Personal responses to EWTD Taskforce consultation

1. **Deputy Director of HR, NHS hospital trust**

Here at [the trust] we are having difficulty implementing the requirements for EWTD due to the claim by Trade union representatives that compensatory rest should be 11 hours continuous rest. We have reached logger heads with them and had to call in the services of ACAS. This as yet as not resolved the impasse.

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2. **Associate specialist surgeon in the Maxillo-facial unit of a hospital trust**

I work as an Associate specialist surgeon in the Maxillo-facial unit of a hospital trust [3 widely geographically spaced hospitals] sharing on-call with 3 consultants to give a 1:4 on call. We are only infrequently up after mid-night and have reasonably few calls after this time , as a result we are all timetabled for a full day—thus making us non-EWTD compliant. To cancel/ not schedule clinics/ operating lists as a routine after night work would mean disruption to patients, and an unjustifiable expense to the trust and the public purse. To combine us in a rota with another local unit may mean a round trip of up to 140 miles for patients, their friends and relatives Common sense should prevail.

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3. **Consultant Occupational Physician, Medical Director, private sector**

I am afraid our feedback is limited as in the 50% or so of FOM members who work in the NHS very few do any out of hours duties. In the private sector we work as we "see fit" but again rarely have out of hours responsibilities for "medicine".

However comments are as follows:

Doctor 1

In the NHS I think the impact of the EWTD was quite significant although my comments are based on personal observation rather than any formal review undertaken by my Trust.

- *Limiting the junior doctors hours resulted in difficulties with continuity of care for the patient and the ability of the junior doctor to follow through a case, thus impacting on learning. The juniors I used to see felt this was an appreciable drawback for them from an educational perspective but interestingly, rarely did the obvious and stayed on voluntarily!*
- *Junior doctor hours were monitored fairly regularly and tightly by Medical Staffing so there wasn't really a culture of significantly exceeding the hours on an informal basis.*
- *The restriction on hours and the tendency for shift work in combination with the demise of medical "firms" led to many juniors feeling far less supported in their posts than in previous years. I think this was a factor in the increasing amounts of stress demonstrated by junior doctors.*

- *Of equal concern was the impact on consultants whose hours were not monitored by Medical Staffing (certainly mine weren't in the 9 years I was there). The reduced availability of junior doctors for out of hours rotas and the change of emphasis on immediate access to consultants meant that senior doctors were working in excess of EWTD and having to be resident on call once again in some specialities. I think this arose from a combination of factors including the difficulties of recruiting juniors to some speciality training posts, but the impact of EWTD on juniors hours cannot be ignored. The result was an exhausted and demoralised tranche of senior clinicians who were seeking to find a way to leave the NHS early rather than staying on into their 60s. The impact for future medical workforce planning should not be underestimated.*
- *Consultants with private practices in addition to their NHS work appeared to be the ones whose hours of work were more closely scrutinised as the EWTD technically applies to both posts combined. It was the perception of many consultants that the NHS was happy for them to work excessive hours on its behalf and turn a blind eye but private practice was "hobbled" at every turn. That obviously is very much a perception as expressed to me by quite a number of consultants.*
- *In terms of OH consultants, it probably had far less impact than on others because of the absence of on call commitments for consultants and trainees. Juniors were therefore able to access appropriate training within the EWTD and maintain continuity. Some NHS OH consultants regularly exceed the EWTD but I doubt any action is taken to address this.*
- *In essence therefore, the impact for OH doctors in the NHS is on the doctors that they see as their "patients" rather than on OHPs themselves.*

Doctor 2

The impact of WTD on occupational medicine is minimal, so there is no concern here. (The trainees survey showed no responses of working excess hours in OM.)

However, I agree with the above comments that I have seen problems in staffing Junior Doctors Rotas to meet the WTD.

It ends up with somewhat strange shift patterns which are disruptive and awkward for the jun. docs & also I would suggest not the best in terms of continuity of care for the patients. The juniors do see emergency patients but often do not find out what happened to the patients after the end of their shift.

My own organisation is a private business as referred to above.

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4. Consultant Paediatric Nephrologist, NHS trust and RCPCH College tutor

We have spent the last 12 months working through all of our junior doctor rotas with the help of an external rota specialist.

We are redesigning rotas including a complex modular H@N rotas and individualising each rota to meet clinical and training needs within compliance requirements. We are initiating transformative change within the non medical workforce.

We have some specific rotas e.g. paediatric liver transplant and paediatric cardiac surgery where achieving necessary training within the limitations of EWTD /New deal is particularly challenging.

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5. Surgeon – details not provided

EWTD is a double edge sword. It is used against trainees by all concerned. EWTD is a great idea for surgical training in principle but practically its application by the management is bad news for trainees.

Its advantages are that
a. a trainee will be saved from exhaustion in surgical discipline.
b. a trainee will be available in hospital at times when their supervisors can provide them relevant supervised training.

Disadvantages are
a. trainees pay is cut substantially by hospital management for working fewer hours.
b. trainees are made to work more than contractual hours becasue of shortage of staff as a result. Rota in most hosptials is non-compliant and thus trainees are not only paid less but also made to work more.
c. Hospitals consider service provision as a priority and therefore training opportunites are lost.

Few examples:

A. In my previous hospital placement, middle grades were asked to cover A&E directly despite being non-resident on call. A request to consider this against the contracted hours was met with strictness by the department. A later monitoring proved the rota non-complaint and salary scales were revised, including backdated. A full shift was introduced and found ''''compliant'''', depite same number of doctors on the rota.

An alternative approach to expanding the existing registrar numbers by just ''one'' would have allowed for onsite presence of the middle grades but that approach was not liked by management because it incurred more expenses.

B. In my current hospital, the job is non-resident on call. There is however no junior between A&E and the department and all the doctors end up being resident on calls. The on calls are allocated to protect clinics and theatre deficiency is covered with nurse practitioners. The following day off is considered optional, and off course most trainees stay the following day to beef up their log books.

In conclusion, EWTD has resulted in pay cuts and number of hours worked has not much changed, but on rota. We should not go back to dark ages and consider implementation of EWTD in a way to get the best out of it. The aim of training should be focused learning. Mere presence in hospitals is unnecessary and therefore rest between intense surgical working hours should be forthcoming to build all round and balanced personalities, rather than exhausted souls.

Hospital management should consider training a priority and those hospitals where training is undermined for service provision should be strictly death with and trainees should be removed from such sites.

Priority should be given to protected theatre time, and that is where learning is crucial in acquiring hands on skills. With this approach, EWTD will have NO ADVERSE impact on surgical training.

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6. No information provided

There is nothing wrong with the EWTD. What is wrong is the way it was implemented within the NHS with inadequate measures taken to enhance medical and surgical education.

Exposure to case numbers was bound to fall if all the doctors did was less hours of the same type of work as before.

Training within the confines of the EWTD would be fine if it wasn't for the fact that junior doctors continue to be abused as willing bodies to do anything and everything that no-one else wants to do and the paperwork demanded by the targets imposed on us has exploded. Employ more clerical assistants so that you can release doctors to do the clinical work and have personalised, focused training programmes and it would be just fine. For example we have a list of all the patients on our surgical speciality so that we can round on them every day and make sure we don't miss any out even though they are spread around the hospital. It's a simple clerical job to keep the list up to date but it takes an hour a day. Whos' job is it to keep this list up to date? A junior doctor does it of course.

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7. Consultant Urologist, DGH

My observations on the EWTD are:

Trainees across the spheres where I practise lack experience, open operating skills and decision making wisdom. All proportional to hours on the job and out of hours exposure.
Virtually every trainee has been aware of this and wanted more paid hours of training.

We have had no middle grade cover in the evenings and nights since EWTD came in.
The consultants are called on to take calls from wards, insert catheters, do technically straight forward minor emergency surgery such as stenting of ureters and exploration for torsions in the night.
Our Trust does not call this acting down.
I am 49 years old and have been "happy" to provide this service on a regular basis (1in 5) in recent years and have never taken time off in lieu or cancelled lists because of tiredness.
I don't think this is sustainable as I get older. To be clear, I have to drive into the hospital in the early hours of the morning to put a urinary catheter in, drive home and then try to get back to sleep. Then return for routine day's work at 8 the next morning.
This happens approximately one night in five.

We have been working hard with our general surgical colleagues to try to train and establish cover from the general surgical on-call registrars and it was particularly disappointing to hear from the RCS

in a recent reply to the British Association of Urological Surgeons that this cross cover would not be supported in the future.

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8. Consultant Orthopaedic Surgeon

What is needed:

1. *We need to get rid of maximum 32-hours of continuous duty for trainees.*

- *otherwise a Specialty Registrar cannot do the afternoon clinic after a night on-call.*
- *32-hours maximum duty reduces training for trainees in craft specialties*
- *It currently increases the number of weekends worked*
- *It reduces training opportunities*
- *It reduces continuity of care*
- *It increase handover*
- *It massively increases travel time*
- *Currently if one trainee fails on diary cards by ½ hour, the whole tier is re-banded, so Trusts change the rota to a full shift, even if it isn't busy enough*
- *It leads to rotas where one "SHO-level" doctor is supposed to cover many different specialties – often with minimal induction into each, and insufficient senior cover.*

2. *We should get rid of the maximum 56- hour duty for trainees at weekends.*

- *Often returning for a Sunday shift starting at 8am on a different weekend is far more disruptive. Some trainees commute 60-90 minutes each journey.*

3. *Simap should not apply to doctors*

- *Simap means counting time resting as work. Often resting for a trainee includes catching up with studying, etc. Many rotas have been converted to full shift with increasing numbers of "middle grades" and locums, reduction in training opportunities, reduction in continuity of care, massively increased travel time (eg returning to 8am Sunday shift) and more weekends disturbed in total. With Simap restrictions lifted, non-resident on-call rotas could be reinstated in many specialties, especially now there is far less operating at night.*

4. *We should not apply Jaeger judgement to doctors*

- *Jaeger requires compensatory rest to be taken immediately. This stops rotas with Saturdays and Sundays together with handover, so weekends are split (Sat OR Sun).*
- *Jaeger also means that there is insufficient time for handover and insufficient continuity of care, especially if the "night on-call doctor" was covering more than one specialty. S/he must go off duty by 9am (if s/he started at 8pm). This is because they wouldn't be able to take "compensatory rest before the next shift" if there is no one else to fill at 8pm of their next night. (The most human way of doing shift rotas is runs of nights, eg: Mon+Tues+Wed+Thurs in one week and Fri+Sat+Sun in another)*

5. *48 hours of "total work"*

- *It is probably important to continue the concept that all specialties have a maximum working time. Many women doctors in the past were put off surgery as a career because it was perceived to be too busy [1, 2, 3]. It is possible to train doctors in under 48 hours per week if training is focussed. No one needs to be heroic to be excellent.*

6. *To acknowledge that doctors at different levels need different things*

Consultants	*Higher Trainees*	*Core trainees, FY2s, FY1s, "SHO equivalent"*
Better on 48 hour maximum NHS work	*Better on non-resident on-call rotas for learning opportunities and continuity of care*	*Better on 13-hour shifts and 48-hour weeks as very intense work. The pro-active ones use "free" time to study and augment learning.*

7. *Ideally, we would get rid of restrictions on how many weekends are worked.*

- *This is a major reason why hospitals are so hugely stretched on Saturdays, Sundays and Bank holidays. Currently if over 1 in 3 weekends (9pm Fri-7am Mon) is disturbed, the whole tier goes up a Banding. Eg, a junior doctor moves from band 1B (40% extra salary) to band 1A (50% extra salary). Trusts don't like to do this.*

Other comments:

- *The way things are monitored and reported upon changes how Trust impose rotas. It may be worth exploring how hours are monitored and reported. For example, the current system means that if any one trainee fails in just a 2-week period, the whole tier of doctors can be re-Banded. This means Trust favour putting shift rotas in, when non-resident on-call or partial shift would work better for training and for continuity of care. The GMC trainee survey is very good, and Trusts are monitored on training now – does monitoring of working hours need to continue?*
- *Operating at night now is limited to life- or limb-threatening cases due to NCEPOD suggestions*
- *In surgery, Specialist Registrars and SAS doctors will rarely have been working all night.*
- *For many specialties, decision-making and interventions at night are either very serious or fairly simple (fluids, backslab, pain relief)*
- *The 32-hour maximum continuous duty period in New Deal means that Registrars who start at 8am and do a quiet on-call night must not finish afternoon clinic after 4pm.*
- *Surgery has some of the biggest geographical rotations. Specialty Registrars may spend 1 ½ hours driving to work, and 1 ½ hours home. If they do a weekend on-call instead of Friday+ Sunday and separately Saturday, they save 6 hours of travelling time over an on call rota cycle.*

Other benefits of change

- *Patient continuity of care is far better with non-resident on-call rotas.*
- *Non-resident on-call rotas mean better allegiance to a firm and better training.*
- *Removing 32-hour maximum and weekend maxima means reduced time spent travelling. Surgery in particular has large rotations, people on split weekends have two weekends per cycle disturbed and travel 4 extra journeys per cycle: Saturday morning and Sunday morning on two separate weekends (eg 6 hours)*
- *If there is no need to split weekends, it is possible to run rotas with 6 or 7 rather than 8 or 10. This saves the Trust £45,000-£70,000 per doctor (salary + banding + on-costs/National Insurance).*
- *For Higher Surgical trainees, there is then better access to Consultant operating lists, etc.*
- *Many rotas were expanded to fulfil EWTR. This means that non-training doctors were placed in rotas at both SHO level "Trust SHOs" and middle grade level "Trust Registrars". This has the effect of encouraging people into surgery but not giving them a realistic career path. It is worse for those doctors and increases the number of doctors needing support and pay on the unit.*
- *There is a certain amount of clinical work to be done. We need to encourage and support other staff (Pharmacy Technicians, Surgical Care Practitioners, Phlebotomists, Administrators, ward clerks, Physicians Assistants, etc). Many would provide better continuity of care and better service*

far more cheaply. They are on Agenda for Change scale, for which mid-point salary is: Band 3 = £17,000, Band 4 = £20,000, Band 5 = £23,000

CAUTION on viewpoints:

There are many doctors who suffered with MTAS and MMC in 2007. Some then were doing ridiculous hours and put onto Band 3 (100% additional salary) which was then removed once EWTD-compliant rotas were mandatory. There is still a cohort of doctors who feel very aggrieved indeed. Future trainees may well prefer to do their work in 48 hours, but then have 120 hours when they are not paid to study, watch operations, write up research, etc. Their salary is good. We do not want to continue the expectation that every hour of studying is also paid for. Previous generations of doctors were stuck on the wards for 80 hours per week, for less salary, and had no time to study.

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