Medical Education England

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 emailed, 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:

MEE EWTD Review - Written Evidence, Medical Education England
Room 531B, Skipton House, 80 London Road, London SE1 6LH
meewtdreview@dh.gsi.gov.uk

Carley Doughty
MEE EWTD Review -
Medical Education England
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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

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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:	**Ron Kerr**
*Please provide your job title:	**Chair**
*Please provide the organisation's name:	**The Association of UK University Hospitals**

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**

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2. Consultation questions

1.	**How would you define high quality training?** Respondents may wish to consider quality both in terms of training outcomes and the methods of training.

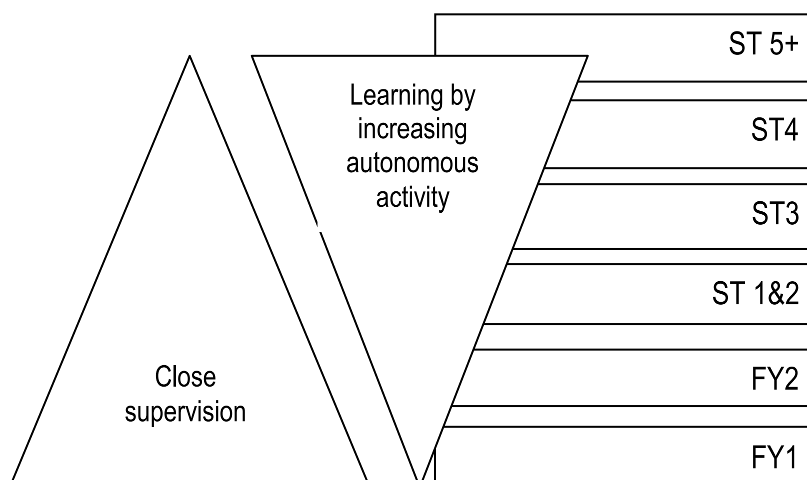
High quality training is the process that allows trainees to acquire the knowledge, skills and attitudes needed to carry out their present role, progress in their chosen career and prepare them for lifelong practice and learning. Training outcomes can be divided into knowledge, skills and attitudes and there are clear methods for assessing all of these domains. Ultimately the outcome of high quality training is a practitioner who is safe to act independently, and with confidence, within a defined field of practise.

Appraisal, assessment and mentorship are essential to facilitate training. Immediate feedback on decisions and actions is an important component of high quality training. Formal case presentations at a point remote in time from the experience are likely to be less effective as the trainee has time to reconstruct their memory of what took place. Role modelling is an essential part of the training process and trainees need to be able to spend adequate time with senior colleagues to allow this to occur. Observing seniors working, asking questions, receiving feedback and reflecting are all part of this process.

Postgraduate Medical training is inextricably linked with participation in service provision. The delivery of high quality health care should be the foundation on which quality training is built. There is a need however, for protected time for training both for the trainee and the trainer in order to provide high quality training. Trainees need adequate time and opportunity to learn to use their clinical skills. In addition there must be provision to support any trainee who performs below the required level of competency.

It should be observed that training involves both supervision and autonomous practice, and that the balance of these two elements is different at different levels. See figure 1.

Figure 1: supervision versus autonomous activity in the context of medical training



Healthcare institutions also require the appropriate infrastructure to deliver high quality training such as adequate IT systems with appropriate access for individuals.

The quality of training can be assessed in many different ways - by success rates in national assessment processes /postgraduate examinations, by feedback from trainees and/or trainers, and ultimately from results and outcomes in patient treatments, though this level of granularity in data is very difficult to assess. To support the assessment of the quality of training Local Deanery Agreements for training can be included in the quality indicators the Care Quality Commission examine as part of the delivery of service at Trust level.

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 overall impact of the introduction of EWTD has been an increased tension between service delivery and the delivery of high quality training. Trusts are experiencing difficulties arranging training programmes around the shift working and restrictive EWTD rotas.

EWTD has increased the pressure on hospitals in delivering services and maintaining the quality and efficiency of these services. As unscheduled care and service needs are necessarily priorities, any gaps in rotas caused by absence due to sickness and understaffing, disrupts departmental educational programme activities. The net effect of this lack of flexibility in the system is that EWTD compliant rotas may not be 'educationally compliant'. In the above context, trainees are asked to cover acute services to a proportionately greater part of their working week, to the detriment of getting more experience in specialist areas of medical practice. In addition, gaps in junior rotas are often filled by consultants, which results in diminished consultant time to teach and reduces the opportunity for consultants to be trained, develop and update necessary teaching skills.

Trusts report that whilst the quality of individual training interactions has remained the same, the quantity of training opportunities has reduced. EWTD imposed shift working has contributed to a loss of the vertical team structure and trainees are expressing concern that the quantity of training interactions is insufficient for them to achieve the depth and breadth of training / experience necessary to be competent and confident. Consultants are also concerned that trainees, particularly those within the craft specialties, are not receiving sufficient training and experience. Where it is evident that trainees are less able seniors are giving them less work to do. The result being that trainees who are relatively late in their programmes are unable to undertake the practical aspects of the specialty.

It is also felt that shift working has resulted in a loss of 'ownership' of patients and loss of continuity of care, which is both a valuable learning tool for trainees and crucial for patient safety. In particular, a combination of the dismantling of the firm system and the introduction of the hospital at night has in some instances has in some instances had the unintended consequence of reducing the quality of learning at night. Cross covering a large number of patients with a team of people with whom you do not regularly work, does not provide the same learning experience as being on call with your own team and looking after your own patients.

Trainees have recognised that experience will need to be generated outside the 48 hour week. Trainees are using study leave time and attend courses in skills previously learned 'on the job' such as neonatal cranial USS skills and simulation surgical skill. The result being that more clinical skills are learned in isolation from patients. Whilst it may be possible to deliver satisfactory training within a 48hr week as per EWTD there must be provision to attend regular theatre/OP/elective duties with their trainers built into

trainees' rotas. Rotas are simply too tight at the moment.

There is currently little hard data to support these views, however, some information has been generated from internal surveys conducted by member Trusts.

Cambridge University Hospitals NHS Foundation Trust
In **O&G** – 11 trainees, 13 trainers surveyed on what they thought the impact of EWTD would be:
No respondents thought that patient care would be improved; 62.5% thought that patient care will be worse; and the remaining 37.5% reported that they did not know what effect it EWTD will have on patient care. 45% of respondents thought that they would need to come in during their off time to complete their modules (4% did not think this was required, 50% didn't know). Over 80% of respondents thought EWTD have some negative effect on training and over 60% thought it would have negative impact on inpatient work.

In Anaesthesia it has been reported that the number of daytime lists has reduced from 4.9 to 3.8 per week (~20% reduction); that the average number of training lists reduced from 3.5 to 3.0 per week (~15% reduction) and that the average number of training lists in module reduced from 2.9 to 2.65/week (~10%).

Cardiff and Vale University Health Board
Willing teachers at all grades have much less opportunity to teach and develop their own teaching skills e.g. senior trainee teaching junior trainee. This has been exacerbated by in Wales where the increased numbers of doctors needed for EWTD compliant rotas are simply not available in many specialties.

Royal Free and Hampstead Trust
EWTD has had some positive increased focus on the delivery of training. In London (and in many other deaneries), there has been a centralisation of structured off-the job teaching. An example is the anatomy programme run in core training and the surgical skills simulated training run in general surgery. There has been an increased emphasis on work-based assessments (and in training the trainers to use them), which both draw the trainee and trainer together (enforced training) and necessitate feedback and reflection as opposed to learning by osmosis.

Locally the overall effect, however, has been detrimental. Hospital inspection visits have shown that an increasing number of trust grade doctors are being employed to fill the hours which has reduced opportunities for training.

In Surgery – An increasing number of higher surgical trainees are taking out of programme experiences abroad because they have not been exposed to adequate operative surgical training at home. Others are undertaking fellowships either pre- or post CCT as they do not feel confident to take on consultant posts straight out of training. Direct questioning of the 'good' trainees reveals that almost all of them are attending their hospitals out of hours, on zero days and in annual leave periods to improve their exposure to surgery. One or two have even gone so far as to arrange honorary contracts in other hospitals so that they can go and gain experience in their zero days and days off.

Furthermore, we are increasingly having requests from core trainees to take time out for further experience, as they do not feel competitive enough to compete for ST3 (as a rule they are refused). This may be resolved if CT3 is approved and comes into effect in the future. There has been a decline in operative experience in those acquiring a RITA G. Furthermore, both at the end of core surgical training and at the end of higher surgical training trainees (i.e. RITA E for SpRs or outcome 3 for StRs) are being held back due to inadequate experience. This has not been for want of enthusiastic trainers.

'Although the apprentice approach to training has long been dismissed as inappropriate by many, for the

craft specialties such as surgery, there has to be an element of this and it has been lost. Using furniture-making as an analogy, the current system will produce surgeons that make furniture for IKEA whereas as customers we really all want Chippendales.'

Newcastle Upon Tyne Foundation Trust

An analysis of requests for study leave demonstrates that overall there has been a 24% reduction in requests for study leave since the introduction of EWTD. A comparison of requests during Aug 09 – Dec 09 with the same period 12 months earlier (Aug 08 – Dec 08) demonstrate that:

- F2 requests are down *68%*
- ST1 / ST2 requests are down *30%*
- ST3+ requests are down *17%*

This reduction in requests for study leave is thought to be indicative of the difficulties trainees are experiencing in agreeing time outside of the workplace for dedicated training opportunities, following the introduction of EWTD.

National Evidence

In addition some data has emerged from comparisons of evidence pre and post New Deal (56-58hours). Evidence from Association of Surgeons in Training (Position Statement January 2009) show:

- a >20% reduction in operative cases performed
- 'Rota gaps in ~ 53% surveyed (n= 466) 69% of those with gaps on rotas have lost procedural training opportunities to provide cover. 64% trainees with rota gaps 'feel that patient care has suffered'
- From 1096 responses 90% trainees reported exceeding rostered hours on a weekly basis, 85% reported attending procedural sessions during a rostered day off. Only 25% felt that the working patterns held by HR departments accurately reflected what they do.

It has been suggested that there is also evidence of trainees not progressing through ARCP as a result of lack of exposure secondary to the reduction of training hours.

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.

It is important to recognise that there have been many other changes over the last few years, such as MMC, New Deal. It is very difficult to tease out the exact contribution of EWTD. The service has responded to all these changes by just getting on with the clinical workload. Rotas are compliant on paper but due to recruitment difficulties, gaps are filled by existing junior doctors undertaking locum shifts to fill any gaps and therefore in reality their working hours of many haven't really been reduced.

Anecdotally:

- Trainees work longer hours than they are recognised for since the start of EWTD, but many do not record this and so there is substantial under-reporting.
- Hospital at night – there is some cross cover by junior doctors however this is not suitable for several specialties.
- A tendency for doctors in their first year of some specialties and some foundation programmes to not work over night in order to maximise the daytime training they receive.
- Management teams are pushing for an increase in permanent staff, in particular non-training grades in order to fill the gaps which used to be manned by trainees in the past.
- Some Trusts are also introducing new resident on call consultant posts.
- There is an increasing reliance on Clinical Nurse Specialists and Technicians.
- Trusts are implementing more flexible working measures for permanent staff to work in evenings and weekends as part of their job plan.
- Trusts are also investing considerable time and energy in robust induction and handover processes.

From information given by Wendy Reid (DH lead for EWTD), SHAs are reporting very few breaches of EWTD, giving a very unbalanced picture. SHAs and PCTs are also using levels of compliance as a performance management tool and also to potentially include financial penalties for breaches as part of the commissioning negotiations – this has a consequence of inhibiting honest debate.

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.

Whilst it may be achievable for a trainee to gain CCST in the prescribed period within the constraints of shorter working weeks it is essential that the available hours for training are not reduced simultaneously, as evidenced by the North American experience. It is inevitable that the newly appointed 'consultant' in the future would not have the same 'exposure 'of experience as before but this group of doctors must be formally recognised and supported accordingly.

It has also been noted that some countries do not include protected educational time when calculating duty hours – only working time is included when calculating whether a rota is EWTD compliant.

There is however the argument training solutions adopted by other healthcare systems may not be that relevant as the NHS is a unique environment both for the delivery of healthcare and for training.

3. Publications to be considered as evidence

Please list any published articles or research papers that you would like the group to consider as evidence. Please note that where the referenced article appears on a password-protected site, a copy should be submitted alongside your response. Given the limited timeframe of this consultation, if you are unable to provide a valid web-link, electronic or hard copy for all other articles/papers, your suggestion may not be considered.

1. British Journal Of Anaesthesia 2009 Oct 103(4) 566-9
Training and the European Working Time Directive: a 7 year review of paediatric anaesthetic trainee caseload data. Fernandez E, Williams DG.Great Ormond Street Hosptial

2. Anaesthesia 2005 Sep;60(9):870-3.
Impact of the European Working Time Directive on the training of paediatric anaesthetists.
White MC, Walker IA, Jackson E, Thomas ML.Great Ormond Street Hospital.

These 2 papers document the reduction in cases performed by anaesthetic trainees undergoing a period of training in paediatric anaesthesia. The 2005 date refers to the 56 hour week and the 2009 to the 48 hour week.

3. Cur Opin Anaesthesiol 2007 Dec;20(6):576-9. The European Working Time Directive: effect on education and clinical care.Waurick R, Weber T, Broking K, Van Aken H.

This review article from German Authors demonstrates the same decline in cases performed across Europe.

4. Cur Opin Anaesthesiol 2007 Dec;20(6):580-4.
Duty hours restriction and their effect on resident education and academic departments: the American perspective. Swide CE Kirsch JR. Anesthesiology & Peri-Operative Medicine, Oregon Health & Science University, Portland, Oregon 97239, USA. swidec@ohsu.edu

In this review residents saw the reduction in their duty hours as a positive step both in quality of education and improvement in life style. Consultants saw an increase in work load and the need for much greater resources. They conclude; Accreditation Council for Graduate Medical Education duty hour rules are generally being followed by American anesthesiology residency programs. Residents perceive an improvement in their overall wellness, but it remains unclear if there has been an improvement in patient safety or quality of resident education. Please note this was in response to the Council for Graduate Medical Education reducing the hours of residents to 80 per week.

5. J Neurosurgery 2009 May;110(5):820-7.
Impact of the Accreditation Council for Graduate Medical Education work-hour regulations on neurosurgical resident education and productivity. JagannathanJ, Vates GE, Pouratian N, Sheehan JP, Patrie J, Grady MS, Jane JA. Departments of Neurological Surgery, University of Virginia Health Sciences Center, Charlottesville, Virginia, USA. jaj6r@hscmail.mcc.virginia.edu

This paper demonstrates that Residents working an 80 hour week performed as well in examinations as those who trained before the hours restrictions, but produced many fewer abstracts for scientific meetings. A survey of Programme directors and chief residents showed that they unanimously felt that a reduction to a 56 hour week would compromise patient safety and training.

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.