

# 10

## Impact Of Regulations On Doctors' Working Hours

The Future  
of Glasgow's  
Hospital Services



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**GREATER GLASGOW  
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## Impact Of Regulations On Doctors' Working Hours

The European Union Working Time Directive applies to hospital consultants. They must not work more than 48 hours a week on average (over a 26 week period). There are also requirements for daily and weekly rest periods. Doctors on-call giving telephone advice or having to go in to the hospital for an emergency are regarded as working.

Although individuals can voluntarily forego their rights and so work longer hours, we certainly cannot organise our system on the wholly unreasonable presumption that specialists (consultants) will inevitably forego their rights voluntarily.

Consultants' rotas need to be designed so that their time is spent on the right balance between:

- ambulatory care work (such as out-patients or day surgery) } which should be timetabled } in advance to ensure } minimum delays } for patients.
- in-patient waiting list work }
- emergency cover which needs dedicated time so that consultants are promptly available for emergencies without disrupting their ambulatory care and elective work.
- time spent on education, research, clinical audit and running the clinical team which also needs to be timetabled to avoid clashing with other responsibilities.

In some specialties (general medicine and some surgical) pressures of emergency work can be heavy at nights and weekends as well as during the day.

The organisation of consultant time also needs to ensure that wherever a

patient needs to be seen by a specialist consultant, it can be quickly organised. Suspected breast cancers need to be seen by breast surgeons. People with serious intestinal problems would usually wish to be seen by someone who specialises in intestinal problems. And so on.

The Senate of Surgery of Great Britain and Ireland says that for a population of 450,000 the general surgery consultant team should consist of 15 general surgeons to cover the sub-specialties of vascular, breast, endocrine, upper gastro-intestinal, hepato-biliary surgery, lower digestive system..... will provide at least two consultants per major sub-specialty, enable (cancer) site specific specialisation and allow a four surgeon emergency vascular rota in addition to a general surgical rota.

Similar principles are proposed for other surgical specialties

The Southern General and the Victoria Infirmary between them have 11.4 consultant general surgeons serving 347,000 people - enough for the population but over-stretched in providing specialist cover since they are covering two separate hospital in-patient units, and also providing an emergency specialist vascular surgery rota.

In Accident and Emergency we currently have 10 consultants based in four sites. It is impossible to provide round the clock cover with A&E specialists on all 4 sites. The proposals concentrate them in 2 Trauma Centres which will allow full A&E consultant cover, and access to a full range of supporting services such as intensive care, general surgical and orthopaedic surgical teams 24 hours a day. National audit has shown that these provisions are important factors in survival following major trauma.

It will also support the development of new services such as head injury management, and improve cover for training, teaching, audit and annual leave, while ensuring that all medical staff are working rotas and shifts which meet European Union directives.

Designing rotas is a complicated art. We show overleaf a simplified illustration of what factors might influence how a 5 consultant team might be organised to provide assurance of more hours of consultant cover in an Accident and Emergency Department.

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5 consultants would each have 6 weeks holiday  
 10 bank holiday/statutory days  
 say 2 weeks study leave  
 in total, say 10 weeks absence each per year

In any one week only 4 consultants likely to be available (1 absent on leave).

So 5 Consultants provide (5 x 52) -50 weeks work per year = 210 weeks.  
 210 weeks @ 48 hours maximum each = 10,080 hours available for work.

7 a.m. to midnight cover 365 days per year = 17 x 365 = 6,205 hours.

Leaves 3,875 hours for other work:

- say 500 hours actually spent on on-call attendance at hospital between  
 12 midnight and 7 a.m. in the year (less than 10 hours a week)

Leaves 3,375 working hours = 65 hours per week (around 16 per consultant) for:

- Supervising Minor Injuries Unit
- Head injury supervision
- Clinical audit and review of practice
- Providing a second consultant present in A&E
- Teaching of junior doctors\other staff
- Review Clinics
- Administration
- Sickness cover

The advice of general and orthopaedic surgeons is that a single in-patient surgical unit on the Southside and single in-patient orthopaedic units on both the Southside and in North Glasgow could each comfortably manage their emergency workload with single emergency teams in each speciality in each place.

Every day on both sites in the South, we currently have 2 emergency orthopaedic teams, that is theatre nurses, anaesthetists and surgeons available to perform emergency operations. The reduction to a single

emergency team would free up that resource to perform elective work and reduce our waiting list for elective procedures in orthopaedics. This would free up enough time to do, for example, 500 extra hip replacements in a year.

If we illustrated this point in terms of hours an example might be as follows. If each hospital has consultant emergency presence in the hospital from, say, 9 a.m. to 7 p.m. each day then the difference in requirement for consultant surgeon time is as set out opposite. It is expressed in very simple terms but it serves to illustrate the point:

9 a.m. to 7 p.m. dedicated time for emergency work = 3,650 hours per year.

So: 2 orthopaedic units with emergency cover require 7,300 hours a year whereas a single team/unit could do the same job using only 3,650 hours. Moving from 2 to 1 releases 3,650 hours a year to be used to reduce non-emergency waiting times without any adverse effect on ability to deal properly with emergencies. An individual consultant complying with EU working hours regulations can work 2,016 hours per year. So 3,650 hours is equivalent of nearly two consultants' clinical working time.

The same benefit can be yielded in all three services illustrated in this example: orthopaedics North and South of the river and general surgery South of the river.

Similar benefits will be felt in smaller specialties where concentration of emergency in-patient responsibilities from two or three sites to one will significantly reduce disruption of work on ambulatory care and waiting lists.

Not only does consultants' working time become easier to plan and less stressful, the release of more productive time would have very major benefits in reducing patients' waiting times.

We have of course looked at whether we should increase the number of consultants. There are some specialties where pressure of work suggests we need more (such as radiology and Accident and Emergency in North Glasgow) but in most specialties Glasgow already has the number of consultants recommended by Royal Colleges, the British Medical Association and so on. Our problems arise mostly from their distribution rather than from there being too few.

Over future years it is likely that consultant numbers will increase further in response to:

- rising workloads in some specialties.
- further specialisation within specialties.
- the need for better training of junior doctors.
- the need for consultants to do more of the clinical hands-on work themselves rather than it being done by over-stretched and inexperienced juniors.

## Impact Of Regulations On Doctors' Working Hours

### Junior Doctors

Junior doctors are those training to be consultants or GPs. They are usually known as house officers or registrars. The ridiculously long hours worked by junior doctors has for years been a notorious problem in the UK. And the various Royal Colleges now insist that their training should be properly organised and supervised. They should truly be seen as trainees rather than just medical "service workers".

The government is committed to ensuring that their maximum working week should not exceed 56 hours. (The European Parliament is pressing for the EU maximum working week of 48 hours to apply). In any event the intensity of work should not be so great that it squeezes out the time and space for quality communication with patients and relatives. And tiredness increases the risk of mistakes. The pressing need to achieve these standards is widely recognised.

Simply increasing the number of junior doctors is not the answer. Although the output of Medical Schools will increase in the UK that will not increase the supply of junior doctors for several years. Nor will Postgraduate Deans, who oversee junior doctors' training, approve training recognition of posts unless they can be sure that the junior doctors will achieve a rich enough mix of clinical experience - assigning more juniors to existing

patient workloads will dilute the clinical range of their experience. Our proposed changes in service re-organisation will greatly help to reduce the chaotic competing demands on junior doctors' hours.

Just as large teams of specialists will give better assurance of specialist cover and greatly reduce mutually damaging conflict between the demands of emergency and elective work, so those same larger teams will give better scope for properly organising the time, work and education of juniors. For example, a small specialty with beds scattered over three sites requires 3 juniors to provide overnight cover. Bringing the beds together means that only one doctor is needed to work overnight. That in turn means much less night work for junior doctors. A dramatic improvement for juniors and as a consequence a better quality of experience between patients and junior doctors.

*Comments on this issue or any other aspect of the proposals to modernise Glasgow's hospital services should be sent by June 30th, 2000 to*

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# Leaflet request form

## Getting Informed

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Greater Glasgow Health Board  
FREEPOST (GW 707)  
Glasgow G3 8BR**

- 1. The Patient's Experience
- 2. Getting It Right For Patients: What It Means For Organising Services
- 3. Cancer Services: Specialisation In Action
- 4. Why Specialisation Matters - And What We Propose To Do To Make Its Benefits More Available
- 5. Creating More Responsive Accident And Emergency Services
- 6. Ambulatory Care: What Is It?
- 7. Minimally Invasive Technologies: Keyhole Surgery And The Like
- 8. The Overall Planning Challenge For Greater Glasgow - Acute Hospitals In A Wider Context
- 9. Some Recent Background History
- 10. Impact Of Regulations On Doctors' Working Hours

- 11. The Number Of Beds We Propose To Provide
- 12. Regional Services Provided By Glasgow Hospitals
- 13. Why Teaching And Research Matters
- 14. Staffing Matters
- 15. How The Finance Works
- 16. Detailed Analysis Of The Options For South Glasgow
- 17. Maternal And Child Health
- 18. Better Access For West Glasgow Residents
- 19. The GRI/Stobhill Partnership
- 20. Why Centralise Cardiothoracic Surgery?
- 21. Radiotherapy: Linear Accelerators - A Patient's Guide

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