



The Royal College of Anaesthetists

Educating, Training and Setting Standards in Anaesthesia,
Critical Care and Pain Medicine

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THE IMPLEMENTATION OF THE WORKING TIME DIRECTIVE – AND ITS IMPACT ON THE NHS AND HEALTH PROFESSIONALS – CALL FOR EVIDENCE

1. The Royal College of Anaesthetists welcomes the opportunity to respond to the call for evidence regarding the implementation of the Working Time Regulations (WTR) and its impact on the NHS.
2. In a response to a discussion on WTR in June 2013, the President of the RCoA, Dr J-P van Besouw stated the following:

The RCoA concur with some of the sentiments expressed in respect of the rigidity of the current regulations and the potential impact that this has to compromise both patient safety and training. We believe that there is a requirement for doctors in training to exhibit professionalism, to avoid clock watching in order to maximise their training opportunities and to ensure continuity of patient care, issues which may be addressed by a renegotiation of the junior doctors contract, service reconfiguration and through the shape of training review. We feel it unlikely that there could be any significant change in the legislation which would improve the situation without the potential for abuse by service managers.

3. The College considers that in anaesthesia and ICM, most departments have managed to achieve compliance to WTR both in terms of the 48 hour limit and compensatory rest period with rotas that provide an acceptable balance of training time (3 consultant supervised sessions per week, and delivery of curriculum), and work life balance for trainees. Evidence from e-Portfolio and ARCPs suggests that WBAs are completed on time by the majority of trainees. However, this requires 8 trainees per rota as a minimum and becomes challenging when there are gaps. Gaps are becoming more frequent as a result of fewer LATs/ or LAS with appropriate competencies particularly at ST6 level, sick leave/maternity leave and Out of Programme time. The pressure on specialty training numbers as a result of the requirement to increase GP training numbers and the unilateral cutting of posts by LETBs threatens to exacerbate this situation. The College has expressed these concerns; <http://www.rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/specialty-training-numbers-national-recruitment>. There are concerns related to managing these gaps and occasions where trainees are put under pressure to cover these either by their own departments or others. The compensatory rest required to accommodate this results in loss of daytime training within the trainees' own Trust. Locum nights taken outside the trainees' own Trust may not be monitored as effectively as should be the case and this should be addressed to ensure patient safety is not put at risk. Currently there is no evidence from the College that patient safety has been affected directly by WTR but further work is required into this.

4. The College does not support anything less than a 1:8 rota for WTR compliance and acceptable training time and would not support a move to a 1:7 for anything other than a short period of time providing adequate cover and supervision is in place. The College often receives requests from hospital clinical directors querying the requirement for a 1:8 rota. The Curriculum; <https://www.rcoa.ac.uk/document-store/curriculum-cct-anaesthetics-2010> is specific on this matter:

Occasionally, there may be a unit of training, where out of hours work is not required; this will be the exception. For units of training where out of hours work is required [the majority], trainees should not work more onerously than 1:8 to ensure that they can meet the many training outcomes that are gained during normal working hours, in addition to those gained out of hours. The College does recognise that there are occasions when additional out of hours work is required due to local circumstances; when this occurs, it should be for short periods only otherwise there will be an adverse impact on the trainees progression through the programme making it almost certain that training time will have to be extended to ensure the learning outcomes are met. Local trainers, in conjunction with their Clinical Directors [CD], must recognise this consequence if excessive out of hours commitments [i.e. more onerous than 1 in 8 for more than the occasional week] are placed above training requirements. Finally, it is important to ensure that any new aspects of emergency work are undertaken initially with close clinical supervision.

5. The following links may be helpful in providing evidence and clarifying the RCoA position with regard to WTR:
- a. College WTR pages; <https://www.rcoa.ac.uk/careers-and-training/working-time-regulations>.
 - b. Joint RCoA and RCS guidance document on WTR compliance; <https://www.rcoa.ac.uk/document-store/working-time-directive-implications-and-practical-suggestions-achieve-compliance>.
 - i. 6.2.3 Adequate structured teaching is possible within the recommended minimum of 1:8 on a full-shift rota. However, a proactive approach is required to ensure trainees can attend.
 - ii. 6.3.5 A 1:8 rota is the minimum to be able to include prospective cover and adequate training. A 1:10 rota allows for more flexibility and training opportunities but it is acknowledged that many of the smaller specialties will be unable to achieve this.
 - c. The link; <https://www.rcoa.ac.uk/content/search?cx=009352006448159467736%3Adf2oiyfg8q&cof=FORID%3A11&ie=ISO-8859-1&query=ewtd> is to the report following visits to SHAs during the implementation phase of WTR. This is referenced in a number of College Annual Specialty Report (ASR) submissions to the GMC. The summarised recommendations to the report are as follows:
 - i. *The impact on training is given a higher priority.*

- ii. *Any 24 hour rota more onerous than 1 in 8 with prospective cover should be considered RED.*
 - iii. *Any 24 hours rota that is 1 in 8 with prospective cover will not be compliant if there is one gap in the rota. Where this is recognised as likely to happen the rota should be considered to be AMBER.*
 - iv. *Further investigation should be carried out on ICM rotas.*
 - v. *Contingencies should be put in place if planned recruitment and MTI solutions fail, through lack of numbers. DH must be aware that many SHAs have planned on recruitment and MTI to alleviate the shortfalls and this may not come to fruition.*
 - vi. *Continued liaison is recommended between the SHAs and RCoA as a continued dialogue will enable SHAs the ability to gain clarity on specialty specific issues that may not be immediately apparent.*
 - vii. *Longer term planning by all key stakeholders including DH, RCoA and SHAs to ensure Hospitals remain compliant following the initial deadline of 1 Aug.*
6. There have been a number of studies into the impact of WTR on anaesthesia training which should also be considered by the taskforce, these include:
- a. Cooper, C. M. S. and Cooper, A. E. (2012), *Anaesthetic training: not better, not worse, just different*. *Anaesthesia*, 67: 937–941
 - b. McIndoe AK. *Modern anaesthesia training: is it good enough?* *British Journal of Anaesthesia*. 2012;109(1):16-20.
 - c. 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):951-6.
 - d. Moonesinghe SR, Lowery J, Shahi N, Millen A, Beard JD. *Impact of reduction in working hours for doctors in training on postgraduate medical education and patients' outcomes: systematic review*. 2011.
7. The RCoA has regularly reported the impact and issues related to WTR to PMETB and the GMC in the Annual Specialty Reports since implementation:
- a. RCoA Annual Specialty Report (ASR) to the PMETB August 2008-July 2009
<http://www.rcoa.ac.uk/system/files/TRG-ASR-2009.pdf>
 - i. **Working Time Regulations (WTR).** *Considerable work has been conducted over the year on assessing the impact of WTR, formally EWTD. The College has conducted 2 surveys, one in January and a further survey at the end of the year. Although most Trusts were compliant by the end of the year on paper and only 23 anaesthetic rotas applied for derogation in both rounds, there are still reported gaps on rotas and substantiated reports that trainees are missing training opportunities because of the 48 hour week and enforced rest periods; 73% of the College Tutors surveyed are seriously concerned at the impact WTR will have on training. An interim report on*

the findings of the survey conducted in September serves to highlight the key concerns over the impact on training and the report is available on request prior to a more detailed report being released in 2010. WTR will have a direct impact on recruitment and there is a renewed need for work to be conducted on consultant expansion and workforce impact. The College will actively engage with DHE, MEE, PMETB and the SHAs on this during the next academic year in reaching workable and sustainable solutions.

- ii. *Concerns regarding patients being treated by more than one doctor over a short period and the effect that this potentially has on patient safety. The reduction of the number of rotas means less availability of anaesthetists to support outlying areas such as emergency departments – resulting in long delays or alternative management of patients with potentially increased risk.*
- b. RCoA Annual Specialty Report to the GMC August 2009-July 2010
<http://www.rcoa.ac.uk/system/files/TRG-ASR-2010.pdf>
- i. **LTFT.** *In recognition of the predicted increase in demand for training on a less than full time basis, RCoA has run an all day meeting (30 Nov 10) aimed at current LTFT trainees, prospective LTFT trainees and trainers with responsibility for LTFT. The meeting “Making Part-Time Work” included talks from Professor Sir John Temple and Dr Anita Holdcroft as well as presentation of the 1st national anaesthetic LTFT trainee survey. This looked at quality of training, opinions on flexible working and implications of the WTD.*
 - ii. GMC ASR Template in 2009-2010 asked Colleges to comment on the impact of WTR nationally for the specialty:
 - a) **RCoA EWTR Survey.** *The RCoA published the results of a post implementation EWTR survey in December 2009. This survey looked at compliance, recruitment, training and the effect on consultant and career grade workload. Concerns raised included the number of gaps on rotas that compromised compliance, difficulties in recruiting middle grade doctors and concerns about trainees failing to reach projected milestones.*
 - b) **Time Taken to Achieve Initial Assessment of Competence (IAC).** *Detailed investigation of training concerns looking at the time to achieve the initial assessment of competence demonstrated that although the WTR contributed to some delays, the reasons were multi-factorial. A more significant challenge appears to be gaining enough experience in obstetric anaesthesia at basic level within the two year basic training programme. Concerns raised by a trainee survey have been followed by a comprehensive trainers’ survey in conjunction with the OAA.*
 - c) **RCoA Input to the Temple Report.** *The College has shared their information with the DH and PMETB contributing to the Temple enquiry into the effects of the EWTR on training. Verbal and written reports were submitted and both consultant and trainee representatives participated in discussion forums.*
 - d) **Difficulty of Compliance to Rigid EWTR Rules.** *The recent GMC trainee survey reports EWTR compliance is still a challenge across all deaneries. Although the*

overall mean compliance is 90% the inter deanery range varies from 78.5-98%. Verbal feedback from College Tutors suggests that the rigidity of the EWTR rules are more difficult to manage rather than a reduction to 48 hours itself. Any potential reduction in trainee numbers is going to challenge this further especially in the current financial climate limiting consultant expansion.

c. RCoA Annual Specialty Report to the GMC August 2010-July 2011

<http://www.rcoa.ac.uk/system/files/TRG-ASR-2011.pdf>

- i. **Training vs Service.** *As a result of WTR and the consequent gaps in rotas to provide service trainees are undertaking an excess of on-call commitment, particularly to ICM at the expense of anaesthesia training. ST trainees are not getting sufficient emergency theatre work.*
 - ii. **Experiential Learning.** *Core competencies are met, but there continue to be concerns that trainees do not receive the experiential learning component to give clinical confidence. Although compliance to the WTR for Anaesthesia is good according to the GMC Trainees' Survey it is clear that trainees are concerned about the lack of clinical exposure.*
 - iii. **Military Anaesthesia.** *The increased commitment to Critical Care Air Support Team (CCAST) and the pressures on training including WTR and the competency based training programme have had an adverse effect on some RAF trainees. The RCoA worked closely with the Defence Deanery to resolve the difficulties RAF trainees were having in combining training with their military commitments to the CCAST task. Following a comprehensive report by the Anaesthesia and ICM DRAs CCAST training is now consolidated into blocks of 4-12 weeks, CCAST training is not counted as anaesthetic or ICM training, Pre-Primary FRCA trainees are not on the CCAST rota and the CCT date is delayed accordingly.*
8. The RCoA Trainee Committee canvassed the view of anaesthetic trainees in June 2013. Their view is that any recommended change to WTR should be taken after having a serious look at the evidence of its impact of training in Anaesthesia. Presently there is no strong evidence to suggest WTR has deteriorated anaesthesia training in the UK. Anaesthesia is an intense specialty which has always been good with training and supervision. As a result of the intensity, an increasing number of consultant anaesthetists are doing 12 hours on-call shifts. As such the Trainee Committee are wary of the potentially backward step of increased hours which would mean increased proportions of on-calls and service provision sessions rather than more supervised training lists in majority of hospitals. Currently they feel there is a good balance between training and number of hours worked. This position is supported by the College as a whole.

R A J Bryant
For RCoA President
21st November 2013