WORKING TIME TASKFORCE CALL FOR EVIDENCE

RESPONSE FROM HEALTH EDUCATION ENGLAND AND THE ENGLAND POSTGRADUATE DEANS

Overarching views

HEE

The merits of the working time directive have been well rehearsed especially for junior doctors. With respect to doctors in training we believe there should be no hint that increasing junior doctors hours is anything other than dangerous to patients and themselves.

However, whilst we believe workers hours must be regulated, the current requirements are insufficiently sensitive to recognise the significant variation in workload and intensity between roles and specialties. The regulation must also recognise the necessity to balance the needs of the individual training (in the case of trainees) and service contribution. Specifically, the Jaeger' or 'Simap' rulings have forced Trusts to organise medical staffing in full shift systems restricting the ability to work in clinical/medical firms. This also restricts handover and provides a lack of flexibility for medical education and training (for example, providing sufficient opportunities for daytime training) as well as incurring significant costs to employers.

Working time clearly has an impact on the current junior doctor contract discussions so should be addressed as a matter of urgency.

England postgraduate deans

Given their role in managing postgraduate medical training, postgraduate deans are well placed to report on the impact on educational outcomes based on experience in their "patch". That said, inevitably there is not uniform experience across all regions and all specialties and a range of responses has been received. However, it is believed the following represents a reasonable summary of an agreed deans' view.

- The evidence for the detriment of long working hours on performance (and therefore patient safety) has been well documented elsewhere.
- The EWTR have generally been viewed as a positive development.
- In many areas, EWTR has catalysed the centralisation of services and trainees generally find themselves busier when at work than they would have been prior to the introduction of EWTR. This has led to a need for better induction programmes and training in the management of the acutely ill patient.

- However, it is acknowledged there are some issues:

    - shift systems do on occasion get in the way of continuity of care and some feel that more senior trainees should be allowed to be resident but not penalised time-wise;

    - surgery, in particular, continues to finds the hours of EWTR inadequate and argues for an on the basis that more time is needed to become proficient in technical skills; and

    - curriculum coverage hasn't been a problem, but shift systems have caused a number of minor training issues, such as missing sessions due to being off/coming in late after being on call.

- Despite these issues, it is believed it is possible to provide excellent training within 48 hours through a range of measures – most notably around ensuring well-structured programmes and placements, and better quality workplace supervisory practices (both educational and clinical).

Specific questions

Have you or your organisation encountered any problems relating to the Working Time Regulations and, if so, around what issue in particular?

The problems encountered are frequently more perception than reality. It is difficult to deliver the service when trainees are limited to 48 hours, but that is because the NHS is so dependent on trainees to deliver the service out of hours. Some trainees say that WTR is preventing them from gaining specific experience, but when looked at closely it is not WTR but the way that service delivery and training are managed.

That said, some concerns were raised:

- most rotas are insufficiently staffed by trained doctors resulting in trainees spending a significant portion of their 48 hour week working without direct supervision and providing Out of Hours/Overnight service. Whilst some unsupervised/OOH work is necessary to allow development this should be limited and the minority of a doctor in trainings working time;

- maintaining training programmes within craft specialties in particular relation to non-resident on-call working. Historically doctors in training would work a resident on-call shift which allowed doctors to remain in the hospital overnight without the time being counted as working time. With the introduction of the SiMAP and Jaeger rulings this became impossible. Working with Trusts to maintain compliance with the 'New Deal' contract for junior doctors, it has become increasingly difficult to maintain those non-resident on-call arrangements for fear of financial penalties to the employing organisation. This can have a devastating impact on training rotas if the doctors are move to full shift working arrangements as it reduces day time training time.

What have you or your organisation been able to do to solve these problems?

Responses included:

- continue to work with a junior doctor team ensuring effective implementation of WTR;

- partnership working with Trusts is important to support and maintain compliance with these rotas. It is important that doctors in training understand the rules for both New Deal and WTR and that they also make every effort to comply with hours limits and rest requirements.

What more could be done to solve these problems?

The obvious solution of increasing the total hours per week any doctor could work thereby breaking the current 48 hour EWTR was not widely supported. It was argued this would be a regressive step and would be deeply unpopular amongst trainees in most specialties (although there are some exceptions in surgical specialties).

Alternatives suggested included:

- reconfigure services either by site or by the way in which the local workforce delivers care and protects training;

- ensure good rota design with input from trainees;

- increase the number of doctors in training on rotas (but this also has an effect on diluting number of elective training opportunities within the increased trainee pool especially if service reconfiguration does not occur at same time to increase the overall workload in fewer units);

- ensure much better direct and indirect supervision, both in hours and out of hours to ensure that training is delivered safely and effectively;

- renegotiation of the SiMAP and Jaeger rulings;

- introduction of a new contract for doctors in training;

- a consultant delivered service should offer better training as it should offer better direct supervision - movement to 7 day a week working should be seen as an opportunity to improve training available to doctors out of hours;

- increase the proportion of OOH work undertaken by trained doctors to maximise trainee time in supervised elective and emergency work within the normal working week. This can be done by increasing the use of SAS/Trust Doctors or by using consultants to provide resident OOH care - the latter will increase the hours in the week in which direct supervision is also available

which may be particularly helpful to trainees in early years of specialty programmes;

- to address the concerns in surgery, consider lengthening of the training programme or the use of innovative approaches such as 'surgical boot camps' rather than a lengthening of hours;

- consider adopting a flexible approach between specialties;

- the judicious use of simulation-based training to accelerate the acquisition of skills- and team-based competencies;

- establish a national network to discuss ongoing or new issues, harnessing and disseminating the expertise across regions;

- role substitution - debates exist, and opinions differ, about the effectiveness of this but there are examples of where this has improved the quality of the work-based experience, and therefore learning of trainees;

- a concomitant expansion in the non-training grades, so that service that isn't absolutely reliant on higher specialty trainees for delivery.

Is there specific evidence (such as publications or studies) you would highlight to the taskforce?

As much evidence as was available was reported in the consultation to inform *Time for Training: A Review of the impact of the European Working Time Directive on the quality of training*, Temple, 2010

The Impact of the Working Time Regulations on Medical Education and Training: Literature Review, A Report for the General Medical Council, August 2012

Using the Working Time Directive for surgical trainees: how to make it work, Victoria Rusius, Medical Education 2010 (44: 630-633)

Safety during night shifts: a cross-sectional survey of junior doctors' preparation and practice, Emma J Jackson, Adam Moreton, BMJ, September 2013

Are there any examples of ways in which the Working Time Directive has been successfully implemented that you would like to highlight?

Examples provided:

- at Wigan and Salford the incoming team agree who will take each of the roles if the resuscitation team is called;

- some groups of trainees are meeting up at an agreed point in the night shift for support and exchange of clinical information;

- at many of our Trusts we have resident on call consultant which is very popular;

- the most innovative solutions have been partnership working between Trusts where they have shared the out of hours element of the posts between Trusts to maintain a service across boundaries. This has worked particularly well for head and neck specialties where there are a limited number of trainees at each site/Trust;

- in Health Education North East, Darlington Memorial Hospital O&G Department is modelling a new service model providing 100 hours of consultant presence across 7 days with 4 nights covered by resident consultants to protect daytime training of senior trainees and enhance OOH supervision and training of junior trainees.