Royal College of Physicians

Response to call for evidence on implementation of the European Working Time Directive

22 November 2013

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 28,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high quality care for patients.

The RCP welcomes the opportunity to respond to the call for evidence on implementation of the European Working Time Directive (EWTD). The following sets out our response to the call, drawing upon our own research in this area and intelligence gathered from RCP fellows and members.

RCP response to call for evidence

Our research strongly suggests that restrictions in working time introduced under the New Deal and the European Working Time Directive have resulted in staffing pressures, with implications for the delivery of patient care and the training of junior doctors. Our findings indicate, however, that the impact of these restrictions have diminished slightly in some aspects as organisations have made the necessary adaptations to job plans and staff have become more accustomed to new working patterns. Below we set out some of the adverse consequences associated with the application of the restrictions on working time as part of New Deal and EWTD.

Impact on patient care and experience

Cancellation of services

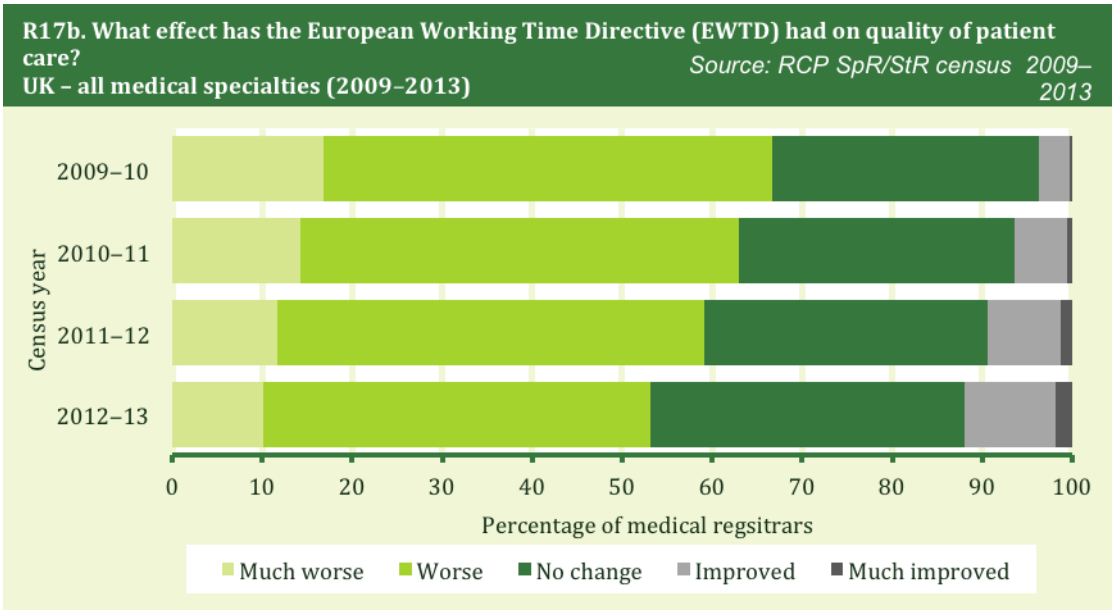
Many consultants take part in on-call rotas for their specialities and are required to attend out-of-hours to provide emergency procedures, for example endoscopy in gastrointestinal bleeding. These rotas are typically on top of a normal working day. To comply with EWTD, compensatory rest to make up for missed rest periods must be taken the following morning, which has resulted in clinics and outpatient or inpatient procedure lists being cancelled. Cancellations can have a potential detrimental effect on patient care as it delays vital consultations between patient and doctor, where diagnoses are made and new courses of treatment are determined. Furthermore, these cancellations tend to be at short notice so that patients have either undergone unnecessary preparation for their procedures, or have taken time off work to attend outpatient clinics.

Disruption to the continuity of care

The restrictions on working time have also had a significant effect on the continuity of patient care. The strict definition of 'on-call' work and the compensatory rest requirements mentioned above, have

led to disruptions in the continuity of care for patients. Handovers have increased as a result, with doctors finding themselves compelled to handover patients at crucial stages in the patient pathway. The patient safety implications of handovers are well documented, as these are a critical point where poor communication and errors can creep in leading to delayed decisions, wrong diagnoses, and incorrect treatment. The RCP has published a toolkit to improve handover, including standardising the process, defining leadership responsibility and carrying out risk assessments.

Furthermore, working time restrictions have led to the shortening of rotations for junior staff in hospital teams, where they not only gain vital experiential training, but also deliver essential patient care. Research taken from our Census of Medical Registrars, below, does suggest that the negative impact of EWTD on patient care has improved over years, however, over 50% of trainees in 2012-13 still felt that patient care was worse or much worse as a result of the restrictions in working time.



Issues around sickness cover

In the NHS, if a doctor calls in sick if it difficult to get other doctors on the rota to cover their shift as their rest requirements would be breached. This can have significant implications for patient care as it means having to use external locum doctors, who will be unfamiliar with the caseload and whose standards of care may be variable. If internal cover is arranged, this will stretch the resources of the teams asked to cover, which will clearly have implications for patient care.

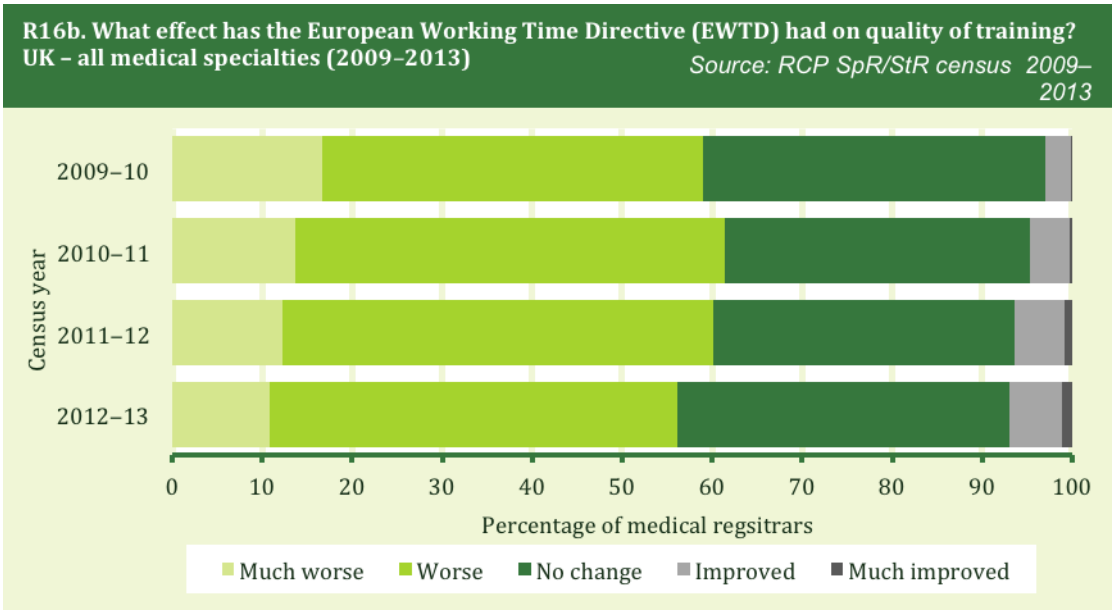
Effect on staffing levels at weekend

Out-of-hours consultant cover has also been affected, which is a particular issue for small district general hospitals providing acute services. RCP's National Survey of Medical Admissions in 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.

Impact on training of junior doctors

Working time restrictions have also reduced essential training time for junior doctors with senior consultants, particularly as junior doctors are often asked to fill in gaps in the rota. Medical trainees are therefore working much of their time at night and unsupervised, which means they are missing out on essential learning opportunities with more senior colleagues. For some this may lead to an unnecessary extension of their training period. This, of course, also has potential implications for future patient care. The below research taken from our Census of Medical Registrars, suggests that training is still a contentious area with almost 60% of trainees still believing that training was worse or much worse as a result of EWTD. This figure has remained fairly constant over the last four years.



Impact on working life for junior doctors

<u>Disruptive working patterns</u>

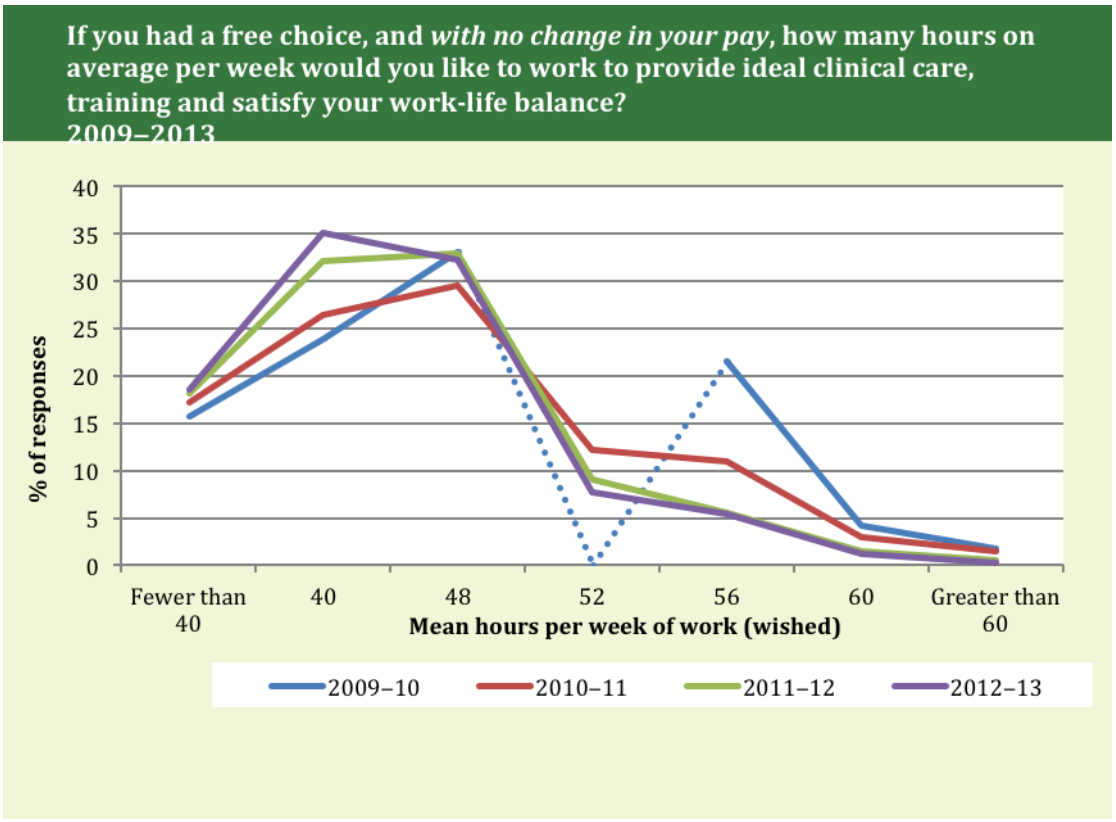
There is evidence that reductions in working time have led to more disruptive working patterns. Following the SIMAP ruling, major changes were made to how medical trainees are employed in hospitals, with most now employed on full shift rotas. These rotas have created significant disruption to working patterns for junior doctors, including disrupted sleeping patterns, job dissatisfaction and

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

sickness rates.[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%.

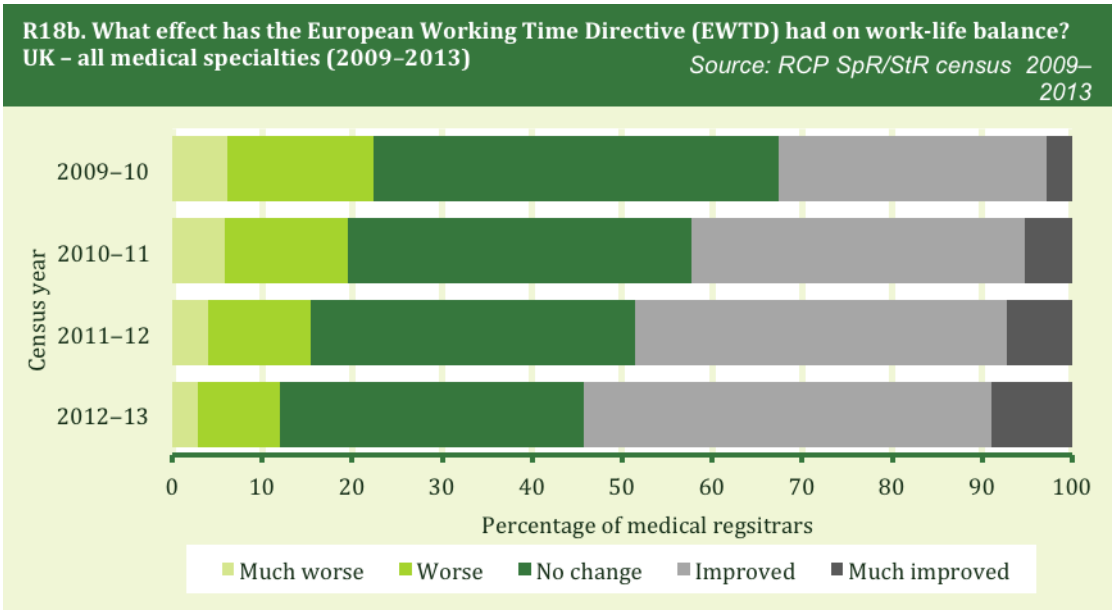
Working hours and work life balance for junior doctors

Over recent years there has been a consistent growth in medical registrars wanting to work less than 48 hours a week. For instance, the graph below taken from our Census of Medical Registrars from 2009-13, suggests that over 50% of medical registrars want to work less than 40 hours a week. There appears, therefore, to be little support amongst junior to work beyond EWTD working hours unless there is a substantial increase in remuneration.



Furthermore, the table below demonstrates that junior doctors believe that EWTD has brought about a marked improvement in their work-life balance, with 54% in 2012-13 believing that there work-life balance had improved as a result, compared to a third in 2009-10.

[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



RCP recommendations to mitigate the adverse impacts on working time restrictions

The RCP does not wish to see a return to long-hour working culture for junior doctors as over-tired doctors are more likely to make mistakes; we want all doctors to enjoy a healthy work/life balance. Hospitals have a duty to improve the working experience of junior doctors and we suggest the following measures to support this:

- where possible hospitals should organise rotas to encourage consistent team membership. Team working should be fostered and encouraged throughout the hospital.
- hospitals increase the length of time to minimum of 6 months for junior doctor attachments to specialties and departments during training rotations.
- we encourage hospitals to implement the tools developed to mitigate the negative impacts of restrictions on doctors' working patterns, such as RCP's toolkits to improve handover.

RCP position on New Deal and the EWTD

The RCP maintains that that the effects of the New Deal and the EWTD are so intertwined that changes to the former will undoubtedly have an impact on the latter. We make the following suggestions regarding the implementation of working time restrictions:

- local variation in the 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. Trusts should be able to apply working restrictions in a way that is suitable to their locality.
- voluntary opt out from EWTD by individuals should be maintained; individual junior doctors can opt to work more than a 48-hour week, but are contractually limited to a maximum of

56 hours. Entire departments, or groups of staff cannot opt out collectively, therefore it is not advisable to plan doctors' rotas on the assumption that every single member of the rota, now and in future, will make that choice.

Miguel Souto
Senior Policy Adviser
Royal College of Physicians
miguel.souto@rcplondon.ac.uk
Phone 020 3075 1215