

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

NHS Medical Education England (MEE)

Consultation exercise, 22nd December 2009 – 15th February 2010

i. Background

The quality of medical training is paramount in ensuring that the healthcare workforce are equipped to deliver safe, high quality care to patients today and in the future. This review will provide an objective, independent, evidence based report, including recommendations, specifically focusing on how the 48-hour week impacts the quality of the training of doctors, dentists, pharmacists and healthcare scientists.

The review is being carried out in a number of stages. Currently we are conducting a literature review of the available research and evidence. This will be supported by evidence gathering from relevant parties in oral, written and survey formats. The evidence will be collated to form the draft report and recommendations and a second series of oral hearings will be held in March 2010 (if necessary, as determined by the review team) for further oral debate and review.

The report will include recommendations on the steps that need to be taken to ensure that the training delivered is of high quality. The primary focus of the review will not be on service issues or the implementation of the EWTD but on producing a workforce that is fit to deliver a quality service to patients. The review will complement the work being done by the Postgraduate Medical Education and Training Board (PMETB) as part of their ongoing programme of quality assurance of postgraduate medical education and training. For more information on Medical Education England and the review, please visit <http://www.mee.nhs.uk/>

This consultation is one aspect of the evidence-gathering process, which includes oral evidence collection and a quantitative survey.

ii. Guidance for submission

Please respond to the questions below. Use as much space as required and attach source documents if applicable. Please give evidence/examples where possible and identify whether your comments are general or linked to a particular profession or specialty within that profession. Respondents may wish to consider these questions in the context of the phased introduction of the EWTD – i.e. the effect of the introduction of the 56 hour working week in August 2004 and the effect of the 48 hour working week in August 2009. If you are returning your response by email, please keep it in an unlocked and malleable format (No PDF documents please)

iii. How to submit a response

All responses should be submitted electronically to meewtdreview@dh.gsi.gov.uk under the heading 'MEE EWTD Review - Written Evidence'. If you are unable to submit by email, responses should be sent to:

Carley Doughty
MEE EWTD Review -
Medical Education England
Room 531B
Skipton House
80 London Road
London
SE1 6LH

Responses received after the 15th February 2010, either hard copy or electronic, will not be considered.

If you have any queries please contact Carley Doughty on 020 79725791 or Kirsten Miller on 07554 334321.

iv. Report

The review team will consider all evidence submitted, and will produce a final report in April 2010

1. Details of your response

About you

Mandatory questions are marked with an *

If you are responding on behalf of an organisation	
*Please provide your name:	The Group of Anaesthetists in Training (GAT)
*Please provide your job title:	Chair of the Group of Anaesthetists in Training
*Please provide the organisation's name:	The Association of Anaesthetists of Great Britain and Ireland (AAGBI)

If you are responding as an individual	
*Please provide your name:	
*Please provide your professional group: Please delete as applicable:	Medical/Dental/Pharmacist/ Health Scientist/Other
If Other, please provide a brief description of your profession	
*Please provide your Speciality or Course: If you are a trainee and have not yet picked a speciality, please record 'Pre-specialisation'	
*Please provide your relationship to training: Please delete as applicable:	Trainee/Trainer/Other
*If you are a trainee, please indicate your stage of training: Please delete as applicable:	Undergraduate/Graduate/ Postgraduate

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

2. 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>The provision of a plan for individuals recruited according to specified criteria to enable them to reach a clearly defined end-point in as efficient and relevant a way as possible.</p> <p>The criteria for reaching this end-point need to be specific, measurable and achievable within the time limits of the programme, which should also be clearly stated but flexible. The trainee needs to know where they are aiming, how they will get there and how they will know when they have got there. The plan needs to be agreed with the trainee in such a way as they feel they have ownership over it and a personal responsibility to maximise their training opportunities; this will provide them with confidence in the plan and motivation to complete it to the best of their ability. Regular reviews within a structured framework should be incorporated to allow for early identification of problems and enable quality to be controlled. Emphasis should be placed on both the bigger picture and the finer detail in order to maximise day-to-day training opportunities and to enable the trainee to utilise the local strengths and innovations around them.</p> <p>Multiple methods of training should be employed, and a mixture encouraged rather than prescribed, recognising that some methods suit some individuals better than others. The employment of a flexible approach to training methods, within the boundaries of the training scheme, will motivate the trainee to aim higher than simple achievement of a specified minimum standard. However, a holistic approach to this system would also emphasise the importance of developing a well-rounded trainee with a sensible work-life balance.</p> <p>In the world of anaesthetic training, this end point is the ability to practice independently as a consultant within the medical profession. To this end the trainee needs to be able to take on gradually increasing levels of responsibility as their competence and confidence increase. This is necessarily linked with time spent within the scheme, but should not be solely time-based.</p>	
2.	<p>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.</p>
<p>Full implementation of the EWTD only took place in August 2009. The Group of Anaesthetists in Training (GAT) undertakes an Annual Training Survey at our summer Annual Scientific Meeting in July; therefore last year's results are not wholly applicable to the current situation. Our 2010 survey, once performed, will provide a year's worth of data relevant to full implementation. Our current information is thus based on personal experiences gathered on an informal basis from our members, of which there are around 3500 (90% of the total number of anaesthetic trainees at the last assessment.)</p> <p>It would appear that our training scheme has so far not been adapted consistently to fit the changing environment and workplace culture. The outcome as stated in the previous answer has not changed and neither can nor should it do so. However, the workplace training is felt to have turned into a frantic paper-chase with actual day-to-day valuable training opportunities sacrificed for the chance of "ticking a box" or "completing a form". This has been emphasised by changes in the rota system, especially in smaller hospitals, which have significantly diminished the time spent</p>	

in theatre during normal working hours, and hence reduced the opportunities to get the paperwork done. There is understandable concern over the knock-on effect of this situation as regards a reduction in numbers of cases within trainee logbooks, and particularly a reduced exposure to more uncommon incidents and a change in the performance level and supervision of the trainee. An article in *Anaesthesia* in March 2009 looking at changes in out-of-hours workload since the initial phase of EWTD implementation concluded that an increase in this workload was due to higher work intensity rather than more actual shifts worked. It also showed no change in the supervision levels of these cases, but this was felt likely to be a type II error due to the small numbers involved.

Rota gaps are a big issue; although some hospitals appear to have got it right with well thought-out and structured rotas, there are many which have not and are struggling to cope with a reduced number of trainees to fill the slots and a reduction in the number of tiers of trainees present within the hospital out-of-hours. This has a subsequent effect on consultant workload, particularly concerning for new consultants making the transition from trainee level. It appears that larger centres are coping with the change better than some of the smaller regional hospitals. The on-call rotas are less onerous and the trainees are therefore able to spend more time in theatre with associated training opportunities. In the smaller centres there are fewer people on the on-call rotas; with the overall reduction in hours the on-call hours have remained static with a severe reduction in training hours. For example, from one hospital, after removing study leave and annual leave from a 1 in 7 rota the time in theatre was reduced to, on average, half a day a week. This, combined with the necessity to cover ITU and obstetric anaesthesia out-of-hours, has led to very minimal opportunities for general anaesthetic training. How competencies can be achieved during this time is concerning.

Any flexibility and ownership that the trainee felt seems to have diminished, with a corresponding drop in morale, motivation and confidence. There seems to be a cohort of disgruntled, stressed and fatigued trainees with no obvious incentive to “aspire to excellence” in their profession; pushing above and beyond the minimum dictated baseline now has to be fitted in between out-of-hours work but within a culture where they are told things are better than in the past. The trainee remains acutely aware, however, of their individual responsibility to seek training at each opportunity, with a tendency to focus on this to the detriment of job enjoyment and satisfaction – the real motivation for lifelong learning. Many feel that their work, family, home and social lives have all been adversely affected by poorly-managed full implementation of the EWTD.

Quality of training methods may actually have improved as we, as a profession, look for novel and innovative ways for competency achievement – for example the increased use of high-fidelity simulators and the Royal College of Anaesthetists e-learning programme. It is generally felt that the training quality is good when the training is available, but that opportunities to experience it have diminished since August 2009.

<p>3.</p>	<p>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?</p> <p>Respondents should consider changes related to training which:</p> <ul style="list-style-type: none"> • Resulted directly from EWTD • Resulted indirectly from EWTD • Are potentially unrelated but nevertheless are perceived to impact on the quality of training.
<p>Directly – Rotas have changed in two main ways: a period of time off to compensate for weeks with a huge excess of hours (up to 90hrs), or shift patterns which start and finish at times which prevent the proper practice of anaesthesia (such as late starts and early finishes), neither of which is ideal. A large number of trainers are working very hard to attempt to achieve compliance for the trainee and simultaneously maintain training standards, often with great difficulty. There is awareness from senior clinicians and trainers that training needs to be delivered in a shorter time-frame, often away from the workplace, and many trainers have tried to engage with this idea. However, many departments appear to be too reliant on trainees for service delivery to be able to adapt to this, and it certainly perpetrates a culture of perception amongst senior members of staff that trainees have become clock-watching, shift-aware paper-chasers. This in turn can demoralise the trainee further, and stories of how much better it was “in my day...” are unhelpful in encouraging the next generation of professionals. Some departments are delaying the implementation as they may have advertised jobs to fill rota gaps. These job adverts have a limited appeal and potentially few prospects. There is a general awareness of the bulge in CCT holders being produced in Anaesthetics at present, but often no funds or opportunities to employ these individuals.</p> <p>Indirectly – Attitudes seem to have changed, as mentioned above. The act of sending a trainee away before the work is finished (as consultants are often compelled to do) diminishes the professionalism of the trainee and denies a valid training opportunity. A cornerstone of professionalism is the ability to choose when and where additional time can be spent on interesting or challenging work. Management appear to believe that if a trainee is unable to cover a theatre list they are not providing a service to the department, hence ignoring that service provided when on-call. This is very discouraging to the trainee and fosters a poor relationship. Personal development seems to be discouraged by this system; a lack of training time and flexibility in the system has led to a loss of ownership over training and subsequent demotivation. Multiple gaps and short-notice changes to working patterns increase a sense of frustration and intrusion into the work-life balance of the trainee. Strict out-of-hours working with a reduction in trainee numbers available out-of-hours and restricted access to senior help risks inappropriate delegation of responsibility. The other major reason for reduction in trainee morale is the withdrawal of facilities such as on-call rooms and hot food – something that was the mainstay of terms and conditions of service in previous era. The feeling of “you are doing a night shift therefore you should be working all night” is not necessarily backed up in actual experience, and coupled with differing opinions from nursing and management staff has led to trainees having nowhere to go to rest should the opportunity present itself. GAT has multiple years of survey evidence showing withdrawal of these facilities, and it is commonly known there are particular problems for trainees who have a long commute to/from work. Most importantly, however, is the feeling of despair that comes from being treated as the bottom of the pile.</p> <p>Potentially unrelated – The general reduction in the responsibility given to trainees may or may not be caused by the EWTD. Departments now feel empty with few trainees present in the daytime. Less interaction between trainees means that previously important social networks decline and the trainee may become more vulnerable. The opportunities to pick up clinical or social problems are reduced by less trainee-trainee and trainee-consultant interaction; the ‘at risk’ trainee may be missed with disastrous consequences. Clinical governance may also be affected</p>	

as trainees are unable to attend departmental or local meetings or contribute to them. Overall this is due to less daytime presence rather than the decrease in hours per se.

4. What lessons can be learned from national and international experience about the delivery of high quality training within time constraints?

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.

GAT has links with trainees in Australia, New Zealand, Canada and the USA through our Common Interest Group (CIG) and believes we can learn from studying international training.

Trainees in Australia are able to achieve their training aims in little over 40 hours a week. They also train in fewer years. This time reduction is not something that is desirable in the UK at present; if anything there would be a need to extend time in training if competencies are not achievable within the current time constraints. It is difficult to compare Australian standards with our own in a robust way at present but clearly a decrease in UK standards due to hours limitation would be undesirable. Having spoken to our Australian trainee representatives via our CIG they do appear to have less onerous on-call commitments and more daytime training.

The CIG Canadian trainee representative describes their experience as one of long hours and shorter training that seems to be developing in the opposite direction to our own. There is also a difference in their trainee supervision levels, which are extremely high until such a time as they are appointed to consultant posts, at which point they suddenly start independent practice. However, there is also a big difference in the way their theatre suites are physically set up, allowing for easy access to immediate help should it be necessary. At present this is not always the case in the UK, although it is a model which has been looked at in some areas. The US system is also similar to this, and they have no restrictions on their hours worked at present.

Reduced rota flexibility in the UK is making it increasingly difficult for trainees to go Out-Of-Programme and obtain individual and varied experience of working in overseas training schemes. This could produce valuable ideas for how the UK scheme could be modified under the current changes. There is concern that this loss of opportunity risks producing a very “generic” trainee within the UK and that a lack of diversity within the training experience could have a negative impact on the quality of both anaesthetic training and patient care in the future.

The NHS employs, and therefore deems competent, anaesthetists from around the world who have trained in a variety of systems of a variety of lengths, so it is clearly possible to train to a specified standard within a reduced-hours framework. However, it requires a massive shift in UK NHS culture and thinking. It is still widely regarded as unprofessional that trainees today do not work the long hours that our predecessors did, and we need to move on from this way of thinking and from the delusion that reduced hours of work equates to an easier life. As mentioned above, travelling distances, disruption to family life, circadian rhythms and a lack of decent facilities when at work all contribute to poor performance and disenfranchised trainees.

4. Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory code of practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you would explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

Medical Education England will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.