Response to the DDRB call for evidence questions

From the Association of Anaesthetists of Great Britain & Ireland (AAGBI) and the AAGBI Group of Anaesthetists in Training (GAT)

Submitted: 23 December 2014 (edited August 2015)

1. What were the pay-related issues in the consultant contract negotiations for which agreement could not be reached? What proposals were put forward? How do these proposals link to the Heads of Terms?

Loss of progression was unacceptable, as safeguards could not be agreed between negotiators. If automatic progression is lost there must be contractual safeguards that define progression, as appropriate, to prevent rogue trusts from simply ignoring progression to limit the salary bill.

Proposals to reduce the period of premium time is not justified, these are the times outside of normal hours when a consultant may well be busy if called into the hospital. These are also the times when a person might expect to spend time with family and maintain a work-life balance. Again the employers' side failed to agree any safeguards to prevent overloading the senior staff with out of hours work

2. What are your views on the recommendations and observations as set out in the DDRB's report *Review of compensation levels, incentives and the Clinical Excellence and Distinction Award schemes for NHS consultants*?

These awards encourage excellence and reward work both in the trust to achieve excellence, and outside for work with other bodies. This work should be over and above work remunerated within the job plan, not instead of work already paid. The awards do benefit those that go the additional mile and should remain. In many cases a huge number of hours are spent on work outside the trust for the greater good of the NHS, work which indirectly benefits the trusts and often directly benefits patients. We have no doubt that the number of volunteers for posts in medical management, education, research and development, and on national committees and consultation groups would fall without these awards. This would be to the detriment of the NHS as a whole.

Any loss of existing awards might result in senior experienced consultants over the age of 50 choosing to take early retirement as it would not be able to make up for the lost pension by staying. This would generate substantial extra costs for the pension service coupled with a loss of contributions; there would also be a 'brain drain'.

3. What evidence do you have from other sectors that provide 7-day services, and what is your justification for such comparators?

The police force work a 7-day week in many specialties. There is a full complement of staff which allows them to take annual leave during nightshifts or at weekends, since these are viewed in the same way as daytime weekday shifts. What is their retirement age?

4. What were the issues with the doctors and dentists in training contract negotiations for which agreement could not be reached? What proposals were put forward? How do these proposals link to the Heads of Terms?

Please see the attached BMA document directly relating to this issue, which the GAT committee endorses. Interestingly we have noted that there were disagreements with all of the terms of reference regarding the new junior doctors' contract, such as 'The contract will provide safeguards against unsafe working hours and patterns', and 'Deliver both safe working patterns and safe total hours of work'.

From the East of England Deanery, several hospitals are struggling to keep to the RCoA recommendation of a maximum on-call frequency of 1 in 8. There are simply not enough trainees to staff on-call rotas with this frequency in mind. This will obviously have an impact upon training opportunities.

As such the contract needs to reflect the following Heads of Terms which pertain to training:

4.5: This is an employment contract which encompasses training, personal development and service delivery required as part of the job.

4.6: Jobs should come with a work schedule describing how a doctor in training in a job is expected to spend their time and the duties of the post-holder, including the available training provision and learning opportunities.

5.1: The working hours and pattern of working hours for doctors in training need to:

- comply with relevant legislation
- be safe for patients and for doctors in training
- recognise that both service delivery and training will continue to take place throughout the 7-day week.

With regard to point 7.2 in the terms of reference: we will review the existing contractual arrangements for facilities bearing in mind changes in working practices and the importance of safety.

We would like to share some evidence regarding the tragic consequences that fatigue can have.

Both the GAT committee and the AAGBI have knowledge of at least one fatality (in Scotland, Manchester and Oxford) following a road traffic collision involving a physician who was immediately post nights.

Several potential contributing factors were identified:

- long distance to travel home 30–60 minutes
- poor rest facilities during on-call
- no opportunity to rest in the hospital post nights
- nights are not physiological even if they are in the form of a 12-hour shift

Anaesthetic trainees within the East of England LETB were surveyed about fatigue, post on-call rest facilities and driving home and there were several relevant findings:

- In the East of England LETB they have seen on-call rooms for anaesthetists turn into offices for secretarial staff because they are not 'financially viable'.
- Several departments have access to post-on-call facilities but these require booking in advance.
- Many trainees experience dangerous levels of fatigue and exhaustion while driving home post on-call. This ranges from short journeys home to those which are over an hour. This is worrying given that the Magistrates' Sentencing Advisory

Committee states that 'If a driver continues to drive when sleepy it is to be regarded as an aggravating factor when it comes to sentencing.'

- One trainee has fallen asleep at a roundabout.
- Thankfully there have been no fatalities within the LETB but there have been at least five road traffic accidents.
- One trainee has woken up after bumping into the kerb of the central reservation on a duel carriageway.
- Three trainees have written off their cars, with one involved in a three car collision requiring time off work because of neck injuries.

This evidence shows that future negotiations really need to focus on rest facilities for physicians especially if 7-day working is to take hold.

5. What pertinent information do you have on the working patterns of doctors and dentists in training?

A fall in the number of doctors in training coupled with reduced working hours pushes departments to rely on locums (often internal) to maintain service or to use a consultant's resident out of hours which is extremely costly in terms of time lost. The alternative is to increase the frequency of junior rotas while trying to maintain learning time. Other solutions such as PAAs will take time to train in sufficient numbers, require supervision and are unable to cover the full range of our specialty.

The Temple report [1] emphasised that although doctors could be trained to a high standard in 48 hours to be compliant with the European Working Time Regulation (EWTR), this would be hampered if trainees were poorly supervised or worked disproportionate amounts of out of hours work.

Trainee satisfaction across specialties has improved with the EWTR hours reduction [2].

Directly related to anaesthesia, junior anaesthesia trainees have had more supervision since the regulations were introduced and senior trainees have had similar levels of supervision. There has also been a reduction in the number of sick leave days taken by anaesthesia trainees since the introduction [3].

The GAT committee has written and received a response from Mr Jeremy Hunt, Secretary of State for Health, highlighting concerns regarding the government's review of the impact and implementation of the EWTR [4].

Anaesthesia trainees in four areas of the UK have reported issues with delivering anaesthesia provision in theatre suites where there is no doubled up anaesthetist, and therefore nobody readily available to help if required in a time critical emergency. The AAGBI have published a safety statement due to patient safety concerns directly relating to these reports [5].

Working patterns in terms of DCC:SPA time also have an impact on departments and training. The impact of the widespread introduction of 9:1 contracts in Scotland has been written about in The Bulletin of the Royal College of Anaesthetists [6]. Lack of SPA time means activities such as teaching and training, educational supervision, service improvement and quality improvement have all been curtailed. The impact of only new consultants having such contracts, in effect creating two tiers, has been detrimental. Comments on this include 'disillusioned, unfair, divisive, detrimental to department, creates resentment', 'detrimental to patient care as hinders development of new services, education and research', 'short-sighted and alienates newly appointed Consultants', 'undermines the specialty and the profession'.

LTFT/flexible working: Access to LTFT working has improved. However, reductions in the number of trainees in some specialties mean that this may become limited in the future. In central Scotland, restriction to LTFT training has occurred due to service requirements (min 80% LTFT, FT work for some attachments). As outlined in the scoping report for the contract for doctors in training, the current pay arrangements for LTFT trainees are overly complex meaning that trainees often get paid incorrectly. In addition, LTFT trainees

working within Lead Employer Trusts often have to ensure that Host Trusts get the correct banding information to the LET; otherwise they are downbanded and underpaid. This does not happen for FT trainees, emphasising the difference in pay arrangements.

A trainee from a hospital in the east of Scotland has reported that, until a month ago, the anaesthesia trainee rota was a 1 in 6 on-call, with the FT trainees being asked to cover the extra shifts on top of the 1 in 6. Due to this increased service provision there was a reduction in training time and normal days. There were inequalities with rota patterns compared to those working LTFT, who worked on-call 1 in 16 rather than 1 in 6. This was highlighted when one LTFT trainee reported doing over 40 paediatric anaesthesia sessions (training lists) and the FT trainees averaged 20–25 of these sessions.

6. What are the services the NHS would like to be able to provide seven days a week, but which it does not provide at the moment, and why?

- Increased obstetric cover so elective caesareans can occur seven days per week
- Elective surgical lists at weekends. Although it is important to note that there are already lots of Working List Initiatives at weekends that are covered as extras
- Pre-operative assessment clinics at weekends
- Pain procedure lists or outpatient clinics at weekend
- All assessments, diagnostic and therapeutic services

Elective weekend services as a contractual obligation would be hugely unpopular with medical staff for the reasons mentioned above. However, the impact here is on much more than medical staff. There would be a need to have a properly staffed hospital across all departments, as it would be on weekdays, to enable consultants to function fully. There could be no stepping down of ward staffing levels and support departments with a 'Sunday service' as now. This has not been fully costed by the DoH negotiators, and would be very expensive even if sufficient staff could be found. From a consultant's point of view, if a consultant spends Saturday or Sunday in the hospital theatre, then there will be days in the week when the consultant will not be there. This simply converts Saturday to Monday. We also need junior staff to function and there are clearly not enough of them in surgical and medical departments to allow for that. Emergency theatres, trauma lists and ICM are all regularly consultant delivered at weekends.

7. What 7-day services/unsocial hours' services are currently provided and what is the cost differential compared to normal working hours?

Emergency theatre cover, 24h cover of delivery suites, 24h staffing of intensive care units are currently provided. Trainees receive a banding supplement to reflect the anti-social nature of their out of hours work. This is typically paid at 40% or 50% of their basic pay.

There is clearly a need for increased out of hours input from consultants of all specialties in emergency cover and treatment. This work is often particularly unsocial, of high intensity and tiring. It should be remunerated at a higher level than now, possibly on a graduated system:

3 hours per PA up to midnight from 7pm and 2 hours per PA thereafter. At weekends it should be 3 hours per PA from 7am to 2pm and 2 hours per PA thereafter.

Some hard to recruit specialties (e.g. in the emergency department and acute medicine) should have a higher starting salary to encourage recruits. This should be at an individual trust level and defined by metrics that could include: number of times the post was advertised before successful recruitment, number of applicants per post, proportion of job plan as out of hours work.

8. Which staff groups will be required to provide the desired 7-day services and what will be the impact on staffing levels on each day of the week? (i.e. what is the model for the workforce?)

All (Consultants, SAS, trainees).

In anaesthesia we would require full support services at weekday level if we were to provide a 7/7 weekend service. This would be required even with a partial elective service and would not have economies of scale that are achieved during the normal working week. These staff are required as the standard to which we practice elective surgery should be the same on Saturday as it is on Monday. This would include lab staff, a full complement of ward staff, physiotherapists, etc. This would have significant implications at a theatre staffing level with around a 15–25% increase in staff costs needed to fund the additional staff with their associated unsocial hours payments. These staff would not be available initially so would rely on overtime payments at even greater cost.

For anaesthetic staff themselves, the premium time rate would result in a 12-hour shift on a weekend day utilising four PAs, which is around half of a consultant's clinical PAs. Replacing these weekday PAs would require an expansion of consultant staffing (see example below). In addition, as this would most likely be taken out of the next working week (to ensure we did not have an over tired workforce), the normal working relationships between existing pairs of surgeons and anaesthetists would be intermittently disrupted, with lost efficiency during the week. (This is already apparent when consultants take leave).

Example:

- 9 operating theatres working 10 hours on a Saturday
- Anaesthetist present one hour before list to pre-assess patients and one hour after for care in recovery
- Total anaesthetic day
- 9x12 = 108 hours = 108/3 = 36 PAs
- over one year = 1872 PAs
- assuming new consultants work 8.5 PAs of DCC and not allowing for on-call commitment with a 44 hour working week year

This would require 5 WTE of staff to backfill the 9 lists gained each Saturday.

Via the trainee network leads (anaesthesia trainees who report to GAT), trainees have reported that, in several hospitals, there are many gaps in 'out of hours' rotas within anaesthesia as it stands at the moment. In several hospitals, consultants are being asked to cover these rotas and this then takes them away from other elective duties on weekdays. Consultants covering resident on-call night duties are currently also very costly. Increased recruitment and therefore increased costs would be necessary to facilitate increased out of hours working while maintaining patient safety.

The same services and staffing levels will need to be available that are currently available during normal working hours and trainees will need to be supervised to the same level as they are during normal working hours [7].

The Royal College of Paediatrics and Child Health found that reconfiguration of acute services and implementation of consultant delivered care in response to the EWTR had maintained adequate exposure to training opportunities [8].

This includes consultants being resident on-call as part of this arrangement.

The Academy of Medical Royal Colleges' report on the benefits of consultant delivered care also highlighted that successful care is dependent on a team-based approach involving a range of healthcare staff [9].

Emergency services are currently provided throughout the NHS, often by consultants, seven days a week. If elective services were to be provided at weekends then there would

need to be safeguards in place to ensure that staff receive appropriate rest. The AAGBI guideline on *Fatigue and Anaesthetists* provides more information on the detrimental effects of fatigue on anaesthetists and by extension on patients [10].

It is likely that if elective operating was to be extended to included Saturday and Sunday, critical care services, acute pain services, pre-assessment services, day surgery units would also need to be expanded to meet this demand

9. What are the pay, staffing and motivational barriers and enablers to 7-day services in the NHS? Are there examples of how any of these barriers have been overcome?

The principle barriers are around custom and practice along with work-life balance and family issues. So far these have been overcome by paying enhanced 'waiting list rates', as if you pay enough someone will almost always turn out to do the work, however this breaks down at holiday periods and is largely dependent on fiscal drivers.

If 7-day working means that doctors will be expected to work weekends more frequently than they do at present, then one fundamental staffing and motivational barrier is that society is built around having weekends as time away from the workplace. Time to see people who are not working or at school (family or friends) and the majority of the workforce (outside the NHS) don't work weekends. Family time is important for society and regular 7-day working will make this difficult.

In addition, at the present time, childcare is not readily available at weekends. A large proportion of the workforce (not just medical staff but all NHS workers) will have dependent children for some portion of their career, which makes it logistically difficult to work weekends except infrequently, and undesirable as weekends are time to spend with their children.

10. What evidence do you have on the willingness of staff to work on every day of the week? Does willingness vary by staff group, and/or by the availability of premium payments? If so, how?

Some staff are willing to work extra weekends, but at present this is always for additional pay, which is usually paid at a higher rate than normal weekday pay. Furthermore this additional working is optional and not a regular commitment. It is unlikely that any particular group would wish to work everyday of the week.

Premium payments, after tax, only represent a marginal increase on normal pay, these will need to be increased substantially.

The current consultant contract is time-limited; therefore if more work is delivered at evenings and weekends, then less time will be delivered during normal working hours, unless there is an expansion of the current workforce. Care must also be taken to ensure that there is sufficient time to train the trainees during the week.

11. What would be the likely long-term impact on recruitment for posts that require 7-day working, compared to posts that do not?

Extremely unattractive, you only have to look at accident and emergency and the acute medical unit. These are difficult to recruit to, often with long-term vacancies in many hospitals. It might also result in a further drift away from 7-day working specialties to those where it is not required. We should also note the increased feminisation of the medical workforce, which may result in this being exaggerated further.

With regard to consultant contract negotiations, 7-day working should be shared by all consultants and not just new appointments. Having the ladder pulled up will lead to disillusioned trainees and may contribute further to the brain drain. This would have a negative effect, with 7-day working posts being unpopular. Recruitment will undoubtedly fall.

Emergency medicine has seen problems with retention and under-filled training posts which is hypothesised to be related to an increase in anti-social working hours.

12. What are the implications of equality policies and legislation for 7-day working?

There could be religious implications, Sunday being a holy day and Saturday the Sabbath. There will be gender issues with regard to family and childcare is not readily available at weekends if both parents are working. As mentioned in response to question 9, potential equality issues could arise due to different healthcare workers prioritising being off work at weekends due to family commitments, including parents, carers and those with disabilities and partners who also work weekends.

13. What evidence can be provided of the impact on patients of 7-day services?

It can be convenient for patients if surgery is elective. There is some evidence of improvement in outcomes (see Paul Aylin's lecture on http://www.learnataagbi.org/). However some studies have failed to demonstrate a removal of the adverse mortality rate for weekend admissions but have reduced it, implying there is more required than simply getting consultants in at weekends.

The Academy of Medical Royal Colleges' report earlier this year, based on the best available evidence, concluded that medical care delivered by fully trained consultant doctors has several demonstrable benefits, including improved outcomes for patients and benefits for the training of junior doctors

www.aomrc.org.uk/general-news/benefits-of-consultant-delivered-care.html

A national survey of NHS anaesthesia delivery with a 98% response rate demonstrated that anaesthesia is a consultant-led service with senior doctors present for 87% of all anaesthetics and for three quarters of those administered "out of hours" [11].

It is difficult to know what the impact will be at this stage. However, tired and overworked staff will be more likely to make errors.

14. How has the demand for the delivery of 7-day services altered in recent years and what are the reasons for this? How do you see the demand for 7-day services changing in the future, both in terms of changing patients' demographics and the additional choices that 7-day services would give to patients?

The demand for 7-day services has inexorably increased from employers as they struggle and fail to meet 18 week and 4 hour accident and emergency stays. We are not certain that all patients want their surgery at weekends; after all, it is their rest time as well. This should be surveyed across the country. The requirement for 7-day working in accident and emergency departments is irresistible, driven in part by the non-availability of primary care at weekends, resulting in significant 4 hour breaches across many trusts. However this requires all grades of staff to be present, along with the senior decision makers.

15. What is the underlying cost model for the delivery of 7-day services? What would be the costs and savings?

Anaesthetists provide many services in the evenings and at weekends, both elective and emergency. This has been driven by working time directives. The current drive for more 7-day working is motivated by perceived cost savings, but this will not happen unless workers are employed on different contracts which are less well paid. We do not support this. There are also resource issues. For instance, if there is a shortage of hospital beds it will be made worse by weekend working, as there will be fewer beds available on Monday morning.

The Academy of Medical Royal Colleges document, *Seven Day Consultant Present Care: Implementation considerations*, discusses some of the issues around developing 7-day

services [12]. Notably it states that 'achieving this transformational shift in care is likely to require additional consultant appointments'.

16. What are the pay, staffing and motivational issues and costs around any transition to 7-day service provision?

The big issue here is how you persuade existing senior staff on contract to move. Any attempt to force them would very likely result in considerable disruption of services. The only practical way is to develop a new contract for new starters and allow the old contract to diminish over time. Differential pay rises would help persuade people to move but there would be a period of years with different contracts in place.

Forcing existing consultants to move to a new contract would require legislation, firing and rehiring or a variation in an existing contract. These would all be resisted strongly by the BMA, etc., and are not without the considerable risk that many older consultants would either retire, not be rehired or seek recompense through the courts for constructive dismissal.

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