The Royal College of Ophthalmologists

European Working Time Directive

College Suggestions

This document is a slight update of a very helpful document produced by Mr Stuart Cook, Vice President/Chairman of the Training Committee in 2003 and Mr Nick Astbury, Vice President/Chairman of the Professional Standards Committee in 2003. Since August 2004 the Medical Workforce has complied with the European Working Time Directive.

The average working week should be 58 hours (maximum duty 13 hours followed by an 11 hour break). Being resident on-call is defined as working. The aim is to reduce the 58 hour average working week to 56 hours by 2007and to 48 hours by 2009.

The government stipulates that:

1) EWTD must be achieved.
2) No recruiting of extra doctors is permitted.
3) Service targets must be met.

In addition to that, The Royal College of Ophthalmologists and other medical Royal Colleges would wish to see minimum disruption to the delivery of training and no extension to the duration of training.

Whether all this can be achieved without detriment to any of the component parts is arguable. However, ophthalmology may be better placed than many other medical disciplines because of our work pattern. Despite this, our current working practices will need to be reorganised to facilitate compliance with the EWTD. No one solution will be applicable to every department.

This document will put forward some scenarios of appropriate practice. Each unit will need to produce local proposals. The needs of a small rural unit with three consultants will be quite different from the needs of a large inner-city unit with many consultants. The number of trainees and other doctors will also differ.

Since 1 August 2007, all trainees admitted to run-through specialty training programmes and Fixed Term Specialist Training Appointments (FTSTAs) will be known as Specialty Registrars (StRs).

Possible Solutions

The bulk of the working week can be managed in an eight or nine hour working day (normally within
the time frame of 8a.m. to 6p.m.); however it may be necessary for some training units to have a different arrangement of hours depending on local circumstances An accident and emergency service may or may not be
necessary between 6p.m. and 9p.m. Thereafter, in the vast majority of units it is probably unnecessary to have ophthalmic medical staff resident on-call. If an individual is non-resident then he/she is considered to be not working for the purposes of the EWTD.

If that individual is called by telephone they are considered to be working for that time. Being available for work for the purposes of this exercise is not actually regarded as work (following the Spanish 'Simap' case).

Other issues arise as a consequence of this approach. Is generic cross cover required in ophthalmology? i.e. for prescribing analgesics etc. This type of problem can probably be avoided by better management of ward patients when doctors are available, within working hours. Permitting nurse practitioners to prescribe medication may also be an appropriate solution. Given the very small number of medical emergencies it may not be necessary for ophthalmology to participate in a general cross cover (local solutions may dictate otherwise). Occasionally ophthalmology trainees may be required to be part of an on-call rota that involves broader cross-specialty cover for non-specialist problems, however it is not appropriate for OST trainees to be on-call for the specialist problems of other specialties which are outside their areas of competence.

The number of tiers of on-call may be minimised, avoiding repetition of care.

1st Tier Nurses/Nurse Practitioners
2nd Tier StRs/SpRs
3rd Tier StRs / SpRs (likely to be very large institutions only)
4th Tier Consultants

StRs and SpRs may take part in the second tier (first on-call). This will not be onerous.

StRs and SpRs will not generally be required to be resident on-call. In certain circumstances hospitals may be required to provide overnight accommodation for SpRs/StRs if the distance between the SpRs/StRs domestic residence and the hospital is too great to permit timely access to the hospital in the event of an emergency.

Geographical Rationalisation of Services

Rationalising services geographically may be necessary where a number of smaller units exist within the same locality. The key to this is staff numbers. If a small unit does not have adequate staff to maintain an out of hours service and comply with the EWTD then sharing on-call with adjacent units and having a centralised acute referral service may be a better option.

It is also recognised that geographical distance is not the same as the time taken to get between point 'a' and point 'b'. It may take longer to travel a short distance in the city than it does in the country. Smaller units may wish to consider providing centralised acute referral services even during normal working time as this may provide better service for patients. Patients need to be re-educated as to where the acute referral service is located but this

obstacle has been overcome in many cases in general accident and emergency services.

In conjunction with this the reduction or re-design of 'walk-in' eye services for non-urgent patients may also improve the running of
emergency departments. Many departments utilise nurse practitioners who see at least a third of patients. Booking systems also improve the efficiency of the service.

Current Training in A&E - OST (Ophthalmic Specialist Training)

It is recommended that year 1 and year 2 OST StRs should do up to a maximum of two sessions of ophthalmic A&E a week. It is recommended that year 3 onwards OST StRs may do up to a maximum of one ophthalmic A&E session a week in place of a general clinic.

Current Training in A&E - HST (Higher Specialist Training)

SpRs are allowed to do one session of A&E in place of a general clinic during the working week.

Who provides out of hours service?

The second tier will be made up of StRs, SpRs and in some instances the SAS doctors (Specialist and Associate Specialists). The EWTD has been implemented in other EU countries. This has proven less of a headache, as the doctor to patient ratio is generally higher (3.0 to *5.0/1000* patients compared to the UK who have 1.7 doctors/1000 patients). Increasing the number of doctors within the population is a part of government policy.

The Importance of RSTA Sessions

The Training Committee has received requests for advice concerning an example where the following occurred:

SpRs/StRs were being rostered to be on call the evening before they had RSTA session (research, study, teaching, audit) the implication of this is that if they are up during the night they are then obliged to be off at 1.00 pm the following day and the time that would have been used for RSTA is invalidated. The Training Committee was also informed that if the individual had a clinical commitment such as a theatre list and he/she was unable to fulfil as they were up the preceding evening one of their colleagues would loose their study session to cover the theatre list.

Both of these scenarios are unacceptable as far as the Training Committee is concerned. The RSTA sessions are as much part of the curriculum as clinical activity and cannot be regarded as a soft option that trainees can miss. Clinical work should either be scaled down or cancelled if the clinics cannot be run as a consequence of EWTD. It is inappropriate to sacrifice personal study time for the needs of the service on what appeared to be a regular basis.

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EWTD Case examples and solutions

1. Smaller units	May continue to function unchanged with certain local provisions*	1:5 non-resident on-call with 11 hour rest in 24 hours	75% of units
2. Larger units	A change in on-call system will be needed	E.g. collapse on-tiered system 1:5 becomes 1:10	20% of units
3. Special cases	Will need to consider partial shift system / shift system for on-calls	Max duty time 13 hours	+/- 5% of units

*Alternative provisions/solutions to be explored locally:

1. Collaborative on-call with nearby units with centralised acute services
2. "Skill mix" – consider use of nurse-practitioner to deliver some of the out - of - hours emergency ophthalmic service.
3. Reduce or re-design open access (walk in) hospital based eye services for non-urgent eye disorders
4. Broader cross-specialty cover for non-specialist problems
5. Use of SAS doctors in the on-call rota
6. Reduce likelihood of out-of-hours events

Key points:

- Reduce or re-design open access (walk in) hospital based eye services for non-urgent eye disorders
- Avoid residential on-call
- Reduce unnecessary out-of-hours work
- Imaginative local on-call schemes in ophthalmology will prevent the EWTD interrupting trainee education and service delivery

Worked examples:

1. Minimum number of junior staff required to be WTD compliant:

= 5 participating in on-calls i.e. 1:5 on-call
(This would be a quiet unit with relatively light out-of-hour commitments)
e.g. 5 days of 9 hour shifts = 45 hours
Leaves 13 hours per week for on-site on-call work. (Meets 2004 target)
Leaves 3 hours per week for on-site on-call work (Meets 2009 target)

- Weekend on-calls would have to be integrated with this

- The impact of prospective cover would need to be evaluated
- 11 hours in 24 rest period will need to be adhered to
- Total working time is assessed over a reference period to provide a weekly average

2. Busier Units:

e.g. 5 days of 9 hour shifts = 45 hours
Leaves 13 or 3 hours for on-calls per week depending on target
Busier units will struggle to be compliant and will have to decrease on-call frequency.

The Training Committee
RCOphth
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