European Working Time Directive

by

the Association of Surgeons in Training

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1. Summary:

1.1. ASiT enthusiastically supports the need for revised working patterns in order to address social changes in the workforce, and the intensity and demands of the modern NHS.

1.2. The European Working Time Directive has been implemented to address issues of Health and Safety for workers, and aims to reduce the total number of hours worked to 48 hours by 2009.

1.3. ASiT accept that previous working practices are unacceptable, and there will be a reduction in the number of hours available to train, and methods of improving efficiency of training must be supported.

1.4. The SiMAP and Jaeger rulings by the European Court of Justice are severely restrictive to developing compliant working patterns for surgeons-in-training.

1.5. ASiT believe that the conflict in definition of ‘work’, between the EWTD and the ‘New Deal’, has expedited the move to full-shift patterns of working for surgeons-in-training.

1.6. ASiT strongly believes that the EWTD, and in particular full-shift working, is severely detrimental to Surgical Training. Observed reductions in index operative cases performed, in a large study of ASGBI Surgical Trainee Logbooks, of 21% will significantly affect the length of time required to train surgeons, in order that they are able to provide a high quality healthcare system for the future.

1.7. ASiT believe the full-shift patterns of working that are now commonplace may be detrimental to the health of the worker if introduced at an early stage of working life, and worked for a prolonged period of time through the training period.

1.8. ASiT strongly believe that the, EWTD enforced, full-shift patterns of working are detrimental to the lifestyle of surgical trainees and their families.

1.9. ASiT strongly believe that the EWTD is detrimental to patient care within the current NHS through poorly structured working patterns leading to cumulative fatigue, increased incidence of medical errors, and decreased continuity of care.

1.10. ASiT is of the opinion that patients should be considered as a ‘Social Partner’ under Article 138.

1.11. ASiT unreservedly supports the proposed amendments to the definition of on-call and work, along with amendments to the reference periods for working hours. We must lobby the Department of Trade and Industry and European Bodies to ensure that this proposal is carried through.
1.12. ASiT strongly believes that the ‘New Deal’ and Junior Doctor’s Contract will provide a significant hurdle to Healthcare Trusts permitting a return to more beneficial ways of working, for financial reasons alone. We must insist that there is no financial disadvantage or obstacle to novel methods of working in order to protect the training of surgeons, and to improve patient safety.

1.13. ASiT must insist that there is parity of remuneration for work done, and that no individual is financially disadvantaged compared with their peers, by choosing to work a rota system that is more beneficial for training. Failure to observe this places individuals within a rota system under undue pressure from peers and supervisors alike.

1.14. ASiT believe that collaborative rotas, and further structuring of on-call commitments may allow more beneficial methods of training to take place, where this is not already in place.

1.15. We strongly a principle of developing a Register of Accredited Trainers in order to help with more efficient delivery of training within the shortened timeframe.

1.16. ASiT must insist that Trainees are themselves well prepared, and well selected, for surgical training in order that they maximise the training opportunities available to them.

1.17. ASiT views the Development of the Intercollegiate Surgical Curriculum Project as an encouraging development, and Trainees must fully embrace this concept to focus and target training to the required areas.

1.18. ASiT fully supports the European Union of Medical Specialists (UEMS) proposal for a working week including 48 hours of combined service provision and training, with an additional 12 hours of funded dedicated training time per week.

1.19. ASiT supports the principle that there must be a significant amount of time spent in the delivery of training, and we encourage Trusts and Government to appropriately recognise this time to train through remuneration and resources. Without this step, we will have an undertrained generation of surgeons incapable of delivering the service to meet the demands of the modern NHS.
2. **Introduction and Background:**

2.1. The Association of Surgeons in Training (ASiT) represents UK trainees from all Surgical Specialties, excluding orthopaedics, who are represented by the British Orthopaedic Trainee Association. ASiT is the second largest speciality association within the offices of the Association of Surgeons of Great Britain and Ireland (ASGBI) with over 1600 voluntary members. ASiT has representation on the councils of the Surgical Royal Colleges, Specialist Advisory Committees, Joint Committee on Higher Surgical Training, and many others.

2.2. ASiT welcomes the opportunity to represent our opinion on the European Working Time Directive, and provide evidence for the effects of the EWTD implementation in surgery.

2.3. In the 1990s, only 10% of all employees in the UK worked 40 hours a week compared to 34% of employees in the rest of the European Community (EC). Similarly, 41% of British male workers were employed to work more than 46 hours per week, compared to only 23% for the EC. In the absence of legislation and a legal basic working week, it was possible for employers to avoid paying overtime altogether.

2.4. The European Union’s Social Affairs Council passed the European Working Time Directive (EWTD) in 1993 under Article 118a of the Treaty on the European Union\(^1\). This has now been installed under Articles 137 and 138. Directives under Article 138 require consultation with all of the ‘social partners’.

2.4.1. Regulations are to be phased in by 2009, when the maximum working week will be 48 hours per week, with an interim restriction to 52 hours per week by 2007.

2.4.2. Rest requirements are stipulated at 11 hours of continuous rest in a 24-hour period.

2.4.3. The Sindicato de Medicos de Astsenciac Publica (SiMAP) ruling, by the European Court of Justice on 3\(^{rd}\) October 2000 states “time spent on call by doctors in public medical emergency services must be regarded as working time, and where appropriate as overtime, within the meaning of the European Working Time Directive, if they are required to be at the health centre.”\(^2\)

2.4.4. The ‘Jaeger’ ruling, from a case taken by Norbert Jaeger, from Keil, Germany, on the 8\(^{th}\) April 2003 states “on-call working should be considered in its entirety to be working time, even where the doctor in question is permitted to rest and sleep during periods of inactivity”.

2.4.5. Implications of SiMAP and Jaeger are that: All time spent in the workplace is regarded as ‘work’, regardless of whether at rest or not. Periods of rest in the workplace cannot be counted towards the period of compensatory rest.
2.5. Regulations governing changes to working patterns were devised to lead to a better work-life balance, and health of the worker. Social changes in the medical workforce reflect the change in priorities, and give impetus for change with more than 50% of UK medical students being female, and increasing numbers of doctors are marrying doctors, with figures thought to be approaching almost 50%.

2.6. In 1991, the Government, NHS Confederation, Academy of Medical Royal Colleges and the Junior Doctors Committee of the BMA approved the 'New Deal' for junior doctors. The aim was to reduce the working hours of junior doctors to 56 hours of actual work a week. The number of contracted hours a week was reduced to 72 hours, including time at home, but while on call.

2.6.1. ‘New Deal’ Rest Requirements are stipulated at 5 hours of continuous rest, on at least 75% of occasions, per 24-hour period.

2.6.2. The initial principles of the European Working Time Directive reflected the principles of the ‘New Deal’.

2.6.3. However, the SiMAP and Jaeger rulings are in conflict with the definition of ‘working time’ as laid out by ‘New Deal’.

2.6.4. Breach of the overall hours limits, rest requirements, or other working conditions, as laid out in ‘New Deal’, leads to non-compliance with the Trust then subject to financial penalties, in terms of salaries paid to Doctors-in-Training.

2.6.5. In many cases it appears that the rest requirements and other working conditions are more problematic, rather than the overall hours worked, for ‘New Deal’ compliance.

2.7. EWTD impacts on the time available to train ‘Surgeons-in-Training’.

2.8. A change on Rota system has predominated in the drive for EWTD and ‘New Deal’ compliance.

2.9. Full-Shift working patterns are felt to be detrimental to health and lifestyle for the worker.

2.10. The role of the patient as a ‘Social Partner’ is yet to be fully explored.
3. Methods of Compliance:

3.1. Increasing the number of doctors in the UK

3.1.1. Compliance with the 48-hour week will lead to a loss of 476,000 working hours, which is equivalent to 9,900 junior doctors.

3.1.2. An additional 7,500 consultants are required to deliver service.

3.1.3. As a Short-Term measure, many trusts have appointed non-career grade doctors.

3.1.4. Longer-Term solutions include additional recruitment of medical students to medical schools.

3.1.5. Modernising Medical Careers aims to streamline the process to consultant level, decreasing the number of years spent in training grades. The 'End-Product' of this is yet to be fully realised.

3.2. Shift work

3.2.1. Full-Shift patterns of work allow compliance with total numbers of hours worked, and more importantly compliance with rest requirements.

3.2.1.1. Majority of these rotas incorporate working seven consecutive night shifts, rotating with day and evening shifts.

3.2.1.2. The rota design has been constrained in Surgery, due to the comparatively low number of doctors providing cover, and a desire to minimise impact on training and patient care.

3.2.1.3. Majority of Full-Shift Rotas in Surgery comprise a maximum of seven doctors.

3.2.2. Enables trusts to employ doctors on both EWTD, and more importantly from a financial point of view, 'New Deal' compliant rotas.

3.2.3. Shift work requires several 'handovers-of-care' through the various doctors working during a 24-hour period, excellent record keeping, and cross covering between specialties. Several of these factors may contribute to medical errors.

3.2.4. Medical negligence claims have increased by 72% between 1990 and 1998, and 10,000 new claims have been received in 1999-2000 alone (National Audit Office, 2001). Whilst this could be the result of increased reporting, it is conceivable that this could also coincide with reduced training and experience of doctors.
3.3. **Hospital at night**

3.3.1. Aims to redefine how medical cover is provided in hospitals out of hours.

3.3.2. Out-of-hours cover moved from professional demarcation and grade, to generic competencies.

3.3.3. This results in fewer doctors in the hospital out-of-hours.

3.3.4. Cross-cover of specialties is required, which is inappropriate, and potentially unsafe, at a higher surgical training level.

3.4. **Increased consultant input**

3.4.1. 73% of 873 consultants questioned noted an increase in their workload as a result of patterns of working in order to achieve compliance with EWTD\(^8\).

3.4.2. Loss of ‘Traditional’ Team Structure of Consultant, Registrar, SHO, and PRHO. Tiers of cover frequently lost with EWTD compliant Rotas.

3.4.3. Training Opportunities decreased with increased consultant provision of service.

3.5. **Nurse specialists**

3.5.1. Increasing number of medical, and non-medical, tasks such as catheterization, are devolved to nurse practitioners.

3.5.2. The role of surgical nurse assistants, and Surgical Care Practitioners, are an extension of this trend.

3.5.3. The role of Nurse Practitioners could be used more effectively to free up a trainee surgeon’s time, out-of-hours.

3.6. **Centralizing services**

3.6.1. Collaborative emergency rotas involving rotas between neighboring hospitals, with transfer of emergencies may reduce the number of staff required to be on call at any one time, and in certain specialties have been shown to improve patient care and time to definitive surgery.

3.6.2. Many vascular surgical departments are making use of such rotas\(^9\). However, this involves increased travel for patients and may be a danger in the case of true emergencies, dependent on the nature and transfer mechanism involved.

3.6.3. Collaborative rotas and centralizing service provision, contradicts the government’s desire to make increased local NHS provisions.
4. **EWTD and Surgical Training:**

4.1. ASiT strongly believes that the effect of reduced working hours compromises the ability of training to be delivered, in a satisfactory manner, within the timeframe allowed.

4.2. In the 1980s, surgical trainees worked approximately 120 hours per week, gaining approximately 32000 hours of training. A retrospective study has found that SpRs trained during the Calman era are gaining less operative experience than their predecessors in the 1980s, as identified by the operative logbooks.

4.3. Total hours spent in training will be reduced from 21000 to 18000 with a further reduction from 56 hours per week, to 48 hours per week.

4.4. Audit of 46,000 Trainee Operations in Operative Logbooks by ASGBI in 2005 showed a 21% reduction in index cases, as listed by JCHST, performed by trainees since implementation of EWTD. Furthermore, a reduction of up to 44% for certain cases, such as Varicose Vein Surgery was noted.

4.5. Studies confirm a 17-26% decrease in global trainee operative experience. Attendance of trainees at Operative sessions decreased from 99% to 76%. These decreases observed were despite throughput of the unit remaining unchanged, or in certain cases increasing by up to 19%, therefore making the observed reductions an underestimate.

4.6. Data confirming 20% reductions in operative experience are with reduction to 56 hours per week. This will be further compounded by reduction to 48 hours per week.

4.7. The observed decreases in operative cases performed are also reflected with decreased attendance at outpatient clinic sessions.

4.8. Overall throughput of units was not found to be decreased, with consultants making up the deficit of work lost through decreased attendance of trainees.

4.9. In a survey of 220 surgeons, 88% of SHOs, 100% of SpRs, and 96% of consultants were opposed to the introduction of the EWTD.

4.10. Confounding factors, which will further impact on Surgical Training in the EWTD, era are the impact of Independent Sector Treatment Centres and the reduced time for training with the Modernising Medical Careers initiative.

4.11. There has been a loss of the trainer/trainee bond with a move towards shift rota working which decreases motivation of the Trainer to train, and the Trainee to commit to the Training process.

4.12. ASiT believe that training opportunities are likely to be even further reduced, with a decrease in the working hours limits to 48 hours per week.
4.13. ASiT strongly believe that the impact of EWTD, and a trend towards shift patterns of working, are severely detrimental to the future provision of a healthcare service. We believe that the deficit in training currently observed cannot be recompensed, and therefore the training process will produce a generation of ‘consultants’ who will not be as skilled as their predecessors, and whom will fall short of public expectations.
5. **Shift Working and Health:**

5.1. ASiT acknowledge that the number of hours traditionally worked are no longer acceptable, or appropriate to the intensity of work in the modern NHS.

5.2. Traditional ‘on-call’ type patterns of working have been poorly evaluated with regards to the impact on the health of the worker. Although there is some evidence that these may be detrimental in terms of sleep patterns, stress, and mental health, there exist critical gaps in the literature\(^{16}\).

5.3. Shift working has been intensively studied. Workers who are not used to working a period of night shifts, and who alter between periods of night and daytime shifts experience significant disruptions to their circadian rhythms\(^ {17}\)\(^ {18}\).

5.4. Currently employed Night Shift working, for trainee surgeons, involves staff being awake for the duration of the night shift, whilst on-call working would have been associated with periods of rest gained at night.

5.5. The effect of disruption of circadian rhythm has many physiological and psychological consequences, although much of the evidence is related to long-term night shift working. There is, however, evidence from similar working patterns in industry, to those currently worked by trainee surgeons.

5.6. There is increased risk of cardiovascular diseases, including Ischaemic Heart Disease in Night Shift Workers\(^ {19}\)\(^ {20}\). Other cardiovascular effects include increased Hypertension, elevated BMI, increased rate of smoking, and increased mortality in night shift workers.

5.7. Gastrointestinal effects include an 8-fold increase in Peptic Ulcer disease in Night Shift workers\(^ {22}\)\(^ {23}\).

5.8. Incidence of Diabetes Mellitus higher in those working night shifts (3.5%) compared with day shift workers (1.5%)\(^ {25}\). Also evidence of impaired glucose metabolism and hyperlipidaemia.

5.9. Significant risk of Low Birth Weight and preterm babies for pregnant night shift workers, and a positive correlation between night shift working and spontaneous miscarriage.

5.10. Excessive sleepiness, insomnia, and mood disorders are commonly reported among night-shift workers.

5.11. Daytime sleep is problematic for Night Shift workers, due to them obtaining 2-4 hours less, poorer quality, sleep. Significant reduction in REM Stage-2 sleep has been recorded. This will lead to cumulative fatigue when working successive night shifts\(^ {28}\).
5.12. Risk of injury, both at home and in the workplace, has been found to be higher in night shift workers, compared to daytime worker\textsuperscript{29}.

5.13. There is an increased frequency of fatigue related motor vehicle accidents for a person driving home upon completion of a night shift\textsuperscript{30,31}.

5.14. ASiT believes that the pattern of working, currently introduced to achieve EWTD and ‘New Deal’ compliance, may be detrimental to the long-term health of the worker. We believe that the cumulative fatigue, and evidence of increased risk of injury in the workplace may jeopardise the care of our patients.

5.15. ASiT believes that there is little evidence to suggest previous rota structures were detrimental to worker health or patient care. The long-term outcome for on-call systems, where rest may be taken, has not been evaluated. In contrast there is substantial detrimental evidence, from industry, relevant to similar patterns of work now commonplace in surgical training.

5.16. ASiT believes that the future health of the workforce may be compromised by working such shift rotas, over a longer period of time, which will lead to problems with workforce recruitment, retention, and increase periods of sick leave from a profession where it is traditionally low.
6. **Shift Working and Lifestyle:**

6.1. ASiT believe that a change to a full shift rota, has a significant impact on lifestyle for those working night shifts. This impacts not only on social life, but family life, and structure.

6.2. Full shift pattern working sees the individual spending an increased number of days in the workplace, with corresponding increase in number of out-of-hours shifts.

6.3. 42% of Senior House Officers and Specialist Registrars feel that their quality of life has worsened as a result of shift rotas.

6.4. 67% of consultants reporting a deterioration in their quality of life, possibly due to increased recall when on-call, since the introduction of EWTD compliant rotas for trainees.

6.5. There are implications for time spent with children, additional interference with daytime sleep, due to normal society functioning such as phone calls and outside noise, and intolerance of society of shift work.

6.6. There are reports of increased incidences of divorce amongst night shift workers.

6.7. Social interaction with children of night shift workers is problematic and there is evidence of children of nightshift workers being adversely affected.

6.8. ASiT believe that the effects on lifestyle serve to affect the morale of the workforce, in turn leading to problems, with a poorly motivated, underperforming, workforce more likely to make mistakes.

6.9. We support the belief that reduced tolerance for this working pattern, can lead to decreased recruitment, increased retirements, and increased career pathway changes.
7. **EWTD and Patient Care:**

7.1. ASiT believe the evidence already presented raises major concerns over the ability to provide adequate patient care, both now and in the future.

7.2. The aim of the EWTD is to protect the health and safety of the worker, and its role is also extended to the protection of the patient from workers who are fatigued on duty. The ability of a surgeon to effectively deliver care depends on them being alert, healthy, and most importantly, adequately trained to deliver the service which the patient requires. The ability to deliver the care required is dependent on the surgeon recognising the patient’s needs, and being in a position to act on them.

7.2.1. ASiT believe that the implementation of the EWTD actually decreases the level of patient care currently offered, and has the potential to decrease patient care even further in the future.

7.2.2. Decreased quantity of training exposure will lead to a workforce with less experience than is currently available, and therefore unable to deliver the service expected by the patients under our care.

7.2.3. The methods of working employed to comply with EWTD increase the likelihood of medical errors, compromising the future safety of the patients under our care.

7.2.4. There is evidence that the patterns of working currently employed lead to a cumulative fatigue of the workforce. There is evidence of increasing errors with successive shifts worked, which are worse than previous methods of working, and decrease patient safety.

7.2.5. There is evidence of increased accidents in the workplace with potential for detrimental patient care.

7.2.6. There is a loss of continuity of patient care, which increases the potential for errors, or omissions of care, to occur. Of 873 consultant surgeons, 84% felt that the continuity of care of patients had worsened due to shift work. Surveys of both Surgical and Medical Specialist Registrars suggest that we feel the quality of patient care is diminished whilst we are working shift rotas.

7.3. The observed reductions in training are likely to be further increased due to the impact of Independent Sector Treatment Centres, and in particular Modernising Medical Careers. This initiative will decrease the length of time spent in training, and therefore further decrease the exposure of surgeons-in-training to appropriate training opportunities. This, we believe, will further decrease our ability to deliver a service to meet the needs of the patients and the NHS.

7.4. The role of the patient as an integral ‘Social Partner’ is yet to be fully explored.
7.4.1. Directives under Article 138 require consultation with all ‘Social Partners’.

7.4.2. Directives under Article 138 should benefit all of the relevant ‘Social Partners’.

7.4.3. ASiT believe the patient to be an integral ‘Social Partner’, in the European context. In this setting, the EWTD should serve to benefit the patient.

7.4.4. Many workers fulfill two roles in the setting of Public Services – both providers and users. Therefore it is easily conceivable that the worker and patient are on equal standing. Also, given that the public services are also funded from revenue generated from the public, the public can be regarded as overall employers in the setting of the NHS and therefore are equal ‘Social Partners’.

7.4.5. ASiT does not believe that the patient as a ‘Social Partner’ is benefited by the EWTD.

7.5. ASiT believe that the EWTD, and the methods of working to comply with EWTD and ‘New Deal’, compromise patient care and the future provision of an adequate healthcare service for the NHS.
8. **Solutions:**

8.1. ASiT strongly believe that URGENT solutions to the detrimental effects on Surgical Training are required.

8.2. ASiT believe that novel attempts at rota structuring and adapting to Night Shift working to comply with EWTD and ‘New Deal’ have failed the training of surgeons, and further attempts are likely to be futile.

8.3. ASiT, and other official bodies associated with Surgical Training must lobby Government, through the Secretary of State for Trade and Industry, and European bodies to support a proposed amendment to the EWTD.

8.3.1. In September 2004, under the Presidency of the UK, a proposal for an amendment to the EWTD was made.

8.3.2. The main features of this proposal would be to insert two new definitions, namely “on-call time” and “inactive part of on-call time”, being more closely related to ‘New Deal’ definition of ‘work’.

8.3.3. The reference period could also be extended up to one year subject to consultation with concerned social partners, but under no circumstances can be higher than the duration of the employment contract.

8.3.4. Compensatory rest would be clarified and must be granted within a reasonable timeframe not exceeding 72 hours for daily rest.

8.3.5. If this proposal was to succeed it would effectively allow a return to on-call patterns of working on a 1:6 resident on-call basis, assuming an actual work rate of 50% whilst on-call, working every weekday, with no compensatory rest days off, 6 weeks holiday and an academic afternoon per week.

8.3.6. However a return to old working practices is not the aim and this is presented only as an example of the flexibility that may be achieved. We would suggest that 24 hours on-call could be worked with the following day, or part of the following day off as compensatory rest.

8.3.7. This proposal was lobbied by the Department of Trade and Industry but failed to gain uniform support at the Employment, Social Policy, Health and Consumer Affairs council due to problems with the voluntary nature of the opt-out, and the fact that there was no specification as to whether the regulations applied per worker or per contract. (applicable to Firemen and Locum doctors etc who may hold 2 jobs).

8.3.8. An amended proposal is to be discussed under the Austrian Presidency in the near future and must be strongly supported in order that optimum training programmes can be designed within the constraints of EWTD.
8.4. ASiT strongly believe that training opportunities must not be jeopardised by non-essential, non-training, activities being performed out-of-hours. This “inactive part of on-call” must be protected through extended working roles of other healthcare professionals and we support the development of teams within hospitals, such as a Hospital-at-Night team in order that surgical trainees are not being called unnecessarily.

8.5. Expansion in the roles of Clinical Nurse Specialists, and Nurse Practitioners will also decrease the number of non-essential tasks being performed by trainees out-of-hours, and therefore protecting the “inactive part of on-call”.

8.6. ASiT believe it is reasonable for a surgical trainee to be forced to take compensatory rest during a daytime, if they have been involved in an activity of training benefit disrupting their rest, however it is not acceptable for trainees to lose daytime training opportunities if they are re-writing drug charts or inserting IV lines.

8.7. ASiT believe that whilst the amended EWTD proposal will allow on-call working to take place, the constraints of ‘New Deal’, and the Junior Doctors Contract will become much more restrictive and problematic.

8.7.1. The drive to shift patterns of working has been driven by the requirement of Trusts to reduce banding payments to Doctors-in-Training and enforcing ‘New Deal’ compliant rota.

8.7.2. Given the requirements for rest provision and working hour’s limits, the only guaranteed method of achieving guaranteed ‘New Deal’ compliance is a shift pattern rota, and hence we have been moved more rapidly in this direction.

8.7.3. Therefore, even with acceptance of the amended proposal, there is still likely to be non-compliance with on-call patterns of working due to the requirement for a minimum of 5 hours uninterrupted rest per night on 75% of occasions. This will prevent Trusts from permitting a return to on-call working practices.

8.7.4. ASiT strongly believe that any amendment of EWTD, which may be of benefit to training, must also be supported by an agreement that there will be no financial disadvantage to allowing working practices, which are beneficial to training and patient care to be instituted. This may take the form of an amendment of the New Deal and Junior Doctor’s Contract to allow compensatory rest to be taken in line with the new proposed EWTD regulations.

8.7.5. ASiT strongly believe that local arrangements, in order to comply with ‘New Deal’ on paper, but which are not compliant, are not satisfactory as these place undue pressure on individuals.

8.8. If the average number of hours can be referred over a period of 12 months, it becomes possible to structure rota to work a period of intensive on-call
commitment, within a busy acute hospital, gaining a significant exposure to emergency surgery, complemented with a period with very minimal on-call commitment in a treatment centre, or elective facility.

8.8.1. ASiT believe that structuring of experience through various centres on one contract will benefit trainees in being able to comply with hours restrictions. Collaboration between Trusts and a significant level of local organisation is required.

8.8.2. ASiT believe this model may be extended to allow Surgical Trainees to gain experience in Treatment Centres, or on Waiting-List initiatives in other centres. This will significantly enhance the ability to be able to gain elective operative experience.

8.9. Novel methods of staggering out-of-hours profiling through various stages of training could serve to benefit trainees at a stage when they are capable of making best use of their skills.

8.9.1. Surgical trainees at various stages of training could be appointed to each individual training unit.

8.9.2. Trainees in ST1 to ST3 could comprise part of a Hospital-at-Night team, learning generic skills and emergency management, whilst still having some daytime exposure.

8.9.3. Trainees in ST4 and ST5 would have reduced, emergency, out of hours commitment in order that they focus on learning practical skills relevant to their future practice.

8.9.4. Trainees in ST6 onwards would form an additional tier of a rota, on a collaborative non-resident on-call system, covering multiple sites, at a stage when their skill base can make best use of the emergency operative and management exposure, and under consultant supervision. This would allow for rotas to be comprised through several hospitals to increase the number of doctors providing cover, but without compromising daytime exposure.

8.10. ASiT strongly believe that the delivery of training must be significantly enhanced in order that the time available is used as efficiently as possible.

8.10.1. The definition between training time and service time must be clear. ASiT support the UEMS proposal of 48 hours combined service and training time, with an additional 12 hour period of funded, dedicated training time. ASiT would propose that this 12 hour period is the essential portion of the training post, and taken out of the deanery funding for the post, and therefore compulsory to be delivered. Any additional time required by the trust would be paid up to a total of 48 hours, with banding increments reflecting the total amount of work undertaken. E.g. if the trust only requires 36 hours service, this would be funded by the trust fulfilling banding payments to the extent of 48 hours.
8.10.2. ASiT believe it is within the remit of the Deaneries to regulate the Training time associated with training posts, and would urge that this dedicated training time is given priority.

8.10.3. Only people who are deemed capable, and appropriate, must deliver training. The Joint Committee of Higher Surgical Training has developed a policy on the minimum standards for trainers. These must be enforced, and a Register of Accredited Trainers developed, with trainees allocated to these Accredited Trainers.

8.10.4. Trainees must take responsibility to ensure that they are proactive, keen, and well prepared, in terms of background knowledge.

8.10.5. It is essential that the Trainees are well selected at the point of entry to training, by a comprehensive, robust, and reproducible method.

8.10.6. ASiT Strongly supports the development of an intensive surgical curriculum, as with the Intercollegiate Surgical Curriculum Project, will aid the delivery and targeting of training, appropriate to level, and trainees and trainers alike must embrace this.

8.10.7. ASiT believe that the ‘time’ to train must be appropriately recognised by Trusts and the Government, if adequately trained doctors are to be provided for the future of healthcare delivery within the NHS.

8.11. It is the view of ASiT that there must continue to be an incentive for Trusts to train and service the needs of trainees for the future of healthcare provision.
9. References

2. Sindicato de Medicos de Astencia Publica (SiMAP) v Clinseillaria de Sandid y Consumo de la Generalidad Valencia C-303/98. EC, 2000.


10. Associated and Supporting Organisations

The following associations have been involved with the conception of this report, contributed to the content of the report, and fully support its principles:

10.1. The Joint Committee of Higher Surgical Training (JCHST)
   10.1.1. Mr Gordon Williams, Chairman JCHST.
   10.1.2. Presidents of the Surgical Royal Colleges.

10.2. The Royal College of Surgeons of England EWTD Working Party
   10.2.1. Professor John Lowry, Chairman
   10.2.2. Mr Bernard Ribeiro, President RCSEng.

10.3. The Association of Surgeons of Great Britain and Ireland
   10.3.1. Mr Denis Wilkins, President
   10.3.2. Professor Brian Rowlands, Vice President

10.4. The Senate of Surgery

10.5. The British Orthopaedics Trainees Association (BOTA)
   10.5.1. Mr Matt Freudmann, President
   10.5.2. Mr Craig White, Vice President

10.6. The Rouleaux Club (Vascular Surgical Trainees Group)
   10.6.1. Mr Toby Richards, President
   10.6.2. Ms Alex Kovalic

10.7. The Senior Urological Registrars Group (SURG)

10.8. The Dukes Club (Colorectal Surgery Trainees Group)

10.9. The British Association of Paediatric Surgery Trainees Group

10.10. The British Neurosurgical Trainees Association (BNTA)

10.11. The Plastic Surgical Trainees Association (PLASTA)
   10.11.1. Mr Taimur Shoaib
   10.11.2. Ms Alexandra Turner

10.12. The Mammary Fold (Breast Surgery Trainees Group)

10.13. The Carrell Club (British Transplant Society Trainee Group)