical screening standard" referred to here? Does it relate to the different the examination requirements in Schedule 1 that apply *before* appointment and periodically *after* appointment?

1.23
Comment: A further reference to SEQOHS. Please refer to my comments on 1.18

1.24
Comment: This section is confusing. To what extent does ORR expect that the employer will arrange and pay for tests rather than the GP? This should be made clear and be based on sound employment law principles. Failure to clarify this will create a large number of queries and disputes.

Dr David Shackleton,
Specialist in Occupational Medicine
RSSB Medical Adviser

11 March 2019

By e-mail

Dear Ms Butler,

Thanks for forwarding the draft consultation information. I think standardizing the medical nationally is an excellent idea and long overdue in implementation, in my opinion.

I think the content of the medical examination and frequency seems reasonable.

I think on a practical stage it is worth ensuring sufficient approved psychologists are available. I can imagine any driver/railway personnel off with MH illness has the potential to require assessment prior to return and if there are not sufficient resources, this may delay a return to work.

Kind regards,

Dr Paul Davies

by e-mail

HEALTH

COMMENTS ON TDLC GUIDANCE DOCUMENT and
Comments made in e mail (Paul Carey) dated 6-3-19

I would like to point out difficulties with "fitness coding "mentioned under the title: "**Recording of the results of medical examination"**
The email of 6 March 2019 states (sic): "*We strongly recommend that information from medical examination is recorded in consistent way across train operators and doctors use standard industry fitness classification F1, F2, U1 and U2 ".*

It is of vital importance that ORR is aware of difficulties of such rigid approach.
Having said that I want to point out that consistency across the board seems reasonable. However, the way such consistency should be achieved must be reviewed and discussed so that the "coding" is brought up to date and is commensurate with various legislations and individual company policies (mainly attendance) including the Equality Act.

It is widely known that the fitness coding is used across the board, not only for the occupation of Train Operator, but for all the grades within the railway industry including administrative grades and grades that are not safety critical. This in itself causes a problem (which may be for individual TOCs to address), but also causes a problem in advising about Train Operators fitness. This is because the codes as such are restrictive and possibly often misunderstood including the same code (in terms of work ability) being interpreted differently by different people.

F1 = Fit (in this case for train operating role), F2 = Temporary restrictions (this does not account for adjustments , which are different from restrictions or for gradual return to work) ; U1 = Temporarily unfit, U2 = Permanently unfit (this is interpreted as not fit for work in the railway industry -not necessarily as train operator thus possibly not opening the doors for redeployment) S Although the underlying thought behind enforcing the codes is consistency and ease of (cross) understanding, the effect is far too often the complete opposite. Such understanding of coding is not fully commensurate with The Equality Act, or with the company and medical advisors' intention and willingness to rehabilitate all members of staff, including train operators, back to work as soon as possible.

In many cases, return to work is one of very useful rehabilitation methods. However, passing the driver as F2 with advice that they cannot drive full shift) would in reality mean that they cannot drive trains. To illustrate: if the train driver is a full-time train driver and cannot return to full time driving, although can return to driving as such, could be coded as F2 (temporary restrictions – meaning restricted number of hours driving). According to company regulations, such a driver cannot resume driving until they are F1. That of course inhibits their early return to work and possibly slows down their progress and rehabilitation.

If (to account for that) the driver is coded as F1 with additional comment that his hours should be increased gradually, two different things could and have been happening:
1 manager will deem him /her as not fully productive -not working full time and request F2 instead or
2 If they are coded F2 to start with, another manager may not allow them to drive at all (thus possibly slowing down their rehabilitation)

To make things even more complicated in comparison to a part time driver, who would be F1 if he is able to drive, the full-time driver would be F2, meaning he cannot drive full time which in 'HR books' may mean that their capability needs to be managed. Although the guidance applies to train drivers it is worth mentioning that use of such codes is even more complicated in the non-safety critical grades, or other safety critical grades that are not train drivers.
Here at GTR Heath we have plenty of individual examples of issues and complications the above (in essence restrictive coding) is causing. A lot of our time is spent in discussion with managers which code would be appropriate in which case. Despite that, it is the fact that same or very similar cases and situating end up being coded differently which in itself negates the main point of *being consistent.*

Where the argument may be that a degree of training can be done with managers and clinicians to try to ensure consistency of understanding, the fact will remain that there is high likelihood that such understanding will differ from TOC to TOC and from one OH provider to another.
I suggest that the original coding system has been outdated and is no longer fit for purpose of easy understanding and consistency. In addition, rigid use of codes , especially across all the grades is having negative effect on health interventions such as early rehabilitation and can very easily due to poor understanding be leading TOCs down to road of ET.

I therefore strongly suggest to the ORR to take this issue as a separate consultation so that adequate solution is found; solution that would serve the purpose of being consistent across all the TOCs but also a solution that would be commensurate with early rehabilitation and The Equality Act.

Dr Illeana St Claire – MD FFOM GMC
Chief Medical Officer
GTR HEALTH

By e-mail

Robbert Hermanns
Consultant Medical Practitioner
Health Management Ltd
A MAXIMUS Company

Heading	section	comment
1.4 Under TDLCR Schedule 1 the pre-appointment medical examination must include as a minimum the following elements:	Any blood or urine tests where there may be necessary to judge physical aptitude (such as testing for diabetes)	I very much support this comment, given the observation that metabolic syndrome, obesity, obstructive sleep apnea and diabetes are very common and appear on the increase.
	Tests for psychotropic substances (such as illicit drugs or psychotropic medication) and the abuse of alcohol calling into question the fitness for the job	Is it ORR's view that this could also require blood examinations? Most alcohol dependent people are able to abstain for a day or so if it otherwise would jeopardize a job application, so a breath alcohol test would likely be negative.
1.5 Once a train driver has been appointed, the periodic medical examinations must include as a minimum the following elements:	Blood or urine tests to detect diabetes and other conditions as indicated by the clinical examination	I propose 'Blood and/or urine tests to detect ...'
1.9 A train driver must have an additional medical examination:	the driver has been involved in an occupational accident or any period of absence following an accident involving other people;	would this include a non-occupational accident, say RTA, and if so, could this be clarified please?
1.10 If a train driver passes a medical examination before it is due but that examination is		this would likely require in practice a different approach to fit certification, where the full

limited only to some elements of the periodic medical examination, then the date of the next periodic medical examination remains three years (or one year if the driver is 55 or older) from date of the last full periodic medical examination. A complete periodic medical examination must be passed at the required frequency to ensure that all the conditions for holding a licence are still being met.		TDLCR medical review date is clearly differentiated from an earlier review date for another reason. In my experience TOCs' recall systems are currently not sophisticated enough to make that differentiation, unless this is made more explicit in the guidance.
1.13 Employers must apply legal provisions protecting pregnant train drivers		Provide a link or reference to the duties under the management regulations for pregnant and breastfeeding women
1.18 We strongly recommend that medical examinations are carried out in accordance with Safe Effective Quality Occupational Health Standards (SEQOHS) which are available at:		This comment could, in practice, disqualify any sole practitioner providing registered doctor services of a high quality, due to substantial costs and effort required to obtain the SEQOHS accreditation. 'Encourage' for larger TOCs would seem more appropriate, especially since it is debatable what improvements in quality SEQOHS could bring to a high quality sole occupational (accredited specialist) practitioner. (may be relevant for heritage railways)
1.23 The doctor and any other clinician who may have contributed to the medical examination should record the actual test results against each element ready for the final review by the recognised doctor. If there are differences in clinical opinion following an examination these should be discussed and a final decision on the driver's fitness should be		it is my understanding that it is common practice among OH services to let nurses conduct repeat (not new entrant) examinations against a pass or fail protocol and sign off on the results. Does the definition of 'any other clinician' cover this practice when an ORR registered physician is always available to provide advice in case of suspected/potential fail?

reached by the recognised doctor before the outcome of the examination is communicated to the employer		
1.24 Ultimately, it is for the train operator to decide and communicate to the driver whether they are fit to drive trains taking into account the outcome of the medical examination		see my comment above about the sophistication with which TOCs and drivers track our recommendations. Could you make it more explicit that the need for ongoing review/investigations sooner than the full TDLCR fitness examination is in essence a 'conditionally fit F2' certificate. Example: recommendation for annual cardiac investigations (echo, ETT) frequently ignored.
2.3 a recognised doctor considers that the driver should undergo occupational psychological fitness examination;		I believe this is a very important and useful statement, considering that there is mounting evidence that, for instance, diabetes/hyperglycaemia and/or retinopathy are significant risk factors for (acute and chronic) cognitive impairment. Medication could also cause cognitive impairment Some further guidance would be welcome.
2.6 Occupational psychological fitness examinations must be conducted by a recognised psychologist who is on our register. The psychologist may be qualified to only carry out written tests or be qualified to carry out all the multimodal tests. Our register shows which type of test a psychologist may carry out.		what about the qualifications and registration state of psychologists that treat drivers subsequent incidents/trauma and/or psychological illness and provide the TOC with a view on fitness for work? Do they need to be registered to do that independently or is such a fitness decision ultimately the decision of the ORRDoc?

3.4 We are looking to develop audit arrangements in respect of the medical examination and are considering how these can be established		very welcome development. However, would you also be willing to make suggestions for the production of annual reports to TOCs that would provide a more holistic view on the service provided, the perceived health of the workforce and any health or safety improvements/recommendations the OH provider wishes to make. The greatest challenge I perceive is to move beyond individual fitness for work and sickness absence assessments and actually promote a more active approach from the TOCs. Us ultimately removing drivers who weigh over 170 Kg or who have multiple morbidity and medication incompatible with safe driving from the footplate seems a bit late. In addition, such annual reports could inform the inspectorate as well about more structural issues that have been identified.

By e-mail

1 Questions to the ORR

1.1 Guide for train operators

Question 1, Clause 9 Bullet point 4

Please can you provide clarification on what the criteria is for keeping the ORR informed of the changes to the drivers competence and fitness where they are relevant to the continuing validity of the licence. For example what medical condition constitute to this and in reference to competence will this be when a driver signs off one route as not competent, the whole route or fails an assessment that requires more training .

Question 2, Clause 9 Bullet point 6

Due to all of this information being contained electronically within our online database and the information being available to retrieve upon request, MTR would like this to be the means of providing this information rather than keeping a physical register updated, would this be acceptable?

Question 3, Clause 1.3/1.4

Can the ORR clarify how these checks should take place and what is the minimum qualifications required, or is sufficient that someone declares that have received a minimum of 9 years education?

Question 4 Clause 1.12 and 1.19

Can the ORR please clarify if the acceptable way that a driver can demonstrate to an ORR inspector should they leave their licence at home or misplace it? Could this be an electronic copy, a number the ORR inspector can call or recite the licence number to the ORR inspector to check?

Question 5 Clause 2.3

MTR would like to know the relevance of someone changing their gender to the EU licence regulations, and would like this to be removed from the requirements

Question 6 Clause 2.3 Bullet 6

Can the ORR clarify that that clause 2.3 bullet 3 is relevant and why we would need to inform them when a medical has taken place, for the ORR to tell us of the date of the next medical examination, when the ORR appointed doctor has issued the TOC and driver with a periodical medical certificate that has an expiry date stated.

Question 7 Clause 2.3 Bullet 4

Can the ORR clarify if the requirement in Clause 2.3 bullet 4, will the ORR issue a replacement licence in the example where a driver does not have prescription glasses but now does require them?

Question 8 Clause 4.6

Can the ORR clarify that they will accept the Psychometric assessment results as the language requirement, and that the ongoing CMS assessments will be acceptable?

Question 9 Clause 4.29

Within the Guide to training and examination requirements section 4.1 bullet 2, MTR would like clarity of the wording, Does this mean that the minimum experience required for a certifying assessor is 4 years?

1.2 Medical Examinations

Question 10 Clause 1, point 1.4

I would like to know the minimum they have listed for a pre-employment medical examination are registered OH doctors aware of this as I don't believe we are carrying out the minimum requirements of the medical as per ORR. Why does the Dr. carrying out the assessment need to do a cognitive test, communication tests and psychomotor test?

Question 11 Clause 1, point 1.9

A train driver must have an additional medical examination if a train driver has been on sick leave for a least 30 days.
Would this just be an OH referral /review appointment with an OH Dr?

Question 12 Clause 1, point 1.21

Does the examination certificate have to be in this format as we are currently not getting it in this format. If so is this communicated to ORR registered Drs?

Kind Regards

Rob

Rob Mawby
Head of Driver Training Strategy

mtr crossrail

By e-mail

Hello Sue,

I have reviewed the documentation that has been sent through as part of the consultation into updating and simplifying the guidance regarding Train Driver Licenses and the new suite of four guides to replace the old single guidance document.

The new format of individual guides is preferable to the old format of one guide covering all aspects of TDLCR and allows individuals with different duties under the TDLCR to find the information they require more quickly.

The guides are easy to read and provide the requisite information for us as Duty Holders to manage the TDLCR process.

Many Thanks

Paul

Paul Bennett
Head of Operational Standards

By e-mail

Sue

Please find attached comments from and on behalf of RPS OH.

We hope these are of help and would iterate the comment that RPS OH is amenable in principal to providing further input if that would be of assistance.

Regards

Paul Baker

Comments in response to ORR draft document Train Driving Licences and Certificates Regulations 2010: A guide to the medical and occupational psychological fitness requirements, February 2019.

Provided by and on behalf of RPS Occupational Health:-
Dr Ray Quinlan Chief Medical Officer
Dr Sally Roblin Consultant Occupational Physician
Dr Paul Baker Consultant Occupational Physician

RPS OH is agreeable in principal to supporting availability of one of its ORR registered doctors in order to provide further input such as discussion of review of text if that would be of help.
We welcome the document and the opportunity to offer comment. Medical standards and correct implementation of them are vital but have tended to be somewhat overlooked by the Railway Industry in this Century. Such documentation has many benefits including that it facilitates Train Operating Companies (TOCs) being more informed purchasers of OH provision that is both cost effective and of the necessary quality.
We hope our comments are of assistance to ORR in drafting the document.

General
We would strongly encourage ORR to consider use of the term Medical “ASSESSMENT” throughout the document as the umbrella term for the overall process.
This would allow for clarity of understanding. EG especially par 1.10 where it would help to provide distinction between the medical assessment process and its components of medical examination. Para 1.11 does use term assessment to some extent and that provides clarity.
The term medical examination would then be used for that and that alone – IE doctor examining someone either by means of physical examination or specific medical test (e.g. audiogram)
It would recognise that much of the assessment (and indeed decisions re fitness for work) has to be made on basis of medical history (symptoms reported by train driver) in absence of any specific examination findings. EG Ischaemic heart disease may have significant symptoms but NO abnormal findings in the routine periodic assessment.
(With an MS word version one could do a replace action of the whole document and then go back and just use “examination” as above.)

Summary and then wherever else occurs
We suggest consideration of NOT using the term “pass the medical” but rather something such as “meets the fitness requirements”. We think that at the cost of one more word this would

create a more conducive milieu for all concerned and would fit better with present employment practices and related legal requirements.

Para 1.2

We welcome this clarification. Perhaps it could be simplified by stating “must take place no later than day of 56th birthday”.

This could then be shown very simply in table Age	Expiry date
Less than 53	3 years from date of periodic
53-54	Date of 56th Birthday
55 or greater	1 year from date of periodic

Para 1.4 and 1.5

We suggest that the document would be strengthened by ORR setting out specifically the requirement to check that glasses prescription is within specified parameters. To be candid, it is apparent that this is omitted by at least some (if not most) OH providers, despite it being absolutely clear in the schedule which is almost a decade old now. There is a very similar requirement for HGV driving licence D4 medicals; the licence is not issued if this has not been done. Surely that should be the same for train drivers.

Para 1.7

We would recommend that ORR specifies that the general medical examination should include Mental State Examination.

This para states that Doctors may include other elements. We agree but would suggest that ORR should be unequivocal. Clearly, examination of heart, chest etc. must be carried out by a medical practitioner; no nurse or OH technician would be qualified to do so. This is mentioned here because it provides context for other paragraphs regarding who is qualified to conduct the various elements of the assessment.

We would suggest that the text in current 1.7 would be greatly improved if it encompassed two paragraphs; the second would start from “recognised doctors ….”.

In addition, we would suggest that this would be an opportunity to set out a fundamental aspect of such assessments, which we would describe thus:-

Assessment of fitness for train driving, in effect consists of determining fitness for two components

1 Driving of the train (in cab) itself and being able to access /egress cab from track level. (The later entails what is tantamount to ladder climbing and so the train driver must be physically capable of doing that and maintaining 3-point contact.)

2 Carrying out Emergency Train protection and other tasks in emergency situations. This may include full ballast walk and assisting passengers to evacuate a train.

Para 1.8

The term “likely” in this aspect has been used with no proper definition by the Railway Industry for decades. That creates the potential for inconsistency of application.

Network Rail in the most recent revision of its medical standards (2017) specified a benchmark. We would encourage ORR to specify a benchmark and we think that DVLA group 2 standards would be a useful benchmark because

1 They are evidence based

2 They are continually reviewed
3 They are freely accessible
4 Occupational Physicians are familiar with them
5 In practice most OHPs have applied this approach for many years.
Of course, there should be a caveat that there is a need for clinical discretion in order to apply them for a different task driving but again OHPs are familiar with that (EG The concept of Group 2 “light” for police response drivers on blue light)

Para 1.9
Sick leave – does this mean 30 consecutive days? Sometimes 30 days absence can be accumulated within a year from multiple periods of absence.

Para 1.12
We would suggest that (as for any employer) if the TOC considers that the driver is not fit for train driving duties then they **must** remove them from such duties immediately pending appropriate medical assessment.

Para 1.15
This seems to be incorrect as drafted.
Para 1.7 confirms (correctly) that there are elements of examination that can only be conducted by a medical practitioner (doctor). Some (probably most) of the assessment can and in practice is usually delegated to a nurse (esp. audio, vision testing etc.) But given what ORR has stated in para 1.7 (with which we agree) then para 1.15 needs to state that a nurse can carry out some / many elements of the assessment but the general medical examination **must** be conducted by a medical practitioner (doctor). In turn, the complete assessment process (with all its elements of examination) must be under supervision of an ORR recognised doctor.

Para 1.16
Possible simplification of text
All medical certificates must be signed by an ORR recognised doctor, including ORR register number.

Para 1.20 and Para 1.21
Such a system may be custom and practice but it is important to understand its origin and the potential difficulties (particularly of the F2 category) when used against a background of 21st century employment practices and disability legislation.

The system is nearly one hundred years old having been derived (approx. 1930s) from that used in the British Army in the first half of the 20th century. It was consolidated in second half of 20th century during the time of British Rail but prior to the inception of UK disability legislation – in particular, Disability Discrimination Act (DDA) 1995, subsequently subsumed within The Equality Act 2010. The system has never been properly reviewed or changed nearly 25 years on since the first (and probably most fundamental) of these legislative changes. Whilst ORR’s focus is health and safety it must recognise that OH practitioners (and employers) have to work in accordance with employment and disability legislation. Hence, the later must be taken into account in this type of situation where there is in practice considerable overlap between imperatives of Health and Safety Law and other legislative requirements.

Given the above it can be understood that the system arose from a command and control structure of engagement of individuals and solely in regard of fitness for role (whether soldier or

train driver). It did not (and did not need to) encompass consideration of adjustments in order to try to maintain employees at work if that could be accommodated.

This is then problematic for post DDA OH provision in regard of F2 classification.
Pre DDA – certificate was only about role of train driver and so F2 meant that the driver could continue to drive subject to some form of restriction.

However, if a driver was not fit for train driving even with some restriction then he was U1. This was unambiguous.

Post DDA – OH provider has two aspects to consider
Fitness for role - so if not able to carry out all normal duties then should be U1.
Fitness for work (with adjustments) – following DDA coming into force, it would be potential discrimination to indicate U1 unless the driver is truly not fit to be at work in any capacity.
Hence, OH providers tend to use F2 even when the driver does not meet the standard and is not fit to drive trains because OH is required to advise on adjustments and that is usually something such as “fit for any non-safety critical duties” (i.e. in effect alternative duties to train driving).

Hence, in practice OH practitioners feel obliged to use F2 even though more often the train driver is not fit for train driving at all.
The difficulties that this causes include (and ORR may want to seek a view from TOC senior operational managers)

1 The train driver is certified F2 and so is considered fit for work – even though he cannot drive a train.

2 The train driver continues to be at work on normal pay unless driver manager authorises him to be away and he agrees to that

3 In practice only very few train drivers can be deployed to alternative duties (the only common exceptions being driver managers and Union Reps)

4 The train driver spends all of his shift sitting in the mess room (or equivalent).

5 This is unhealthy for the train driver – sat down all day etc.

6 It can cause friction within the workplace because it is very apparent to those working their shifts that others are sitting in the mess being paid a full salary.

The problem is compounded by TOCs requesting certificates with element of general health recorded by rather nebulous terms such as satisfactory or unsatisfactory.
The solution (assuming ORR wants to keep the categorisation system) is simple but it requires ORR to specify it. It should be made clear that these medical certificates are ONLY certification as to whether a train driver meets the defined medical standard (medical fitness) for the role of train driver. The certificate DOES NOT encompass any opinion or advice about medical capability to perform alternative duties. This would then be analogous to OGUK and MCA fitness certificates, which are only in regard of fitness to work offshore and at sea respectively. If someone does not meet the medical standard to work off shore or at sea then the certificate states that. Any assessment of fitness for alternative duties is separate (most usually via OH referral).

This would then require a classification something like (see comments re 1.7 above for context)
F1 – Meets standard in full. (Fully fit for all train driving duties including emergency train protection).

F2 – Does not fully meet the standard but can continue train driving subject to accommodation of adjustments (which would be specified on certificate)
U1 – Does not meet the standard (Driver not fit for driving duties and this cannot be overcome by adjustments). Temporary.
U2 – As for U1 but permanent.

So, F2 might encompass a return to work following illness on reduced (phased) hours. But if the train driver is not medically fit to carry out train protection then he does not meet the standard and would be certified U1. (It would not be reasonable for double crewing solely to provide cover for train protection duties).

This would then be more consistent with the Network Rail system for track workers for which level 1 can only apply if the person meets the standard in full. Similarly, F1 can only apply if someone meets the standard in full. If standard is not met, then F1 should not apply. As many OH practitioners carry out assessments in relation to both Network Rail standards and Train Driving standards such consistency would be advantageous.

If ORR were to specify as above, then there would be many benefits including:

1 The system would have been updated in regard of present-day disability legislation and OH practice
2 It would provide clarity and OH practitioners would be able to act without having to balance potential conflict from different aspects (such as H&S, employment law, disability legislation etc.)
3 The categorisations F2 and U1 would be clear and would be used more accurately
4 That would allow for meaningful data which if collated would inform the health agenda and help determine relevant strategy and deployment of resource.

By e-mail

Section	Comment
Pg. 6. Pre-appointment medical examination	It needs to be considered whether a mental health and cognitive impairment/dementia (N.B. re-licencing) screening tool is included here
Periodic medical examinations after appointment	Mental health and dementia screen if clinically indicated
Train drivers must also not be suffering from any medical conditions, or be taking any medication, drugs or substances which are likely to cause either…	How will this be assessed? SSRIs may impact something people's cognition but certainly not everybody's. Impact of medication needs to be assessed on a case by case basis. Can the ORR provide guidance of a period of stabilisation on new medication and determining after this period any impacts on cognition etc.
1.9 A train driver must have an additional medical examination: □ after an occupational accident or absence following an accident	Would this include a SPAD? Needs clarification of definition and what is included
Who can carry out medical examinations?	There needs to be consideration of who carries our thorough mental health and dementia assessments where required. This would need to be a clinical practitioner with a specialist mental health/older adult background, i.e. a psychiatrist or clinical psychologist.
What equipment and facilities should be used for medical examinations?	For mental health and dementia assessments, consideration needs to be given to what validated instruments could be used
What information should be recorded in a medical examination?	How are assessments that require follow-up and repeat appointments managed/recorded? (e.g. in the case of stabilisation on medication, or undertaking a comprehensive cognitive assessment)

What is tested under the occupational psychological fitness examination?	It may need to be clarified here that the tests related to memory and learning are occupational tests rather than clinical tests. Their utility is not for the assessment of clinical cognitive decline.
What is tested under the occupational psychological fitness examination?	How are occupational psychological results communicated to OH? This should be approached through a collaborative multidisciplinary framework
Recognition process for doctors and psychologists wanting to carry out examinations under the TDLCR	There needs to be criteria for those conducting clinical mental health or dementia assessments
What are the criteria for recognition of psychologists?	Where the term 'psychologist' is used, it needs to be clarified where this refers to 'occupational psychologist' (as it does throughout the current document)
Understanding of the specific nature of work of a train driver on the railway and the railway environment (demonstrated either through employment at an examination centre which has passed the external audit and understanding of train competency framework or demonstrated through suitability for carrying out testing for train driver recruitment as well as knowledge of train driver competency framework);	There should be a industry-approved course for this with assessment of competence and periodical reassessment

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southeastern

Train Driver Licences and Certificate Regulation 2010 - Consultation Southeastern Feedback

Guide for train operators
Southeastern are supportive of the changes to this document, the separation of information on training, examination and medical requirements makes it much easier to navigate through.

Key facts leaflet for train drivers
Southeastern welcome the production of information by the ORR aimed directly at drivers. This will help address some of the concerns and clarifications that have been raised by drivers during the initial period of licencing.

Guide to the medical and occupational psychological fitness requirements
Southeastern have no comments or objections to the contents of this document.

Guide to Training and Examination Requirements
This document is much, much improved from what currently exists. Feedback points are:

- There's a need to turn bullet points into numbered points for ease of reference. See 3.1, 4.1, 5.5, 5.7, 5.9, and 5.11
- 2.16 formatting issue (colour) "on to the register."
- 2.2 they need to find a different way to incorporate the text bubble comment on Regs 30 & 31.
- 3.1.2 needs to be split into two separate bullet points.
- 3.1.3 needs to be split into two separate bullet points.
- 3.1.7 what would equate to a 'valid certificate'? Can we just create and issue (we kind of already do)?
- 4.1.4[i] I assume the apprenticeship requirements on functional skills meets this.

The clause relating to barring of a trainer/assessor training and assessing the same individual appears to have been removed. Is this the case or is it covered by other impartiality clauses. This requirement is still present in the European Commission Decision (Chapter 4, Article 9 [d]).

In relation to European Commission Decision;
- Chapter 1, Article 6 raises a pertinent point around new lines and stock. Some level of commentary may be helpful to be added into the TDLCR Guide to training and examination reqs on this.

There's something about the years of experience required for examiners, which could affect driver instructors, Trainer/Assessors and driver managers. TDLCR 4.1.2 years' experience does not align (although not too significantly) with years required in 3.1.6 for 'trainers'. The ECD echoes this; Chapter 1, Article 4, 2.[c] vs. Chapter 3, Article 8, Point 2, Paragraph 2.

We are not sure of the point of having two different requirements and there is a thread of concern around age discrimination – i.e. it's realistically impossible to become a driver manager until age 26 at present.

Thank you for the consultation opportunity. I attach the draft consultation with my annotated comments. I've underlined some typos to help ensure they're not missed in the final version. The comments are reproduced below. I look forward to your feedback on these.
Best wishes,

Lanre

Heading	Section	Comment
1.4 Under TDLCR Schedule 1 the pre-appointment medical examination must include as a minimum the following elements:		1.4…I think a stronger statement may be required regarding responsibility to ensure cognitive, communication and psychomotor tests have taken place. I.e. Does the recognised doctor have to be reassured that this is catered for before certifying - in which case he will be within his rights to ask to see reports from occupational psychologist before certification?
1.7 General medical examination is a clinical examination that includes, as a minimum, examination of the heart, chest, musculoskeletal system and nervous system. Doctors may include other elements as part of the examination if they consider it is necessary to do so to assess whether the train driver will pass the medical examination requirements. The purpose of the examination is to assess the driver's medical fitness to carry out train driver duties.		I strongly support 1.7. Some providers use non-doctors as medical assessors and do not insist on a medical examination but base medical involvement on health declaration and presence of findings on OHT/OHNA routine tests This should discourage that practice. As I expect they could not justify having undertaken an examination of heart & chest without a proper physical examination. I would go further to say that an absence of symptoms on questionnaire is insufficient to fulfil this criteria. & ECG and Spirometry alone

Recognised doctors are required to have knowledge of railway operations so that they understand the physical requirements of a driver's role, including the functions they may have to carry out during an emergency situation, and are able to assess a driver's fitness accordingly.		are insufficient to conclude that the heart and chest have been examined. This should help ensure a good standard across the industry and help avoid cost cutting induced risks.
1.15 A medical assessor (this may be a nurse or a doctor who is not on our register) may carry out medical examinations **but they must be under the supervision of a recognised doctor.** A medical assessor in this case may not be located in the same place as the recognised doctor, but we expect the medical assessor to have suitable access to the recognised doctor for advice, interpretation and medical opinion during examination of the train driver. Medical assessors must also have suitable experience and qualifications to carry out the examination.		1.15 Is there a need to define acceptable suitable experience and qualifications?
1.21 Under current industry practice, the doctor records the conclusion of the examination using one of the following categories:		1.21. It may be helpful to expand that the categories are with reference to driving duties only. Some TOCs appear to require at least F2 certification to allow drivers to alternative duties & this can be a challenge with U1

		certification and rehabilitation back to work.
2.3 A train driver's occupational psychological fitness will not usually be re-assessed once a train driving licence has been issued. However a train driver may need to have an additional occupational psychological fitness examination (or parts of such an examination) where the employer considers to it necessary to check the driver still meets the conditions for holding a licence.		2.3…or any period of absence following an accident involving…. This could be interpreted as any RTA etc. whether or not the driver was driving. Is that the intention?
2.6 Occupational psychological fitness examinations must be conducted by a recognised psychologist who is on our register. The psychologist may be qualified to only carry out written tests or be qualified to carry out all the multimodal tests. Our register shows which type of test a psychologist may carry out.		2.6..My experience of the register when looking for recognised psychologists on the register was not encouraging. Main problems encountered were: 1) sometimes the listed person is not the psychologist but a firm/or other responsible for employing the psychologist or working with the psychologist 2) Most of the psychologists work with the largest provider of these assessments and when an outcome is challenged difficult to find a truly independent alternative recognised psychologist to provide a second opinion [scenario that I was faced with]. This was while back so maybe register has been updated and 1) is no longer a problem.
4.1 All applications for recognition must demonstrate		4.1…Registration alone is insufficient, they doctor must have a license to practice

independence, competence and impartiality. The criteria used to test this are as follows;		and be in good standing with GMC, and any other relevant body [FOM] etc.
4.1	Registered medical practitioner with the General Medical Council;	4.1… May be worth specifying level of qualification. A diploma in occupational medicine by itself may be judged insufficient to be a recognised doctor with the potential for clinical governance responsibility and for supervising medical assessors.
4.1	An understanding of all the duties of a train driver and experience of work in a railway environment;	4.1 "….an understanding…." Is there any plan for specifying an applicable standard for how it will be ascertained that this criteria is met… e.g. knowledge tests and minimum period of supervised work in railway environment?

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