

# WORKING TIME REGULATIONS AND THE NEW DEAL

## An opportunity for a new model of inpatient service?

Michael Bird, FRCA

The Working Time Directive (WTD) has now been applied to limit the hours worked by junior doctors. Can the University Hospitals of Morecambe Bay Trust (UHMBT) rise to the challenge of implementing this directive for consultant staff while maintaining clinical services and training? This summary of the WTD (see below) is taken from the Trust's newsletter, published as the *Weekly News*, and edited by Rachael Whitaker, whose contribution we acknowledge. The *Journal* has adapted the document to fit the consultant contract: is it achievable for consultants? The *Journal* asked Mike Bird, a member of the Local Negotiating Committee for Consultants.

### UHMBT's summary on WTD

- Staff should work no more than six days every seven, or twelve days every fourteen
- Staff must have the opportunity to take a 20-minute break – such as lunch or tea break – if they work for more than six hours in one go. This break cannot be taken at the beginning or end of a shift
- No staff should work more than an average of 48 hours per week, *averaged over a 17-week period*
- The average of a 48-hour maximum working week includes overtime, waiting list initiatives and on-call, and any hours worked for a different employer. It also includes work-related travel and training (supporting professional activity, 'SPA')
- A recovery period of at least 11 hours in every 24-hour period should be built into rotas
- The amount of compensatory rest given if this 11-hour period is compromised should equal the time lost from the 11-hour break
- Opting out of the WTD is discouraged by the Trust

## INTRODUCTION

This article is an overview of the issues facing acute trusts as a result of the conflicting demands of training and service within the constraints of working hours and available budgets. Some possible solutions are considered but it is impossible to be comprehensive within the brief of this journal. Some solutions are in place in UHMBT and other trusts. The views expressed are my own.

## WORK

The Working Time Regulations (WTR) are UK Health and Safety legislation<sup>(1)</sup> implementing the European Working Time Directive,<sup>(2)</sup> whilst the New Deal (ND) governs UK trainee doctors' contracts and pay.<sup>(3)</sup>

Working time is defined as:

- any period during which doctors are working, at their employers' disposal and carrying out their activity or duties
- any period during which they are receiving relevant training
- 'relevant training' means work experience provided pursuant to a training course or programme, training for employment, or both, other than work experience or training

Employees can work up to a maximum of 48 hours per week **on average**, unless an 'opt-out' waiver is agreed and signed. Minimum hours of continuous rest and intervening rest breaks are specified under both WTR and ND and are not subject to 'opt-out' waivers. WTR specifies that there must be an 11-hour continuous rest period in any 24-hour work period. The UK has derogated from such rest periods in the interest of service provision, but only in so far as compensatory rest is due to employees whose continuous rest period is disturbed by the employer's needs. Judgements in the European Courts have clarified that **all** time at the place of work at the employer's behest, whether resting or working, is working time,<sup>(4)</sup> and that compensatory rest must be taken before the next 24-hour work period.<sup>(5)</sup> Trainees are also due a 30-minute break after four hours work.

Most of our trainees work a resident, full-shift, on-call pattern (24/29 rotas). For all partial-shift and non-resident on-call patterns, the ND demands additional rest periods. If these requirements are broken then the work pattern is no longer compliant and is assigned Band 3 (100% rate) for contract and pay purposes. Band 3 also attracts the attention of the Deanery in respect of educational approval.

The North West Strategic Health Authority and Deanery have made it clear that they will not approve trainee posts unless they are compliant with WTR and ND directives

Non-training medical staff are not covered by the ND, but **all** staff, medical and non-medical, are covered by WTR. Non-training staff have traditionally worked non-resident on-call but busy specialties have yet to address rest periods and compensatory rest. It is important to realise, however, that these regulations were introduced as instruments to improve health and safety, and employers have to consider the implications for staff and patient safety of ignoring them.

## TRAINING

All trainee doctors' posts must have educational approval from the local Deanery. The Deanery is guided on the educational content of a post by the Royal Colleges through the Postgraduate Medical Education and Training Board (PMETB). The specialities have their own individual requirements. If posts do not meet the training needs then the Deanery can remove educational approval and funding from the posts. Clearly this could seriously impact on service provision.

## SERVICE

All doctors, in training or not, are contracted to provide a service to the Trust. This service covers all aspects of patient care, scheduled and unscheduled, for 24 hours a day, seven days a week; it must also be provided to professionally and contractually acceptable standards and within a budget.

## THE CHALLENGE

The challenge is to balance the equation:

$$(training\ hours + service\ hours) - leave = 48\ work\ hours\ per\ week$$

Training and service are not incompatible and may well coincide but the distinction lies in the level of supervision and its immediacy.

The 2007 National Confidential Enquiry into Perioperative Deaths (NCEPOD) report on Emergency Admissions summarised most of the issues:<sup>(6)</sup>

- it is important that trainees have sufficient skills to recognise sick patients. Consultants retain overall clinical responsibility of their patients, and they must ensure duties are only delegated to trainees within their level of competence
- the restriction on junior doctors' hours, poses challenges for training and assessment of competence, and for continuity of care
- there must be appropriate handover systems in place
- senior doctors must be available in a timely fashion to ensure an appropriate management plan is formulated
- whilst it may be acceptable for consultants to multi-task, job plans must ensure that they are able to attend emergency admissions when clinical priority dictates
- in order to audit the quality of care it is important that accurate records are maintained which identify the seniority of staff involved and the timing of events

## ROTAS

Patients must have access to hospital services in some form 24/7. The majority of rotas (ten out of the 12 at Furness General Hospital (FGH), 14 out of the 17 at the Royal Lancaster Infirmary (RLI)) are 24-hour, full-shift, resident. Allowing for a handover of patient care of 0.5 hours before and after each shift and two or three shift changes per day then a minimum of 26-27 hours' cover is needed for a 24-hour period, ie 182-189 hours per week.

If we assume that a minimum of around 20 hours of directly supervised work or specific training opportunities is required per trainee (this is the figure given by the Royal College of Anaesthetists), we can calculate how many trainees we need to provide a 24-hour, full-shift, resident rota as follows:

### 24-hour, full-shift, resident rota:

Training, minimum hours	<u>20 hours per week</u> (averaged over 52 weeks)
Service availability hours	26 – (annual/study/sick/ maternity leave)
Leave	6 weeks annual 2 weeks bank holidays 2 weeks study leave 1 week sick leave (2% absence rate)
Availability	26 x (41/52) = <u>20.5 hours per week</u>
Service need	= <u>189 hours per week</u>
To man a 24/7 service	189/20.5 = <u>9.2 trainees</u>

*Ie, to staff a full-shift, on-call rota for a particular task requires at least nine, and realistically ten, full-time trainees.*

Trainees at FGH currently field eight 24-hour, full-shift, resident rotas and the RLI fields 12. There are currently 57 posts at FGH and 102 at the RLI. This is in each case below the minimum complement of 9.2 per rota outlined above – at FGH it is 7.1 and at the RLI it is 8.6. Any vacancies arising in the rotas (when this article was written, February 2009, it was nine at FGH, 11 at the RLI) will further stress the system.

## WHAT ARE THE SOLUTIONS?

### Fill vacancies and/or expand rotas

- money is available at primary care trusts (PCTs) specifically to fund WTR/ND issues (£1-1.5M), *but*
- speciality trainee numbers are centrally controlled (NTNs)
- trust grades/staff grades/associate specialists are almost impossible to recruit in the UK, largely due to legislative changes. Could the recently announced Medical Training Initiative provide a boost?
- Foundation Trainee numbers might be expandable but the service benefit would be limited
- consultants could be recruited to do work that is currently undertaken by 'middle grade' doctors. The implication is that the consultants may have to work outside traditional working hours, or even be resident

### The rota system is out of date and needs redesigning

- most rotas were redesigned in 2003-4 to implement the 56-hour week target for trainees
- cross-cover, particularly in surgical sub-specialities, became the norm
- continuity of care and the team approach was broken
- the 2003-4 exercise required 32 new posts with associated funding
- formal redesign and re-banding of rotas is time consuming

### Redesign roles

- evaluate the medical role in all services
- retain those elements essential to training

- identify non-training elements then equip, train and assess alternative staff to take up non-training roles

### Redesign services

Patients have historically had to fit with services but a more radical approach is to redesign services to fit patients' needs. Such redesign has to take into account all the constraints already listed but has the potential to develop a service that is more flexible and responsive to individual needs. Several developments were seen in 2003-4, mainly as a result of a perceived medical shortage.

### Extend the working day for seniors to include service

The extension of direct consultant supervision of acute medical, surgical and trauma activity into the evening could help to meet training needs by converting service into training opportunities without increasing trainees' overall hours. Additional funding has been identified for PCTs as noted above. However, the UHMBT's attempt to implement a '3-session day' in operating theatres in 2003 was not successful for a variety of reasons and was abandoned.

### Expand/develop roles

Nurse practitioners were trained as assistants for surgery and pre-operative assessment in order to reduce the time that surgical trainees spent on tasks such as clerking patients and holding retractors in the operating theatre. Although this may sound like a good idea, the training that is implicit in working alongside a consultant in a theatre or seeing patients in a ward is in fact lost to the surgical trainee. In addition, there are task-specific developments in phlebotomy, IV cannulation, ECG, etc, that may be able to be developed.

### Hospital at Night (H@N)

In 2003-4, UHMBT was a pilot site for this project. Resident on-call medical services had to be reduced out of hours because of a 56-hour limit for trainees in August 2004. This forced the NHS to think of alternative staffing models. Studies on out-of-hours workload demonstrated that dedicated on-call services in all sub-specialities were unnecessary. In areas of the hospital outside of acute medicine, workload falls significantly after 6.00pm. Most urgent calls on the wards, including surgical wards, are for medical or generic problems. By working to bring out-of-hours work into the working day, it is feasible to significantly reduce demand for doctor-specific tasks. H@N is based around a number of principles:

- *workload analysis* – identify work that spills-over from daytime, bloods, ECG, elective admissions, prescriptions, etc
- *draw work back into daytime where possible* – phlebotomy service, pre-operative assessment clinics, daytime emergency capacity, evening sessions, life-/limb-threatening surgery only after 10.00pm
- *identify 'must-do' out of hours work* – diagnosis, investigation, treatment, IV cannulation, drugs, death certification, etc
- *identify necessary competencies* – doctor-specific or not
- *team formation* – team must either possess or have access to all necessary skills. Develop protocols to improve response
- *education* – ALERT, POTTs/MEWS, IV cannulation, phlebotomy, ECGs, etc
- *handover* – formal communication of identified issues
- *facilities* – communication: facilities and protocols for bleeps, phones, bed information, etc

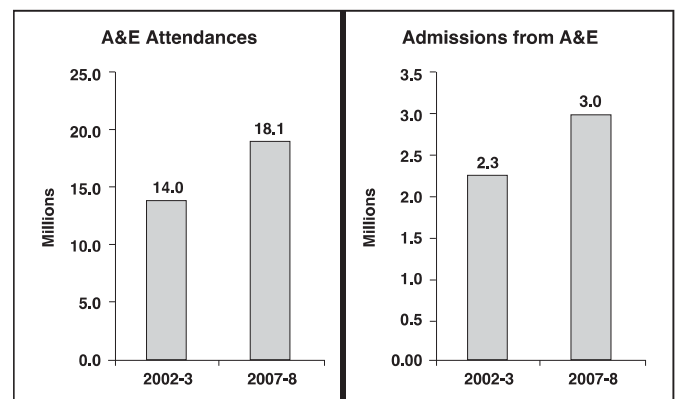
Some of the above are in place in UHMBT, but as with all system changes there is a tendency to regress to old, familiar habits, particularly if the changes are not radical enough.

### HOSPITAL 24/7 (H24/7)

By 2006, 48% of trusts had adopted the H@N concept and this had expanded to 80% by 2008.<sup>(7)</sup>

A report from the Royal College of Physicians (RCP) states, 'The quality of the first 48 hours of acute medical care is an important determinant of clinical outcomes and we recognise the need to guarantee the quality of this care and access to this care, 24 hours a day, seven days a week (24/7).'<sup>(8)</sup>

Acute care needs present 24/7, so appropriate care has to be available 24/7. These needs present through accident and emergency (A&E), general practitioners (GPs), inpatient or outpatients. It is a well-recognised phenomenon that A&E attendances and A&E admissions have increased by 35% over five years.<sup>(9)</sup>



Although figures on acute GP admissions were not to hand, they are almost certainly also increasing. Presentation does not follow 'office-hours' nor does it adhere to predictable pathways. The H@N concept was applied to these needs at night but it currently ignores the day, the weekend and the bank holiday.

Can the principles of the H@N be extended to the hospital in the day, weekend and bank holiday? The challenge is being addressed in various pilot projects in hospitals of all kinds.<sup>(8)</sup> It is far more radical than H@N and demands a fresh look at the way all care, scheduled and unscheduled, is organised.

Staff are familiar with the difficulties posed by the emergency arising during an elective theatre or other scheduled session. Mixing scheduled and unscheduled care tends to diminish both. The H24/7 looks at how scheduled and unscheduled care can be separated. Strict external site separation, as with the Kendal NHS Treatment Centre run by Ramsay Health Care, is not viable for most NHS trusts, but internal geographical and functional separation is certainly possible.

Scheduled admissions can be handled in an orderly manner and care follows reasonably predictable pathways from GP referral to outpatients or admission and discharge into the community. The major interruption to scheduled care

comes from the unpredictable nature of unscheduled care and is seen as the great attraction for the NHS treatment centres. Unscheduled care largely presents to the Trust through the GP or A&E to the new assessment suites for surgery and medicine, whilst there is, of course, existing demand on the inpatient wards. The vast majority of the demand has been shown to be for general medical care, even on surgical wards.

A recent Royal College of Surgeons (RCS) report concluded:<sup>(10)</sup>

- The presence of senior surgeons for both elective and emergency work will enhance patient safety and the quality of care, and ensure that training opportunities are maximised.
- The separation of emergency and elective surgical care can facilitate protected and concentrated training for junior surgeons providing consultants are available to supervise their work.
- Creating an 'emergency team', linked with a 'surgeon of the week', is a good method of providing dedicated and supervised training in all aspects of emergency and elective care.
- Separating emergency and elective services can prevent the admission of emergency patients from disrupting planned activity and vice versa, thus minimising patient inconvenience and maximising productivity for the Trust. The success of this will largely depend on having sufficient beds and resources for each service.
- Hospital-acquired infections can be reduced by the provision of protected elective wards and avoiding admissions from the emergency department and transfers from within/outside the hospital.

## THE ACUTE CARE TEAM (ACT)

Care pathways for the delivery of scheduled care have existed for some time but something different is needed for unscheduled care and the concept of the ACT is being explored around the country.<sup>(8)</sup> The ACT should provide:

- 24-hour service
- consultant lead with extended hours, including weekends and bank holidays
- multi-skilled, multi-disciplinary team equipped to cover all common emergencies
- extended roles and training where needed (IV cannulation, ECG, blood gases, plastering, etc)
- ongoing training of all skills
- operating protocols linking the ACT to specialist non-resident on-call staff, eg surgeons, endoscopists, cardiologists, etc
- single point of referral, external to the hospital or internal
- single point of admission
- single point of communication
- bed-management information
- facilities – team must have dedicated, central facilities for communication, rest-breaks, etc
- formal handover procedures and facilities

Staffing of such ACTs would require reorganisation of medical staff rotas (training and non-training) to replace their existing, conventional, mixed roles. The exact make-up of such an ACT would be for local discussion but would have to be multi-disciplinary to provide the necessary aggregation of generic skills. As recognised by the RCP and the RCS, this may significantly benefit both training and service roles.

Experience in other hospitals suggests that around 12-16 weeks of trainees' work might be devoted to the acute team, 8-10 weeks to annual and study leave, and 26-32 weeks to scheduled care.<sup>(8)</sup>

## SUMMARY

The WTR/ND presents a number of major challenges. Conventional approaches working within the current medical model of care may not succeed. New models need to be explored. Such changes may be radical and unpopular. Leadership will be essential. The amount of work is daunting and the timescale intimidating.

*'He who rejects change is the architect of decay. The only human institution which rejects progress is the cemetery.'* Harold Wilson.

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