The Royal College of Radiologists (RCR)

Response to:

WTD Taskforce – call for evidence

This response incorporates comments from both the RCR's Faculties – of Clinical Oncology (CO) and Clinical Radiology (CR).

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

We will respond to this question both in general terms and then with specific comments relating to our two specialties of clinical oncology and clinical radiology.

General

- Time off in lieu reduces training time in working hours.
- Loss of continuity of training.
- Potential to miss programmed training activities eg organised courses.
- Time off for trainers after on call reduces availability for training
- Impact on service as reduced daytime capacity to deliver service/care due to compensatory rest.
- As a result of the EWTD, doctors entering specialty training are felt to have less clinical experience and require greater supervision.
- Requirement to cover absence for national examinations in addition to out of hours.

Clinical Radiology

The biggest impact the EWTD has had on trainee radiologists is around on call provision. Given the stringent rules on protected sleep and the maximum number of continuous hours of work and compensatory leave, many training schemes have significant issues providing an out of hours Registrar service for on call without severely impacting upon non service commitment training.

Lists are frequently cancelled or transferred to colleagues due to the legal restrictions of the EWTD and compensatory leave pre and post on call.

Time for training is being seriously hampered.

Training schemes are not able to provide the continuous rest required on paper and are forced to go to a shift system. This means fewer trainees available for a larger number of shifts.

Clinical Oncology

The biggest effect the EWTD has had on clinical oncology training is the reduced daytime staffing levels of juniors, in particular at SHO level. The change in shift patterns has been quite dramatic leading to reduced clinical experience, vastly reduced continuity of in patient care, and thereby increased dependence on Registrar ward presence. This takes SpRs away from radiotherapy planning in particular. The recent survey by the RCR's Oncology Registrars' Forum provides evidence to back up this concept and in particular issues with the capacity of the wider team caused by the EWTD.

Overall, the effect of the EWTD on CO trainees is less of an issue than for many other trainees – due to the fact that almost all on call shifts are carried out from home so the EWTD allows working as normal the next day. If CO trainees are incorporated into acute hospital medical rotas however this will lead to significantly reduced training opportunities.

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

- Careful use of on call rotas to minimise impact on training where possible.
- Maximise out of hours work as a training opportunity.
- Combined rotas with other specialties to provide cover and minimise impact (CO).
- Centralisation of on call to major centres with DGH cover provided at consultant level and with use of outsourcing companies to provide some/all out of hours cover (CR).
- Informal arrangements in some Trusts where trainees are welcome to stay and learn even if the EWTD deems them not able to work. There needs to be clarification on this issue as this is not standard nationwide.
- The RCR has made the case and it has been accepted nationally that radiology needs more consultants and consequently more trainees.

3. What more could be done to solve these problems?

- Allowing greater flexibility in how the rules are enforced.
- National high level and practical support to increase funded training numbers in radiology.
- Radiology, especially non-interventional, is well suited to observational learning/training. This is a safe way of training that needs to be encouraged for those who wish to take advantage of having had a quiet shift.
- Interventional radiology training has already been extended to six years from five. Consideration of doing this for other radiology sub-specialties should be considered.

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

   - The RCR Statement on the Radiology Workforce June 2012 - http://www.rcr.ac.uk/docs/radiology/pdf/RCR_CRWorkforce_June2012.pdf

   - The RCR submission to the Academy of Medical Royal Colleges' report on Seven Day Care (p82 - 88) http://www.asit.org/assets/documents/ASiT_EWTD_Position_Statement.pdf

   - *EWTD, the temples report and other drivers towards a consultant-delivered service*. TC Booth, J Collum, TR Taylor. Clin Rad Oct 2011 (Vol 6, issue 10, p1001-1004)

   - The RCR's Junior Radiologists' Forum carried out a survey in 2012 some of which related to EWTD. The relevant findings were that 94% of trainees said that their rota was EWTD compliant but 35% believed that it was impacting their training. This is the same percentage for both non-interventional and interventional radiologists.

   - The position statement by the Association of Surgeons in Training (ASiT) - http://www.asit.org/assets/documents/ASiT_EWTD_Position_Statement.pdf

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

   Broadly the EWTD has offered good guidance on rests and breaks during on call periods, without which there may have been unsafe practice/rotas in place, especially as out of hours medical imaging increases.

The Royal College of Radiologists
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