



Medical Education England Review of the Impact of the European Working Time Directive (EWTD) on the Quality of Postgraduate Training

Consultation Response

The Royal College of Surgeons of England welcomes the opportunity to respond to Medical Education England's call for evidence to support its review of the impact of the European Working Time Directive on the quality of postgraduate training. The College welcomes the review and looks forward to further discussions as the interim findings of the report are prepared.

Consultation questions

1.	<p>How would you define high quality training? Respondents may wish to consider quality both in terms of training outcomes and the methods of training.</p>
<p>Maintaining high quality training in surgery requires effective translation and delivery of the curriculum across the United Kingdom. Trainees have a right to expect the same quality of training wherever it is being delivered. This should include the appropriate balance of clinical supervision and teaching, which varies according to the specialty and the stage of the training. Surgeons in training should not be used as a flexible resource to cover gaps in service provision at the expense of their clinical training. Quality of training is particularly threatened in this way in a service where training hours and resources are being reduced as a consequence of limited hours – of which, a greater proportion are being spent in out of hours service provision. Training does not stop at the award of the Certificate of Completion of Training (CCT) but continues throughout a surgeon's career. It is important that opportunities to train are available to both trainees and consultant surgeons.</p> <p>Methods of training In surgery the requirements of trainees differ according to the level of training, the specialty and their own personal circumstances. Essential for meeting these differing requirements is continuity of training based on an established relationship between the learner and educator.</p> <p>In delivering high quality surgical training the following methods have a role:</p> <ul style="list-style-type: none">○ Simulators – simulator technology continues to improve and advance, providing an experience more akin to surgical practice. We believe this technology is valuable for foundation and first year core surgical trainees for initial development of basic surgical skills and for a limited number of specific technical skills (such as the practice of microsurgery). There is little clinical value, for more senior trainees, in using current simulator technology as fidelity has not yet evolved to a sufficient level to simulate more complex situations and procedures.○ Mentoring – formal mentoring/support schemes should be available to all surgical trainees; particularly as the contact time between consultant surgeons and trainees is being reduced due to restricted hours. Mentoring would also be of particular value to those working flexibly, to ensure they are accessing the training and education they need to progress through their training. Mentoring is also an important aspect of continuing professional development (CPD) for all surgeons. <p>The College believes that the current high standard of training could not be maintained by lengthening training programmes in a reduced hours environment. Intensity of experience for full time or flexible trainees when they are in the hospital has an important role to play in skills</p>	

acquisition and it is essential for all surgical trainees that intensity of training is maintained to ensure the experience needed to be a confident, competent and safe surgeon.

Training outcomes

The aim of all surgical training is to give trainees the skills to become safe, competent and confident consultants, as defined by the PMETB curriculum. These requirements do not just include operative and technical skills and knowledge, but also medical professionalism so that surgeons can practice independently and with regard to the patient as a whole. Once they have acquired the appropriate knowledge and skills, all trained surgeons have a responsibility to train others in order to protect high standards for the next generation of surgeons.

Assessments that allow surgical trainees to progress through their training must remain robust and become effective in demonstrating those trainees who are struggling to achieve necessary skills and who therefore require additional support.

2. What has been the impact of the introduction of the EWTD on the quality of training?

Respondents may wish to consider the impact in terms of quality of the training outcome and quality of the training methods.

The introduction of the EWTD has led to a slow and ongoing erosion of the quality of training. The effects of this are beginning to emerge and will become increasingly apparent as current trainees start to complete their training. It is still too early to see the full effect of implementation of the 48 hour week, but evidence is now being published about the impact of the reduction to 56 hours, which indicates a significant deterioration in access to training.

There is growing evidence that rotas compliant with the EWTD are both increasing doctors' feelings of fatigue and worsening their work-life balance. We highlight the following changes brought about by the EWTD that are having an impact on the quality of training:

- **Shift working** – in order to maintain a 24-hour service and make rotas compliant, many employers have implemented full shift working (at the expense of maintaining on-call rotas). This is a direct result of the SiMap ruling and presents particular difficulties for smaller units. Constraints and penalties within the 'New Deal' have also influenced the move to full shift working to ensure compliance. Full shift working is not only disruptive to training schedules but also to a good work-life balance, as the proportion of out of hours service provision has increased, at the cost of high quality daytime training opportunities. As a result there have been three deleterious affects - trainees have had their overall hours reduced and daytime training reduced further still, in addition to far longer periods away from home and families.
- **Foundation year/core training** – this group of trainees are particularly disadvantaged by the working time regulations. During rotations they rarely meet their trainer and have limited exposure to that area of surgical practice at exactly the time when they need expert guidance and training. Service provision has been put far ahead of training which is, unofficially, deferred to later in the programme.

3. How have those working in the healthcare 'system' (e.g. employers, trainers, service and training commissioners and providers) responded since the introduction of the EWTD?

Respondents should consider changes related to training which:

- Resulted directly from EWTD
- Resulted indirectly from EWTD
- Are potentially unrelated but nevertheless are perceived to impact on the quality of training.

The College, through its own work and membership of the Academy of Medical Royal Colleges and Department of Health's working EWTD reference group, has been monitoring the implementation of the directive since January 2009. As part of this process we observed 'reported compliance levels' increase significantly in the last three months prior to implementation of the 48 hour week. Surveys conducted by the College and the trainee associations indicate that many gaps in these rotas have been covered by locum staff (internal and external) and the goodwill of medical staff. In September 2009 over 900 surgeons responded to a College survey assessing the impact of the 48 hour working hours limit. This survey found that around 50% of respondents were covering gaps in their own hospital with two thirds reporting non-compliance with the new hours limit. This problem is particularly prevalent within rotas claiming 'paper compliance', in which rota gaps have been reported on over 80% of cases. Given the financial penalties for failing to implement the directive, trusts have focussed on making rotas compliant on paper. Trusts are also using consultants and other staff to achieve national targets on waiting times which further compromises access to training. The consequence of this prioritisation has been a failure to take account of training needs, as there are currently no comparable incentives or penalties for failing to give trainees high quality training.

Employers

Employers have interpreted the rules differently, applying a range of solutions. Very few of these have addressed training needs. In order to fill rotas, many hospitals have used clinical research fellows and trust doctors – who are given no training opportunities. There has also been an increased role for nurse practitioners and other allied health professionals, which continues to be implemented in an uncoordinated manner, without clinical input. A survey by the Nursing Times in January 2010 reported 41 per cent of respondents were uncomfortable with the level of responsibility, with a third of nurses saying they had not had sufficient training for tasks they were carrying out as a result of the directive.

Trainers

In order for trainers to train they require time to build a working relationship and help trainees develop their surgical skills over a significant period of time. In many cases, due to rota scheduling, trainees are working with a large number of different consultants. This does not allow for continuity, making teaching and the assessment of competence and progress extremely difficult. Through our surveys we have had numerous reports of trainers being scheduled with trainees on an irregular basis, for example they may only see each other a handful of times during a rotation. This makes training difficult as it takes several training sessions to build a relationship with an individual trainer and acquisition of new skills is therefore delayed. The standard of training suffers as a result of the weakening of the trainer-trainee relationship. We also highlight the increasing restrictions on Supporting Professional Activities (SPA) time in consultant contracts which in conjunction with the lack of flexibility in the 48 hour week and 'New Deal' results in further loss of training time due to non-availability of trainers creating further disconnect between the trainee and trainers rotas.

4.	<p>What lessons can be learned from national and international experience about the delivery of high quality training within time constraints?</p> <p>Respondents may wish to present evidence on lessons learned from both positive and negative experiences, or from the experiences of colleagues and partners in other parts of the country or the world.</p>
<p>In surgery the College believes that a 'one size fits all' approach to training will not work, due to the differing requirements of trainees. There is a need for flexibility among training programmes which the current EWTD requirements do not allow. We have seen a wealth of evidence from across surgery in the United Kingdom which suggests that the EWTD regulations will directly affect the ability of surgical trainees to train to the required standard in the future.</p> <p>The College supports the solution that the surgical training organisations (ASiT/BOTA) want – a flexible working week of up to a maximum of 65 hours. We believe the EWTD as it currently stands has no upper limit on the number of hours that someone can work in each week provided</p>	

that they hit an average 48 hours over the 26 week reference period. This has led to reports from trainees and surgeons of individuals working up to seven night shifts in a row (91 hours) and being required to take compensatory rest the next week. This means they lose out on vital daytime training and clinical time and also goes against the stated objective of the EWTD, which was to prevent long working hours and excessive fatigue.

We also believe that it is timely for a re-examination of the junior doctors contract, to consider whether a move away from the current hours based contract to a session based contract (in line with the consultant contract) could be viable. This would have the benefit of allocating specific sessions to, for example, operating experience, clinics, ward work and independent study. This would help address the competing demands of service needs and training requirements.

International experience

We would urge caution when trying to derive learning from international comparisons. The configuration of the UK health service with its interrelations between training and service are unique. However some relevant and comparable evidence may be gained from the current debate in the United States on the impact on training of the reduction of working hours to 80 hours and from Australasia where hours are being reduced to 72 hours a week.

Publications to be considered as evidence

Article/ paper title	Author(s)	Source journal	Web-link	Have you submitted a hard copy?
How long does it take to train a surgeon?	Jackson G and Tarpley JL	British Medical Journal	http://www.bmj.com/cgi/content/full/339/nov05/1/b4260	n/a
Deaths in Acute Hospitals: Caring to the End? (2009)	National Confidential Enquiry into Patient Outcome and Death	National Confidential Enquiry into Patient Outcome and Death	http://www.ncepod.org.uk/2009report2/Downloads/DAH_report.pdf	n/a
The Lost generation: quantitative evidence for the detrimental impact of the 56 hour EWTD on current surgical training	Chalmers CR et al	Annals of The Royal College of Surgeons of England (Suppl) 2010	In press	Yes
Nurses say patients at risk under working time rules	Santry C	Nursing Times	http://www.nursingtimes.net/whats-new-in-nursing/acute-care/nurses-say-patients-at-risk-under-working-time-rules/5010179.article	n/a
Optimising working hours to provide quality in training and patient safety	Association of Surgeons in Training		http://www.asit.org/assets/documents/ASiT_EWTD_Position_Statement.pdf	n/a
BOTA position statement on the European Working Time Directive and training in Trauma & Orthopaedic surgery	British Orthopaedic Trainees Association		http://www.bota.org.uk/uploads/cms/00178/BO TA%20EWTD%20Statement.pdf	n/a

Response details:

If you are responding on behalf of an organisation	
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Confidentiality	
*Do you consent for your name or the name of your organisation to appear in the index of responses in the group's final report? Please delete as applicable:	Yes
*Do you consent for your response to be quoted in the group's final report? Please delete as applicable:	Yes