Consultation - practical implementation of Directive 2003/88/EC (Working Time Directive) concerning certain aspects of the organisation of working time.

Who we are: The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is the professional representative body for more than 10,000 anaesthetists working in the NHS. The trainee arm of the AAGBI, the Group of Anaesthetists in Training (GAT), is the democratically elected representative body for 3,000 anaesthetic trainees. As such we can comment on the implementation of the Working Time Directive (WTD) in the specialty of anaesthesia and make some observations about its implementation in other hospital specialties and in general.

We have recently written a letter to Jeremy Hunt in response to the Government's plans to investigate further the recommendations of a task force reviewing the impact and implementation of the European Working Time Directive on the NHS in the United Kingdom (http://www.aagbi.org/sites/default/files/Letter%20to%20J%20Hunt%20from%20AAGBI%20GAT%2012AUG14.pdf). This independent task force was chaired by the President of the Royal College of Surgeons and contained representation from the Association of Surgeons in Training (ASiT), both of whom have previously openly voiced their opposition to the EWTD. We are concerned that such strong views could have undermined the objectivity of the taskforce, and suggest that a Chair with a more neutral stance may have been more appropriate. There were no representatives of the Royal Colleges of Anaesthetists, Psychiatrists, Obstetricians and Gynaecologists and General Practitioners amongst task force members, who in combination represent over 60% of the UK's doctors ((http://www.rcseng.ac.uk/policy/documents/wtd-taskforce-report-2014).

In particular we are concerned about the Government's plans to explore the following recommendations and will comment further in the table below:

1. "…*more work should be undertaken to identify 'service' and 'education' elements in the work of doctors in training. This will include how the possibility of separate agreements may contribute to resolving some of the difficulties identified by this review.*"
2. "…*further consideration needs to be given as to how more widespread use of the individual opt-out might be encouraged where safe, both at the sectorial and individual levels*".

1. TRANSPOSITION	
Do you consider that the Working Time Directive has been transposed in a satisfactory way in the EU Member States?	We can only comment on transposition in the UK. The WTD has been transposed and we are not aware of any rotas in anaesthesia which on paper have trainees working more than 48 hours per week on average. For medicine the WTD was introduced in 2004 with a capping at 58 hours/week, in 2007 this was reduced to 56 and in 2009 to 48 hours/week. Evidence would suggest that it is possible to train anaesthetists within a 48 hour working week and that rates of sick leave, as a surrogate marker of wellbeing, were reduced following the introduction of the WTD (1). This paper also demonstrated that the workload delivered by one typical teaching hospital grew by 50% between 2000 & 2010. Financial pressures made no difference to this growth, which was a response to an increase in both elective and emergency work. There is however a significant difference between rotas on paper and rotas in action and we are concerned that rota design does not fulfil the sentiments of the WTD. Although trainees are working fewer hours on average, this is often accompanied by

	antisocial shift patterns, leading to problems with handover and a reduction in team working. Many trainees will also undertake educational and training opportunities, e.g. attending courses, meetings during compensatory time off to mitigate any reduction in clinical exposure. Some regions do not include teaching time in the hours of work yet trainees are expected to attend in order to fulfil annual training and assessment requirements to pass their Annual Review of Competency Progression. Clinical Directors and trainees in many units throughout the UK report that it is difficult to run rotas that comply with the European Working Time Regulations, with the current complement of staff. No allowance is made for maternity leave, or sick leave, despite the fact that the average age of trainees is 28-35, the time at which most professional people have families. Hence, units rely on people doing 'internal locums' and hence working for more than 48 hours, or on external locums, who do not know the hospital and can be of variable quality. Lack of familiarity with the work environment is known to be associated with an increased incidence of adverse events. • When locums are not available, many units report that pressure to provide service and meet waiting list targets, e.g. for patients having cancer operations, means they run whole theatre suites with each anaesthetist working solo, with no spare anaesthetist immediately available to assist a colleague should an emergency arise. Although relatively rare, anaesthetic emergencies, such as being unable to oxygenate a patient or a serious anaphylactic reaction, have potentially life threatening consequences for patients, and are often difficult to manage effectively with only one anaesthetist. Moreover, surgical complications such as major haemorrhage also require the presence of two (or sometimes more) anaesthetists. GAT has examples of such difficulties in many regions including Oxford, Yorkshire & Humber, East Midlands.

	• As mentioned above the effects of reducing the hours of trainees, but not increasing the number of trainees, is that we now have gaps on many anaesthetic rotas that have to be covered by consultants. This problem is more evident in the North of England and Scotland than the South where there are a disproportionately higher number of trainees. The regional distribution of training numbers in anaesthesia does not reflect regional requirements for anaesthetic services. Approximately 25% of training numbers are within the M25, whereas other areas with poorer weighted capitation have fewer anaesthetists in training. Several surveys of trainees, including longitudinal studies of career progression (BMA cohort study) demonstrate that trainees do not relocate for consultant posts, e.g. 90% of trainees in Yorkshire and the Humber are recruited to local posts. The need for consultants to cover rota gaps may make these units less attractive to potential applicants. • When there is a reduction in trainee numbers and consultants filling rota gaps this means that trainees are often working alone, rather than on directly supervised lists, thereby losing valuable training opportunities. 1. Paul RG, Bunker N, Fauvel NJ & Cox M. The effect of the European Working Time Directive on anaesthetic working patterns and training. Anaesthesia 2012; 67(9): 951-956.
If you consider that there is room for concern about	Sir John Temple, in his report “Time for Training: A review of the impact of the European Working Time Directive on the Quality of Training”, (http://hee.nhs.uk/wp-content/uploads/sites/321/2012/08/Time-for-training-report.pdf) had already concluded in 2010 that it was possible for high quality medical training to be

transposition in specific sectors or concerning specific provisions, please give details.	delivered within the 48-hour limit imposed by the WTR, with the caveat that some organisations may need to reconfigure services to support it (1). We observe that some specialties may have been less willing to review working practices and reconfigure services in light of the WTD. A survey of surgeons demonstrated that 61% of consultants and 72% of trainees are working in excess of the European working time regulation of 48 hours per week. http://www.rcseng.ac.uk/news/docs/rcs_ewtd_survey_results_jul_2010.pdf Trainee surgeons may work over their allotted hours in order to get specific experience. They also do this because they believe their consultants supervisors will expect them to turn up. While we understand the importance of experiencing less usual procedures, it is not acceptable for someone who is also covering the next nightshift to work during the day, albeit voluntarily, as this may put patients and the doctor at risk due to fatigue. We strongly believe that we should steer away from a path that may return us to older educational models in which training was achieved through a process of diffusion during unnecessarily lengthy hours spent at work. Instead, individual specialties should continue to look to adapt their ways of working to implement high quality training within the confines of the WTD. This may require local or regional service reconfiguration, as has successfully been employed in the specialties of anaesthetics and paediatrics, or the adoption of more up-to-date training methods. We note that, with the introduction of seven-day working, some of the arguments against the WTD may become redundant. An increased consultant presence at weekends and out-of-hours will ensure that trainees are supervised by consultants at all times, improving both patient care and

	medical training. In their document entitled “Labour Ward Solutions” http://www.rcog.org.uk/files/rcog-corp/LabourWardSolutionGoodPractice10a.pdf, the Royal College of Obstetricians & Gynaecologists recognise this, suggesting that all units delivering over 4000 babies per year should have a consultant present for 16 hours per day, 7 days per week on labour ward Consultant obstetricians are quick to recognise when an emergency situation is developing. There is a clear correlation between consultant presence and good neonatal outcome. These units are requiring the presence of a consultant anaesthetist as well as a consultant obstetrician. Some obstetric anaesthetists currently work 12 hour days from Monday to Friday and there is constant pressure to increase these hours to match that of obstetricians and to provide the same level of service at the weekend as during the week. Consultant presence will not only improve outcome but will also improve training when trainees have a reduced number of training hours. The specialty of anaesthesia has clearly demonstrated that it can train competent anaesthetists within a 48-hour working week (2). We do not believe that surgery is a special case amongst medical specialties, and we would argue against changing the whole system, allowing a return to the long working hours that risked patient safety and the wellbeing of trainees, based on the views of one group. 1. Temple J. Time for Training: A Review of the impact of the European Working Time Directive on the quality of training. England: MEE, 2010. (http://hee.nhs.uk/wp-content/uploads/sites/321/2012/08/Time-for-training-report.pdf). 2. Paul RG, Bunker N, Fauvel NJ & Cox M. The effect of the European Working Time Directive on anaesthetic working patterns and training. Anaesthesia 2012; 67(9): 951-956.
If you consider that	The EWTR have been useful in establishing the requirement for sensible rest periods and raising understanding of the impact of tiredness on effective clinical practice.

transposition of the Directive has been particularly satisfactory in any respect, please give details.	Fatigue is known to have a serious impact on performance, vigilance and hence safety. Cognitive function is impaired, with slower response times, more frequent lapses in attention, impaired memory and poorer ability to do simple calculations (e.g. drug doses) and poorer decision-making. Working continuously for 20 hours has the same impact on performance as being over the alcohol limit for driving. (http://www.aagbi.org/sites/default/files/fatigue_and_anaesthetists_v6_for_members%5B2%5D_0.pdf)

2. SOCIAL PARTNERSHIP	**Comments**
Do you consider that the social partners have been sufficiently consulted and involved by the national authorities before the adoption of national	The NHS organisations that were required to implement this were certainly informed. We are less certain they would have considered that they were consulted. Several organisations struggled to implement EWTD and now EWTR compliant rotas, and non-compliant rotas were still in existence for some time after the 48-hour week was implemented. When a national taskforce was convened by the Government to look at the implementation of the WTD on the NHS, anaesthesia (the largest hospital specialty) and several other specialties were not represented. This independent task force was chaired by the President of the Royal College of Surgeons and contained representation from the Association of Surgeons in Training (ASiT), both of whom have previously openly voiced their opposition to the EWTD. We are concerned that such strong views could have undermined the objectivity of the taskforce, and suggest that a Chair with a more neutral stance may have been more appropriate. There were no representatives of the Royal Colleges of Anaesthetists,

measures transposing the Directive, as well as concerning the practical implementation of these measures?	Psychiatrists, Obstetricians and Gynaecologists and General Practitioners amongst task force members, who in combination represent over 60% of the UK's doctors (http://www.rcseng.ac.uk/policy/documents/wtd-taskforce-report-2014). This suggests that we have not been viewed as social partners on this occasion, which as the largest NHS specialty we strongly believe that we should have been. We have concerns about the Government's plans to investigate further the recommendations of the above task force and have written to Jeremy Hunt expressing our views (http://www.aagbi.org/sites/default/files/Letter%20to%20J%20Hunt%20from%20AAGBI%20GAT%2012AUG14.pdf).
The Directive provides at Articles 17 and 18 for derogations by means of collective agreements or agreements concluded between the two sides of industry. Please	We are not aware of formal derogations in anaesthetic trainee rotas but there is a voluntary opt-out in medicine. As mentioned in our introduction, we are concerned about the Government's future plans to promote this. Whilst this may have merit in a small cohort of trainees for a limited period of time, for instance to gain specific competencies in an intensive period of training, we feel that this should remain an individual trainee's decision, made without undue external pressure. Changing current legislation in this regard would open up trainee rota planning to abuse by clinical and non-clinical managers, either by allowing managers to be able to staff non-compliant rotas with trainees or to decrease the number of trainees in rotas by pressurising trainees into accepting the opt-out. We believe that the design of training programmes must not be based upon the assumption that trainees will opt out. In addition, we are worried by the recommendation that the SiMAP (1) and Jaeger (2) judgements may be overturned. The AAGBI and GAT acknowledge that for some specialties, especially those with a less than adequate training structure, these rulings may

indicate how you evaluate the experience in this regard.	be unhelpful. However, we think that these important rulings help protect trainees from the potential adverse effects of employer exploitation. To quote the taskforce report: "*taskforce members such as the BMA stressed the positive nature of the Jaeger judgment in preventing doctors from overworking, and all taskforce members recognised this point*". We appreciate that a proposal to separate training from service provision may appear to help circumvent the effect that these rulings have on some training programmes. However, such a proposal is not without its potential problems and would appear to contradict the Temple Report recommendation that: "training should be delivered in a service environment with appropriate, graded consultant supervision" (3). Clinical Directors and trainees in many units throughout the UK report that it is difficult to run rotas that comply with the European Working Time Regulations, with the current complement of staff. No allowance is made for maternity leave, or sick leave, despite the fact that the average age of trainees is 28-35, the time at which most professional people have families. Hence, units rely on people doing 'internal locums' and hence working for more than 48 hours, or on external locums, who do not know the hospital and can be of variable quality. Lack of familiarity with the work environment is known to be associated with an increased incidence of adverse events. 1. Case C-303/98. *Sindicato de Medicos de Asistencia Publica (SiMAP) v Conselleria de Sanidad y Consumo de la Generalidad Valenciana* [2000]. ECR I-7963. View at: <http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?isOldUri=true&uri=CELEX:61998CJ0303 2. Case C-151/02. *Landeshauptstadt Kiel v Norbert Jaeger* [2003]. ECR I-08389. View at: <http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?isOldUri=true&uri=CELEX:62002CJ0151 3. Temple J. Time for Training: A Review of the impact of the European Working Time Directive on the quality of training. England: MEE, 2010. ((http://hee.nhs.uk/wp-content/uploads/sites/321/2012/08/Time-for-training-report.pdf).

Are there any examples which you consider as providing possible models of good practice?	

3. MONITORING OF IMPLEMENTATION	**Comments**
Please indicate whether you consider that the enforcement and monitoring of the Directive at national level is satisfactory.	No. The printed rota is often very different from the 'rota in action'. National monitoring has reviewed rotas printed before events and therefore takes into consideration what happens on paper and not what is actually happening in practice. In fact, trainees are often encouraged to submit these data rather than the reality. There is now new software (e.g.

	clwrota) that shows the sessions people actually worked. Future monitoring should include this and also review the hours worked each week by everyone doing a locum shift.
If you see any problems, please indicate their overall impact and make recommendations for improvement.	The impact is that doctors are sometimes working much longer than the 48 hours laid down in legislation. There are clear data both about the impact of tiredness on decision-making in delivering patient care and of car crashes including fatalities in doctors driving home after work. Recommendations would be that an 'on call' room is always provided for each doctor covering night duty to have some rest. Further monitoring should take place, this time using the evidence from newer software such as clwrota, which shows the work actually done.
Can you identify any examples of good practice as concerns monitoring and enforcement?	Some departments have an 'available consultant' system whereby an individual is available each day to cover work commitments of colleagues who were up working during the previous night.

4.EVALUATION	
Please describe any evaluation work carried out under your authority.	A peer reviewed paper has demonstrated that it is possible to train an anaesthetist within a 48 hour working week (1). However all the problems we have mentioned above may mean that trainees are actually working far more hours if internal locums to fill gaps and study leave are included. Nationally The GMC 2014 National Trainee Survey results record high outlier satisfaction for anaesthetics with overall satisfaction the highest for all hospital specialties (85.5/100). Clinical supervision is high at 92.7/100. Foundation trainees undertaking anaesthetic rotations recognise the high quality of training and supervision. http://www.gmc-uk.org/education/surveys.asp?WT.mc_id=MENE140618. The GMC trainee survey has also demonstrated an increase in satisfaction with training for all training levels and specialty groups year on year since the implementation of the 48-hour working week. It was noted that even though those in surgical training posts are the least satisfied, their satisfaction scores also continue to rise. 1. Paul RG, Bunker N, Fauvel NJ & Cox M. The effect of the European Working Time Directive on anaesthetic working patterns and training. Anaesthesia 2012; 67(9): 951-956.
Please indicate what were the main conclusions as regards the socio-economic impact of the	

transposing measures, in particular on:	
• workers' health and safety	There are data to suggest that surgeons have one of the worst rates of car accidents. Although the overall hours are reduced with the implementation of the WTD rotas are often very antisocial including up to 7 night shifts in a row (84 hours/week) resulting in fatigue. Fatigue is known to have a serious impact on performance, vigilance and hence safety. Cognitive function is impaired, with slower response times, more frequent lapses in attention, impaired memory and poorer ability to do simple calculations (e.g. drug doses) and poorer decision-making. Working continuously for 20 hours has the same impact on performance as being over the alcohol limit for driving. AAGBI provides advice about fatigue and the anaesthetist as well as the impact of shift work. (http://www.aagbi.org/sites/default/files/fatigue_and_anaesthetists_v6_for_members%5B2%5D_0.pdf).
• work/life balance	'Less than Full time' – usually about 30-35 hours per week contracts have been available for trainees for a number of years. As the gender change has worked its way through medicine these have become increasingly well used and are vital in keeping women in medical practice. With 70% of medical students being female in many universities this is vital if we are to preserve the medical workforce. However, in anaesthesia we know of circumstances in which it is becoming more difficult to access LTFT training, or restrictions are put in place (e.g. 80% of FT as a minimum, have to train FT for certain rotations (often ICM and obstetrics)). This is a reflection of an inability to provide the service with a reduced working week and a reduced number of trainees.
• business flexibility/competitive	

ness	
• consumer s/service users	
• SMEs	
• administrative/regulatory burden.	The monitoring of trainee doctors hours is deemed by employers to be an administrative burden. Since the introduction of the WTD there has been a complex banding system so remunerate doctors based on numbers of hours worked and the anti-social nature of these hours. There have been large financial penalties for trusts if rotas are non-compliant and it is believed that it can lead to a strain on employer-employee relationships. With ongoing junior contract negotiations employers are keen to discontinue the monitoring of hours and the banding system but we have concerns that this may lead to a return to increased hours of work and no consideration for those acute specialties who work the most anti-social hours at high intensity.
Does the practical application of the Directive in the Member States, in your view, meet the objectives of the Directive (i.e. to protect and improve the health and safety of workers, while providing flexibility in the application of certain provisions and avoiding	Yes

imposing unnecessary constraints on SMEs)?	

5. OUTLOOK	
Please indicate:	
• any priorities for your organisation in this subject area;	We have an ageing patient population with increasingly complex health needs. There are clear data showing that consultant delivered care produces better outcomes, both in terms of quality of life and death rate. The Academy of the Medical Royal Colleges has produced a report on Seven day Consultant Presence (http://www.aomrc.org.uk/projects/seven.html). Currently there aren't enough trainees coming through the system to be able to support our future patient needs. Instead there is an expectation that consultants will work for longer. Yet we know that older people in all walks of life, including medicine, are slower at responding to fast changing emergency situations such as are common in Anaesthesia. Tiredness greatly worsens this. Hence, we must address the workforce problems if we are to have any chance of having sufficient anaesthetists to provide the

	care expected in the 21st century.
• any proposal for additions or changes to the Directive, stating the reasons;	It would be useful to include something about regular breaks being a requirement for those doing very long procedures. We find ourselves working alone doing a single case or list lasting 10 of 12 hours, with nothing but the briefest relief. If a lorry driver is not permitted to drive without a break, neither should an anaesthetist or surgeon. (A lorry driver is at risk of crashing; however, the anaesthetist has rendered the patient unconscious whilst the surgeon is performing a complex procedure. Both of these roles put the patient's life at risk if mistakes are made.)
any flanking measures at EU level which you consider could be useful.	

The previous national reporting exercise launched in 2007 resulted in the adoption in 2010 of the *Report from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on implementation by Member States of Directive 2003/88/EC ('The Working Time Directive,* COM(2010) 802 final. The final report was accompanied by a Commission staff working paper: *Detailed report on the implementation by Member States of Directive 2003/88/EC concerning certain aspects of the organisation of working time ("The Working Time Directive '),* SEC(2010) 1611 final.