



THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House, 79 Whitehall, London
SW1A 2NS

12 August 2014

Dear Mr Hunt,

Re: The Government's response to the review of the impact and implementation of the European Working Time Directive on the NHS

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) and its trainee body, the Group of Anaesthetists in Training (GAT) read with interest the Government's response to the review of the impact and implementation of the European Working Time Directive on the NHS. The AAGBI is the professional representative body for more than 10,000 anaesthetists working in the NHS, with GAT being the democratically elected representative body for 3,000 anaesthetic trainees. The AAGBI welcomed the national review into the effect of the Working Time Regulations (WTR) on patient safety and postgraduate training in England [1,2]. Both the AAGBI and GAT share the same goals as the taskforce: to ensure excellence in patient care and the delivery of high quality medical training.

The report raises several valid points, most importantly that the UK medical training system already produces highly competent doctors who are fit to practise independently. Even in 2009, Sir John Temple had concluded that it was possible for high quality medical training to be delivered within the 48 hour limit imposed by the WTR, with the caveat that some organisations may need to reconfigure services to support it [3].

We note that the government will be accepting all of the recommendations of the report and has committed to exploring all options. We would like to raise some points of concern relating to the following three areas that were highlighted in the press release of the 22nd July 2014 [4].

Identifying training time that is not working time

The taskforce recommended that *"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."*

This would appear to contradict the Temple Report recommendation that: "training should be delivered in a service environment with appropriate, graded consultant supervision". It is not clear from the current report what might constitute training or service, and how this split might vary between specialties. We would welcome clarification from your department and the taskforce about how the split might be accomplished and how remuneration for the educational component would be achieved. NHS Employers are seeking cost neutrality in the current renegotiation of the junior doctor contract. If an educational grant were to be given to trainees in specialties that cannot adjust working practices adequately to train their junior doctors within the WTR, will this impact on the salaries of those trainees in specialties that have made the adjustments successfully?

Raising awareness of the voluntary opt-out

The taskforce report recommends that *"...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"*. 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 [5] and Jaeger [6] 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 be unhelpful. However, we think that these important rulings help protect trainees from the potential adverse effects of employer exploitation. To quote the current 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 the proposal to separate training from service provision may appear to help circumvent the effect that these rulings have on some training programmes. However, as we have noted above, such a proposal is not without its potential problems.

Reviewing working patterns and rotas

The taskforce stated that *"...NHS Trusts should review best practice in the design of working practices and share examples of the successful delivery of patient care and training of junior doctors."*

We agree that recommendations for the scrutiny of rota design and the establishment of robust handover mechanisms are a positive step. However, the taskforce stops short of supporting Sir John Temple's specific recommendation that both better training and better patient care can be provided by moving to a consultant-delivered service, particularly out-of-hours [3], despite the GMC highlighting the AoMRC report on seven-day consultant working during the consultation [7]. As pressure is mounting on the NHS to move to seven-day working, and consultant and trainee contracts are in the process of being renegotiated, this presents a solution that ties current political imperatives to safer patient care, with improved access to consultants for training purposes without the need to derogate the entire UK medical profession from the WTR.

We hope that exploration of these recommendations is achieved with complete stakeholder engagement in a sensible timescale. Professor Williams's Review was commissioned in mid-2013 for a report to be produced by January 2014. To quote the report: *"Given that the taskforce will be reporting to the Secretary of State for Health by January 2014, the timetable is short."* Such a tight timescale for such an important piece of work seems to have left insufficient time to engage with all interested and relevant stakeholders, including the AAGBI and GAT.

We are concerned that there was a lack of representation of the full range of clinical specialties within the task force membership. Conspicuously absent was representation from the specialties of anaesthesia, psychiatry, obstetrics and gynaecology and general practice, who, in combination, represent >60% of the NHS's doctors [8]. For a report on medical training, trainee stakeholders seem also seem to have been grossly underrepresented. Whilst both the BMA Junior Doctors Committee and the Academy of Medical Royal Colleges' Trainee Doctors Group were rightly represented, the only specialty-specific trainee group included in the taskforce was the Association of Surgeons in Training, an organisation well known to object to the WTR. This could have led to misrepresentation of cross-specialty trainee interests.

In the Government's response, you are quoted as saying: *"We share the longstanding concerns about the impact of the implementation of the Working Time Directive on patient care and doctors' training"*. To date, there is no evidence to suggest that patients have been harmed by the implementation of the WTR. The GMC trainee survey has 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 [9]. With regard to sick leave, which can be used as a surrogate marker for overall wellbeing, peer-reviewed evidence suggests that the amount of sick leave taken by trainees has decreased following the introduction of the WTR [10].

With regard to the future, and to quote the current report: *"Many accept that it may be possible to train a surgeon in a 48-hour working week. However, the problem lies with turning this into a reality"*. 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 look to adapt their ways of working to implement high quality training within the confines of the WTR. 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 WTR 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.

The specialty of anaesthesia has clearly demonstrated that it can train competent anaesthetists within a 48-hour working week. We do not believe that surgery is a special case amongst medical specialties, and we would argue against changes that would allow a return to the long working hours that risked patient safety and the wellbeing of trainees. We would welcome the opportunity to share the ideas and innovations that have made this possible for our specialty, and we would be keen to participate in further work exploring the three identified areas from the review.

We look forward to your response,

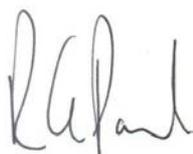
Yours sincerely,



Dr Sarah Gibb
AAGBI Chair of the
Group of Anaesthetists in Training



Dr William Harrop-Griffiths
AAGBI President



Dr Richard Paul
AAGBI Immediate Past Chair of the
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Dr Ben Fox
AAGBI Group of Anaesthetists in Training
Honorary Secretary Elect

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