

Time for training – A review of the impact
of the European Working Time Directive
on the Quality of Training

A response from



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On behalf of the ASiT Executive and Council

1. Introduction

- 1.1. The Association of Surgeons in Training welcomes the opportunity to respond to this report.
- 1.2. The Association of Surgeons is a charitable organisation supporting the professional development of surgeons in training. Our association represents UK trainees from all surgical specialities and is one of the largest specialty groups with over 2,000 members.
- 1.3. Professor Sir John Temple's report identifies many important issues regarding the implications of the European Working Time Regulations (EWTR) for the quality of training that ASiT has highlighted for many years, and which are of concern to all surgeons in training.

2. Executive Summary

- 2.1. ASiT welcomes the independent review of the European Working Time Regulations' impact on the quality of training. This report successfully identifies the multi-factorial and complex nature of the current reduction in training opportunities that ASiT has highlighted for many years.
- 2.2. We are reassured that the review specifically identifies the unrelenting pressure to maintain the same service within reducing hours at the expense of training. ASiT supports the premise that a reduction in the quality of training has inevitable implications for patient safety. The recommendations of the report must therefore be implemented quickly and in full to provide high quality training and protect future patients. There must also be the political will to ensure that this valuable assessment of postgraduate medical training is not ignored.
- 2.3. ASiT is however disappointed that the potential relaxation of the EWTR is not addressed, nor does the report discuss lengthening training to compensate for the reduction in hours. Implementing the recommended

service reconfiguration will require the engagement of all stakeholders over many years. We are therefore disappointed that there are no suggestions to aid the cohort of current junior doctors. Trainees within this current system need to be offered the opportunity to extend training until reforms are in place.

- 2.4. ASiT supports the consultant-delivered model for the future surgical workforce, and agrees that this is the safest and most cost-effective model. We also agree that Certificate of Completion of Training (CCT) numbers need to be carefully planned to avoid wasted resources. The end-point of training (CCT) must consistently produce a consultant product that is trained to the highest possible standard.
- 2.5. Surgical educators need to be identified and educational activities supported in their job plans. Surgical education should be given protected sessions and significant commitment to education rewarded with Clinical Excellence Awards or equivalent.
- 2.6. Whilst data (Surgical Placement and Curriculum Evaluation data) is held by the Joint Committee on Surgical Training on the quality of surgical posts, it is not available in the public domain, and so there is little incentive for local providers to invest in training. There also needs to be meaningful enforcement of recommendations.
- 2.7. The report recommends the involvement of trainees in developing new ways of training and ASiT will continue to offer to represent surgical trainees in these discussions. We hope our position statement on “The future of surgical training” will act as a starting point for discussions.

3. Methodology

- 3.1. ASiT acknowledges the basis for this review: that patient safety could be affected if medical training is compromised by reduced hours available for working. As an organisation we also aspire to producing a world-class workforce. Whilst this review did take place in a time of change in the NHS in an unstable financial climate, it is still imperative that training and patient safety remain paramount. The report acknowledges that working time regulations are most likely to affect the training of hospital doctors. ASiT feels that within this cadre, surgical training is most at risk given the craft nature of the specialty.
- 3.2. The EWTR were implemented in August 2009 and although the report suggests that in September 2008 two-thirds of trainees were working less than 48 hours (according to New Deal monitoring), a survey by our organisation has suggested that official monitoring does not actually reflect working practice. It is therefore important that trainees and trainee organisations continue to have a voice. The report sets out aspirations for high quality training which are mirrored by ASiT and expanded upon in our “Future of surgical training” position statement. We agree that teaching time must be preserved and that trainees should be protected from excessive service pressure, although acknowledge the difficulties in separating service and training.
- 3.3. ASiT appreciates the robust methodology used in the review process but would perhaps have welcomed a greater surgical presence in the Expert Working Group and Team given that concerns raised by surgical trainees and trainers had significantly contributed to the opinion that there was a requirement for a review of this type. We also note the involvement of the PA Consulting group and wondered what costs this added to the project and whether a private consultancy were required for the process in light of concerns over government spending.

- 3.4. The wide consultation at the oral hearings (including representation from ASiT) was appropriate and should have given a balanced view across the profession.
- 3.5. The report clearly illustrates the methodology used to summarise the information gathering process. It acknowledges the difficulty in assimilating anecdotal evidence, although the assertion that if something is consistently repeated it can be seen as valid and used as a proxy for evidence only holds true if all sources are sought and listened to thus allowing a balanced view. The review states that survey data was limited as it represented opinion and not fact. We feel that survey data is more robust than anecdotal opinion and the ASiT survey was not limited by small sample size although others may have been as asserted in the report.
- 3.6. The report states that outcomes of training are long term and could not be used in the review, quoting examination results and quality of care as proxies of training quality. Whilst quality of care alone cannot be used as a proxy of training quality, it should still have been investigated due to concerns that changes in the working pattern with loss of continuity of care have led to poorer patient care. The process and pathways rather than the outcome of treatment may have provided valid data for comparison. Standardized mortality and readmission rates from one region do not constitute sufficient evidence.
- 3.7. The report acknowledges that trainees' reporting on working hours is not reflected in reports of hours to Strategic Health Authorities. Monitoring of working hours needs to be transparent and accurate; for this to occur the organisation with an interest in ensuring a compliant rota should not itself be conducting monitoring.

4. Key Findings

- 4.1. “High quality training can be delivered in 48 hours. This is precluded when trainees have a major role in out of hours service, are poorly supervised and access to learning is limited.” Two of the key functions of the NHS are the delivery of high quality patient care today and training the professionals of tomorrow.
- 4.2. There has always been a fine balance between service and training, but with the reduction in hours a proportionally greater amount of time is spent ensuring that service requirements are maintained to the detriment of training. Trainees in specialties with significant emergency and out of hours service components, which is the case in most surgical specialties, are most likely to lose out on elective training. The situation is compounded where traditional models of training and working are not adapted or developed.
- 4.3. In ASiT’s post-EWTR implementation survey of 1,600 surgical trainees in November 2009, 84% of respondents worked in excess of their rostered hours and 67% were attending work out of rostered time to gain training and experience. This highlights important problems with resident shift working – surgical trainees have less contact with their trainers when working out of hours, with missed learning opportunities, and multiple handovers lead to fragmentation of patient care.
- 4.4. The impact of the EWTR is greatest in specialties with high emergency and/or out of hours workload. The introduction of service targets has resulted in reduced waiting times for patients but has had a knock-on effect for surgeons in training. Surgical training has been neglected as trusts’ priorities focus on meeting these targets. In surgical specialties, data from logbooks is one way of objectively analysing the quantity of experience although it was recognised that this does not necessarily reflect the quality, and may frequently reflect extra hours worked by trainees over and above their employed hours.

- 4.5. It is too early to assess the impact on training using Annual Review of Competence Progression (ARCP) results although these should be used in the future and will provide more information on quality of training.
- 4.6. Traditional models of training and service delivery waste learning opportunities within reduced working hours. Although there is little support for increasing hours or lengthening training programmes, changing the structure of training will require time, and current proposals offer no solution for trainees in the system now.
- 4.7. Trainees in surgical specialties are “opting out” more often and working additional hours, citing the need to supplement the clinical experience they receive from their regular service commitments, or to enable them to work as locums. However, this does not offer a permanent solution to the current training crisis.
- 4.8. ASiT strongly opposes the creation of sub-consultant grades for CCT-holders, and it is necessary for consultant contracts to contain explicit objectives relating to service and training needs, as well as carefully planned SPA time. There is great variation in the level of support that trusts offer consultants involved in education and training. Some consultants have enhanced training responsibilities and this is often not recognised in job plans.
- 4.9. The EWTR could be a catalyst to reconfigure service and training. Expecting the current system to work within the time constraints of 48 hours will lead to frustration and poor training for the surgeons of tomorrow. Several suggestions have been made, including the separation of elective and emergency care, providing good specialty training within the elective setting including private treatment centres, and maximising support and supervision for trainees working in the emergency setting.
- 4.10. Technologies such as simulation can be used as adjuncts to training, but they do not qualify as a substitute for patient contact and experience gained in

the clinical environment. Necessary developments are awaited in this field, together with significant levels of central funding that will be required to invest in such new technology and support services.

5. Recommendations

- 5.1. Professor Sir John Temple unequivocally recommends a consultant (CCT holder) delivered service and we support this aspiration.
- 5.2. Consultant working will consequently be required to be more flexible, with an increase in out of hours work. However the report does not address the significant impact that this will have on elective service and training.
- 5.3. The report states that although newly appointed consultants are well trained, they may be less experienced than consultants appointed in the past. This statement is then followed by a recommendation for mentoring and support for newly qualified consultants. We agree with the recommendation, although we would not want to devalue the experience and ability of current CCT holders.
- 5.4. ASiT agrees that workforce planning is urgently needed to correlate service, patient and training needs, with clear specialty-specific alignment between service need and the number of CCT holders being trained. We agree that health care organisations that train well also deliver high quality patient care.
- 5.5. The Hospital at Night scheme is recommended in this report as a cornerstone of decreasing the hours worked by trainees whilst still supporting training and service. However, we believe that junior doctors are too frequently filling rota gaps and covering specialties in which they may not have the necessary experience.
- 5.6. Regional or national reconfiguration for smaller specialties is recommended to allow units to sustain rotas for service. This is already happening and can

work well. However it can also come at a cost of deskilling the majority and training the minority.

- 5.7. The report recommends that a Multidisciplinary Team (MDT) approach will help to reduce unnecessary demands on trainees. We believe that although the MDT does improve patient care, it will by default also dilute the training opportunities for junior doctors, and is not always cost-effective.
- 5.8. We agree that only departments and/or hospitals that can demonstrably deliver high quality training should be designated training locations. We see this as something units should aspire to achieve rather than being punitive.
- 5.9. The report recommends that trainees and educational supervisors have more input into rota design to maximise training potential. This is an ideal to strive for; however the present reality of abundant rota gaps unfortunately reduces any potential benefit.
- 5.10. The current economic climate makes it difficult to realistically renegotiate employment contracts.
- 5.11. We are delighted that the report recognises that it is not simply the hours that a trainee works but what they do in those hours. In order to maximise training and learning potential, competency-based learning should be adapted to each individual.
- 5.12. Formal patient handovers allow continuity of care and enhance patient safety within a shift system. Educational handovers from one educational supervisor to the next allow trainees to have individually tailored training without unnecessary repetition. Educational supervisors with the requisite qualities will need to be actively selected.
- 5.13. ASiT agrees that a national strategy for increased investment in simulators is urgently needed to accelerate the acquisition of skills and transfer learning away from the patient. Web-based learning should be encouraged.

Consultants need to adapt and utilise all of the available resources to complement their teaching styles.

- 5.14. ASiT agrees with the premise that not all consultants will be dedicated surgical educators in the future, but all consultants and trainees should be educated in training and assessment, and allowed the flexibility to become educators. Those selected to be surgical educators must have a reduced service workload to enable high quality training to flourish.
- 5.15. NHS trusts must have a commitment to provide consultants with support and protected SPA time for education. There must be a prioritisation for training. We agree with the estimation that trainers should have at least 0.25 PA's per week per trainee as suggested by the Medical Royal Colleges, and that smaller numbers of identified trainers may allow better trainee/trainer continuity. ASiT agrees that it should not be the default position that all consultants have trainees allocated to them.
- 5.16. The limited time for training means that new techniques and methods with greater educational value must be urgently developed and delivered. Necessary improvements are awaited and ASiT hopes to soon see the political will to implement the considerable but necessary investment of both time and capital.
- 5.17. ASiT agrees that trainers must be recognised, rewarded and encouraged to strive for excellence so that only the best and most enthusiastic consultants may become trainers. An environment of excellence may also be fostered by rewarding brilliance with Clinical Excellence Awards.
- 5.18. As detailed in our "Future of Surgical Training" position statement, education must be incentivised for trusts. Trusts must not feel financially disadvantaged by training. Similarly commissioners for education must be confident that their investment will be returned.

- 5.19. ASiT supports the need for transparency of funding for training and a return to accountability for local education providers on how that money is spent, with publication of accounts and records. Multi-Professional Education and Training (MPET) funding must be specifically and precisely identified in its contribution to medical education; it must also be ring-fenced and not redirected into providing clinical care.
- 5.20. Educational governance should be mandatory and a board level responsibility for trusts who have training units, with an individual accountable for medical education and training. We would welcome the introduction of training quality ratings that would be contributed to by trainees and linked to educational funding to improve training.
- 5.21. Trainees have little confidence in the current quality assurance of posts, and do not feel that there is a meaningful enforcement of high quality training. Trainees feel that there is a rather *laissez-faire* attitude towards trainees who express concerns over quality of training posts. ASiT would welcome the reintroduction of the quinquennial inspection of posts by the Specialist Advisory Committees on behalf of the Royal Colleges.
- 5.22. The Temple report identifies a lack of proven and reliable outcome measures and quality indicators for training posts. ASiT would welcome the introduction of such ratings if they aided in the identification of high and low quality posts. The Joint Committee on Surgical Training already holds some data on the quality of training posts. Trainees contribute to the cost of their training and should have access to data that may aid their career. Posts with poor quality training results should not automatically receive trainees, and trainees should be able to decline a post if it is suspected to be of limited educational value.

6. References and further reading

- Time for training - A review of the impact of the European Working Time Directive on the quality of training. Medical Education England (http://www.mee.nhs.uk/pdf/EWTD_Final%20report.pdf) 2010.
- The Future of Surgical Training – A Position Statement by the Association of Surgeons in Training (<http://www.asit.org/resources/articles/future>) August 2010.