Royal College of Physicians

Setting higher standards

Royal College of Physicians Parliamentary Briefing

Medical workforce: New Deal and European Working Time Directive

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 27,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

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Summary

Doctors' working patterns have been significantly affected and working hours considerably reduced by both the European Working Time Directive (EWTD) and the New Deal for junior doctors. Although the RCP supports the aim of preventing doctors working excessively long hours, there has been an unintended increase in staffing pressures and other consequences that need to be addressed. The RCP is calling for greater flexibility of application of both the EWTD and New Deal as a solution to these problems.

Background

The EWTD was introduced in 1993 with the aim of regulating the amount of time spent at work in order to protect the health and safety of the European workforce. Two subsequent judgments in the European Court of Justice have had profound effects on junior doctors in particular. The SIMAP judgment in 2000 defined all the time that the worker is required to be present on site as actual working hours for the purposes of work and rest calculations. The Jaeger judgment in 2003 confirmed that the above should hold even if the worker is allowed to sleep when their services on site are not required. EWTD applies to all hospital doctors and has done so for consultants since 1998, but the full implementation of regulation has been staggered for junior doctors.

The New Deal was introduced in 1991 with the aim of improving the working lives of junior doctors and is applicable to England. It limits junior doctor's hours to an average 56 hours per week. These were limited further by EWTD to the current 48 hours in August 2009. Junior doctors are also entitled to a minimum rest period of 11 consecutive hours in every 24, as well as a rest break during working time if they are on duty for longer than six hours. They are also entitled to a minimum uninterrupted rest period of 24 hours in every seven days.

Individual doctors can voluntarily opt out of the EWTD's 48 hour week (while maintaining their rest entitlements) but are currently limited by the more restrictive New Deal to a 56 hour week.

The consequences of the New Deal and EWTD

The application of the New Deal and EWTD has resulted in increased staffing pressures, which has implications for the training of junior doctors and the actuate a consultant-delivered service. The RCP is calling for more flexibility in application of the New Deal and EWTD. The negative consequences of the restrictions in working time are discussed in more detail below.

Training: The training time for junior doctors with senior consultants has been reduced. Application of EWTD and the New Deal has resulted in more rota gaps, which are often left to junior doctors to fill. Therefore many trainee doctors are working much of their time at night and unsupervised, missing out on crucial learning opportunities with more senior colleagues. This may result in the need for prolongation of training for some individuals. This has significant potential implications for future patient care.

Consultant-delivered service: Similarly, there is insufficient out of hours consultant cover. This is particularly problematic for small district general hospitals providing acute services. A survey by the RCP in October 2010 found that only 3% of hospitals provided weekend cover from consultant physicians specialising in acute medicine for 9 – 12 hours and none for over 12 hours. Nearly three-quarters of hospitals in the survey had no cover from consultant physicians specialising in acute medicine over the

weekend.[1] Patients are therefore not receiving the best care in hospitals in the evenings and at weekends. The RCP recommends that any hospital admitting acutely ill patients should have a consultant physician on-site for at least 12 hours per day, seven days a week, who should have no other duties scheduled during this time. All medical wards should have a daily visit from a consultant; in most hospitals this will involve more than one physician.

Cancellation of services: Many consultants take part in on-call rotas for their specialities and are required to attend out-of-hours to provide emergency procedures, for example endoscopy in gastrointestional bleeding. These rotas are typically on top of a normal working day. To comply with EWTD, compensatory rest has to be taken the following morning, which results in the cancelation of clinics and outpatient or inpatient procedure lists. Cancellation of these lists adversely affects patient care, both by delaying the consultation between patient and doctor as well as necessitating re-appointment. Frequently, these cancellations are at short notice so that patients have either undergone unnecessary preparation for their procedures or taken time off work to attend outpatient clinics. Greater flexibility in taking compensatory rest would ease this problem.

Team working: Team working among medical staff has also been damaged by the restrictions on working time. Traditionally, patient care and experiential training for medical staff was delivered through a strong medical team structure. Periods of rotation for junior staff have been shortened resulting in briefer involvement in individual hospital teams. Continuity of care for patients is therefore reduced. This has increased the need for handovers. Handover, particularly of temporary 'on-call' responsibility, has been identified as a point that errors are likely to occur. Failure in handover is a major preventable cause of patient harm, and is principally due to the human factors or poor communication and systematic error. These can lead to inefficiencies, repetition, delayed decisions, repeated investigations, incorrect diagnoses, incorrect treatment and poor communication with the patient.

The RCP has recently published a toolkit that makes recommendations to improve handover, including standardising the process, defining leadership responsibility, include a risk assessment and be monitored and evaluated. The toolkit can be downloaded from the RCP's website.

Poor working patterns for junior doctors: There is some evidence that the New Deal and EWTD, although has reduced working time particularly for junior doctors, has also led to more disruptive working patterns. As a result of the SIMAP ruling, most trainees are now employed on full shift rotas. This has made it difficult for teams to be on duty at the same time, and has eroded team working culture. This has resulted in increased disruption to sleeping patterns, job dissatisfaction and sickness rates among junior doctors.[2] For example, the sickness rate in second-year trainees (foundation year 2) on full shift rotas in the medical specialties in 2009 was 3.5%. Previously, when resident on-call rotas were in place this was 0.8%.

The RCP's recommendations

The RCP does not want a return to long-hour working cultures for junior doctors. Patient safety must be the priority: over tired doctors are more likely to make mistakes. Furthermore, all doctors should enjoy a healthy work/life balance. However, the application of the New Deal and EWTD has lead to staffing pressures and negative consequences for both patients and doctors. Our recommendations are below.

[1] RCP (2010) National Survey of Medical Admissions

[2] Goddard A, Hodgson H, and Newbery N, (2010) Impact of EWTD on patient: doctor rations and working practices for junior doctors in England and Wales 2009 Clinical Medicine Vol 10, No 4: 1-6

The application of EWTD and the New Deal should be more flexible.

- The definition of 'on-call' work is too restrictive and the requirement for 'compensatory rest' to be taken 'immediately' does not adequately ensure good continuity of care alongside its aim of protecting doctors' health. Relaxation of the timing of compensatory rest to be taken within the next 48 hours rather than before the next work period would have particular benefits to patient care.
- Prior to the SIMAP ruling, trainee doctors were able to sleep 'on site' and thus be available for occasional emergencies as needed. This usually kept total working hours less that 48 per week as well as complying with the New Deal. The RCP would like the ruling reversed.
- Local flexibility in application of restrictions on working times is essential. The needs for staff cover in a rural district general hospital are very different from a large urban centre. Trust should be able to apply working restrictions in a way that is suitable to their locality.
- Individual opt out from EWTD should be maintained.

Hospitals also have a role in improving the working experience of junior doctors.

- Where possible hospitals should organise rotas to encourage consistent team membership. Team working should be fostered and encouraged throughout the hospital.
- RCP would like hospitals to increase the length of time to minimum of 6 months for junior doctor attachments to specialties and departments during training rotations.
- Hospitals should implement the tools that the RCP have developed to ease the negative consequences of restrictions on doctors' working patterns, such as improved handover.

The Department of Health and NHS should conduct a review of the medical workforce.

- The NHS should move increasingly to a consultant delivered service. We believe that any hospital admitting acutely ill patients should have a consultant physician on-site for at least 12 hours per day, seven days a week, who should have no other duties scheduled during this time. All medical wards should have a daily visit from a consultant; in most hospitals this will involve more than one physician. This would incur greater staff costs to deliver, however. Achievement would require more hospital rationalisation. Plans for reconfiguring services should consider the need to develop a consultant led service. This needs to be considered in the context of meeting the current 4% to 6.5% efficiency savings.[3]
- There should be a national review of medical workforce planning. The Department of Health needs to plan for a consultant delivered service, determine how many doctors it is necessary to train to achieve this and develop a plan for how to achieve this.

The patient's view

The RCP's Patient and Carer Network is in support of the RCP and its beliefs that the inflexibility of the current directive urgently needs to be addressed, as well as its interaction with national pay and working constraints contained in the New Deal policy. The PCN welcomes the support tools being developed by the RCP (eg standards for handover, medical records, prescription charts) and also feel strongly that an increase in consultant-delivered care that ensures on-the-job training opportunities for junior doctors will provide the basis for improved care for patients for the long term.

[3] Monitor target for 2011-2012, April 2011

Actions for parliamentarians

The RCP would like parliamentarians to support our call to make the application of EWTD and the New Deal more flexible. In particular the RCP is calling for parliamentarians to:

- Write to health ministers calling on them to renegotiate the New Deal so that application is more flexible, as per RCP's recommendations above.
- Urge their MEP colleagues to create more flexibility in the application of the EWTD. A revised proposal for the EWTD is expected before the European Parliament next spring. The RCP is working hard in Brussels to maximise this opportunity to improve the Directive.
- The RCP would also encourage parliamentarians to contact trusts in their constituency to encourage the use of the RCP's tools developed to ease workforce pressures to hospitals. The handover toolkit is the first in a series of acute care toolkits aimed at tackling the difficulties providing high-quality service and training within the constraints of the shorter working hours. Future planned toolkits include the role of the acute physician and the roles and responsibilities of trainees in acute medicine. The handover toolkit and accompanying guidance can be downloaded from RCP's website. Once published, the future planned toolkits will also be available here.

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