Review of the Impact of the European Working Time Directive (EWTD) on the Quality of Postgraduate Training

Evidence from NHS Employers

1. Details of your response

About you
Mandatory questions are marked with an *

If you are responding on behalf of an organisation

| *Please provide your name: | Sian Thomas |
| *Please provide your job title: | Director |
| *Please provide the organisation’s name: | NHS Employers* |

If you are responding as an individual

| *Please provide your name: |
| *Please provide your professional group: Please delete as applicable: | Medical/Dental/Pharmacist/ Health Scientist/Other |

If Other, please provide a brief description of your profession

| *Please provide your Speciality or Course: If you are a trainee and have not yet picked a speciality, please record ‘Pre-specialisation’ |
| *Please provide your relationship to training: Please delete as applicable: | Trainee/Trainer/Other |
| *If you are a trainee, please indicate your stage of training: Please delete as applicable: | Undergraduate/Graduate/ Postgraduate |

Confidentiality

| *Do you consent for your name or the name of your organisation to appear in the index of responses in the group’s final report? Please delete as applicable: | Yes |
| *Do you consent for your response to be quoted in the group’s final report? Please delete as applicable: | Yes |

*NHS Employers represents NHS organisations in England on workforce matters. Our four key activities are: pay and pension negotiations; providing advice, guidance and best practice in employment policy; promoting NHS recruitment and careers; and, support for healthy and productive NHS workplaces.

In relation to EWTD our role has been to represent NHS organisations and advise them on sources of help and support, and their legal obligations. A significant amount of support, guidance and piloting of new arrangements was developed by Skills for Health/National Workforce Projects who were given a contract for providing EWTD transition support within the NHS. Their material can be found at: http://www.healthcareworkforce.nhs.uk/workingtimedirective.html
2. Consultation questions

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<th>How would you define high quality training?</th>
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<td>Respondents may wish to consider quality both in terms of training outcomes and the methods of training.</td>
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In its broadest sense, high quality medical training is that which identifies and recruits people with the right intelligence, behaviours, attitudes and values to support high performance and quality (within the context of taxpayer funded healthcare) and stretches and develops them to deliver a medical workforce which is competent, safe and capable of meeting future healthcare service needs (including for future research, education, training and leadership roles).

Training itself must be evidenced based and outcome focussed, and organised so that it delivers quality and value for money for both the taxpayer and trainee doctor making the investment for the outcome. This should include disinvestment where outcomes are unlikely to be achieved or are not cost effective (e.g., a trainee failing to progress or a training programme with poor results). Measuring outcomes in education and training, against which the impact of reforms and other changes can be assessed, remains a challenge.

<table>
<thead>
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<th>What has been the impact of the introduction of the EWTD on the quality of training?</th>
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<td>Respondents may wish to consider the impact in terms of quality of the training outcome and quality of the training methods.</td>
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At present much of the debate around the impact of the EWTD on training is led by anecdote, rather than informed with evidence. This is inevitably the case given that the requirement for full compliance with the 48 hour EWTD limit and rest periods for junior doctors only commenced in August 2009 (allowing for a limited number of derogations which provide for up to 52 hours per week on certain rotas). The initial 26-week reference period over which this compliance ought to have been achieved concluded in January 2010. Between August 2004 and August 2007 the EWTD allowed doctors in training to work for up to 58 hours per week, and from August 2007 until August 2009 up to 56.

Transition to 48 hours has therefore been gradual. The NHS was preparing for and undertaking transition towards full implementation of 48 hours for many years, but particularly since 2004. That means that, although full compliance has only applied since August 2009, a steadily increasing cohort of junior doctors has been working and training within 48 hours, as transition progressed.

The change can be illustrated by analysing the hours doctors have reported as working and training in the twice yearly 'New Deal' monitoring returns. This monitoring was brought in to support compliance with 'New Deal' hours and rest commitments (and associated pay 'bandings') but usefully serves as a proxy for EWTD compliance over time.

The movement of pay bands up to March 2009 is illustrated in Figure 1. The lower bands (1A, 1B and 1C) are paid for working patterns that should be compliant with EWTD (i.e., within 48 hours):
The latest figures being analysed include the monitoring results from September 2009, and Figure 2 indicates the numbers of doctors reported to be in Band 1 and, therefore, undertaking training and work within 48 hour compliant rotas over time between 2001 and September 2009:

The data in Figure 2 has yet to be verified in full but is shared at this early stage to aid the enquiry. The published data on junior doctors hours monitoring returns is available at: http://www.nhsemployers.org/PayAndContracts/JuniorDoctorsDentistsGPReg/Pages/DoctorsInTraining-JuniorDoctorsTermsAndConditions150908.aspx
The biggest changes have occurred since 2004, and since that time at least 30% of junior doctors have been working and training within 48 hours.

The cost of change was one rate limiting factor. Although the junior doctors contract provides an incentive to employers to reduce junior doctors hours (in the form of reduced banding payments) in many cases the introduction of compliant rotas will have required additional revenue costs (including in some cases new medical posts and/or training and recruitment of other staff) in excess of any savings on bandings. Organisations have therefore sometimes chosen to delay implementing change, and incurring additional costs, until it was absolutely necessary to ensure legislative compliance. In others change has occurred earlier. Another significant factor affecting the rate of change has been the attitude of local clinicians and often an unwillingness to recognise that it is now no longer possible nor sustainable to organise and conduct training the same as in the past.

In relation to the impact of the change to training within 48 hours, and specifically the allegation that it is too difficult to deliver the PMETB approved training curricula effectively within that limitation, firm evidence that the EWTD has adversely affected junior doctors’ training progress (perhaps evidenced by increased RITA/ARCP failures, unsuccessful transition/recruitment from CT1/2 into ST3 or increased referrals to GMC and/or NCAS, or for remedial training etc) has yet to emerge. However, employers are clear that there has inevitably been some impact. Specific changes include:

- Hours available for service, training and supervision are reduced
- In-hours exposure to work and training tends to be more limited (as hours are used to cover essential night time cover, often with less training benefit)
- Work is multidisciplinary and team based rather than in traditional ‘firm’ structures
- Rotas remain ‘fragile’ and any absences can be difficult to cover, sometimes interfering with planned training schedules
- Supervision may be more ‘fragmented’ for trainees and those supervising them.

What limited evidence there is on how these changes may have affected training only covers the period of transition, first to 56 hours and then commencement of the 48 hour requirement, and is mostly evidence of opinion.

PMETB, as the regulator responsible for standards in specialty training, has sought to examine references to EWTD in its quality assurance activity for the period 2005-09, and prepared a report on this. It concluded that where EWTD and compliance had been mentioned the underlying consistent messages were that “implementation of the EWTD is a major undertaking that has required major organisational changes. In many reported cases, it has been a source of stress for the organisations and trainees. In spite of these issues, the implementation of the average 56-hour week has, for the most part, been successful, with 78% of trainees working time compliant. How this will translate into the 48 hour week is unclear.”


PMETB’s national training surveys 2008-2009 (of trainers and trainees) have also examined attitudes to EWTD, and its relationship with other aspects of training and service. The survey found an association between EWTD compliance (at 56 weeks) and trainees reporting:
- being less likely to have made a medical error
- having a higher rating of adequate experience in their post
- study leave being encouraged
- better access to regional specialty specific training events.

Attitudes amongst trainers varied according to specialty, with surgeons being least positive. The actual comments made by trainers and trainees were at odds with the ratings the survey had elicited from respondents and that were more positive. PMETB’s conclusion was that anxieties about EWTD were influencing opinion and attitudes when “there is very little evidence that the concerns about the EWTD reducing the quality of training are borne out in practice and some evidence that complying with EWTD may increase patient safety by improving sleep hygiene.”

The full report is at:

The PMETB surveys of medical trainees and trainers conducted during 2009 can also be viewed on a trust-by-trust and specialty-by-specialty basis via a web-reporting tool at http://reports.pmetb.org.uk

We are aware that the GMC is looking into evidence that the numbers of doctors within Basic Medical Education (the Foundation Programme) being referred under fitness to practice procedures have been increasing (the GMC is examining data on this issue which may be available to the enquiry) but the cause of this increase, or contributory factors, remain unclear. It may be a trend that pre-dates 48 hours.

In respect of employer opinions, in 2008 we held workshops to discuss with employers and doctors their views about the future of medical education and training. At that stage some two-thirds of juniors were working and training under 48-hour compliant rotas.

Our Briefing 52 (Nov 2008) set out a range of conclusions. One of these was a general impression, amongst employers and some senior doctors, that those completing their medical training were not displaying the same range of competence and confidence as their predecessors. This was attributed to the shortened overall length of training under MMC, rather than simply the reduced average working week. It was often said that while they might have most of the competencies required, they lacked the confidence that comes with experience. Like the PMETB survey evidence this is, of course, evidence of opinion rather than objective fact, and it is difficult to compare with previous years.

At more recent meetings of our Medical Workforce Forum (including 10 February where this response was discussed), employers have made the point that, although compliance may have been achieved there are still very significant challenges ensuring that service delivery and standards of training are maintained. This is particularly the case in the craft specialties where EWTD compliance has perhaps had more impact on the traditional ‘apprentice’ and ‘firm’ based approach to training and there has been significant opposition to EWTD.

The other observation of employers is that their trainee doctors are, as a group, somewhat disengaged and perhaps disillusioned. This is thought to be because the quality of their training is being called into question by their forebears, pay (linked to their hours) is reduced from predecessors, and the hours controls that the EWTD and New Deal require engender.
They are also reported to be worried about future career prospects with ‘oversupply’ anticipated in some specialties.

However, these observations must be noted alongside staff survey evidence which indicates that, when compared to their NHS colleagues, doctors and dentists as a whole (trainees and non-trainees) are more satisfied with their pay, less likely to be planning to leave their employment, more satisfied with their jobs, healthier, get better access to training and learning, and are safer and less stressed. They do though report experiencing a poorer quality of life than the average for all NHS staff. The measures of work-life balance for doctors and dentists, while being poorer than other occupations, have improved since the previous survey. Staff survey information is available from the Care Quality Commission: [http://www.cqc.org.uk/usingcareservices/healthcare/nhsstaffsurveys/2008nhsstaffsurvey.cfm](http://www.cqc.org.uk/usingcareservices/healthcare/nhsstaffsurveys/2008nhsstaffsurvey.cfm) and in the NHS Employers Review Body evidence: [http://www.nhsemployers.org/Aboutus/Publications/Documents/NHS_Employers_evidence_to_DDRB_2010-11.pdf](http://www.nhsemployers.org/Aboutus/Publications/Documents/NHS_Employers_evidence_to_DDRB_2010-11.pdf)

The BMA has also consistently supported the introduction of the EWTD for junior doctors, a policy reaffirmed in 2009.

Employers also report an impact upon trainers, who have had to adjust to their trainees being available for reduced hours too. This may mean supervision arrangements need to be modified, which can impact upon job plans and availability for other work. There is pressure to undertake training and supervision in as short a time-frame as possible.

3. **How have those working in the healthcare ‘system’ (e.g. employers, trainers, service and training commissioners and providers) responded since the introduction of the EWTD?**

   Respondents should consider changes related to training which:
   - Resulted directly from EWTD
   - Resulted indirectly from EWTD
   - Are potentially unrelated but nevertheless are perceived to impact on the quality of training.
The main changes that have accompanied the transition to reduced EWTD compliant hours and which can be directly attributed to it are increases in the medical workforce and a move to shift patterns of working for trainees and other doctors. New Deal monitoring data presented in Figure 3 confirms this:

![Figure 3 – trends in working patterns](image)

This transition to full shift working has been driven by the need to ensure that the full hours available within the 48 hour average are utilised for both work and training, and also because the European Court has made rulings (the cases of SiMAP and Jeager) to the effect that all time spent at the workplace on behalf of the employer is counted as working time. This has prevented employers making use of ‘resident on-call’ and other arrangements where previously time spent ‘on site’ but resting would not be counted towards working time.

‘Non resident on-call’ accounts for the remaining ‘on-call’ rotas which is appropriate only for some rotas with limited requirement for recall to site.

At the same time as working patterns have been changed significant growth has occurred in the numbers of medical staff in England as rotas have expanded. This growth is illustrated in Figure 4:
### Table 1 - doctor numbers (headcount) in England 1997 - 2008

<table>
<thead>
<tr>
<th>Category</th>
<th>1997</th>
<th>2008</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant (including Directors of Public Health)</td>
<td>21,474</td>
<td>34,910</td>
<td>62.6</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>1,351</td>
<td>3,212</td>
<td>137.7</td>
</tr>
<tr>
<td>Staff grade</td>
<td>2,557</td>
<td>6,374</td>
<td>149.3</td>
</tr>
<tr>
<td>Doctors in training</td>
<td>30,313</td>
<td>49,178</td>
<td>62.2</td>
</tr>
<tr>
<td>Other hospital grades*</td>
<td>11,141</td>
<td>5,029</td>
<td>-54.9</td>
</tr>
<tr>
<td>GP Providers</td>
<td>27,200</td>
<td>27,347</td>
<td>0.5</td>
</tr>
<tr>
<td>Other GPs</td>
<td>846</td>
<td>6,663</td>
<td>687.6</td>
</tr>
<tr>
<td>GP Registrars</td>
<td>1,343</td>
<td>3,203</td>
<td>138.5</td>
</tr>
<tr>
<td>GP Retainers</td>
<td>900</td>
<td>507</td>
<td>-43.7</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>97,125</strong></td>
<td><strong>136,423</strong></td>
<td><strong>40.5</strong></td>
</tr>
</tbody>
</table>

*1997 figure includes some doctors now counted within the staff grade
Ever since the inception of the New Deal back in 1991 at the time of the 80-hour week and 1 in 2 rotas, and heightened since 2004 with the EWTD entering UK law for juniors, there have been calls from the service not to reduce hours for fear of damaging training opportunities. The balance between safe working practices for staff and patients and the training needs of individual doctors has always been a very difficult one.

It has undoubtedly been a significant challenge for employers to change working practices and introduce complaint 48 hour rotas, including rest periods. We surveyed two trusts in each SHA area in September 2009 and found that the main obstacles to EWTD compliance reported at that time were:

- recruitment difficulties (including the late notification of successful applicants, or doctors switching offers at the last minute)
- lack of clinical leadership or engagement
- unwillingness of junior doctors themselves to change (linked to the pay banding arrangements which rewarded longer hours at higher intensity)
- resources to instigate service delivery changes (eg changing working practices, or introducing centralised services)

The messages offered by employers in this survey included:

- the need to maximise the supply of doctors
- they were working hard on compliance and expected credit for this
- a new juniors contract was needed which did not provide financial incentive for non-compliance (separate monitoring for ND and EWTD is a problem for medical staffing departments and juniors)
- compliance is fragile and many continue to work longer hours via individual opt-out arrangements, to suit their training needs and to meet service requirements (gap-filling).

One specific area causing difficulty is in creating sufficient time for safe handover periods. We believe more needs to be done here, including working in multi-disciplinary teams and improving record keeping and access to patient notes so that safe round-the-clock working patterns can be maintained. However this is a local, organisational issue, and one which should not impact adversely on the quality of training overall.

The tension to create the right balance in managing service cover and delivery (which in itself contributes to learning) as against protected training time is arguably exacerbated at this juncture with nearly 50,000 doctors in training (a huge increase in numbers since 1997, following medical school expansion and the funding of additional training programmes). In time, as the proportion of doctors in training reduces, in line with workforce projections, it should become easier to balance training and service. A smaller proportion of doctors in the service will need access to training opportunities, and the call upon educational supervisors to provide training support will reduce. That does raise the issue of what service roles will be available to undertake the other work but that is not an issue for the quality of training.

For the moment there is variation in the degree to which different organisations have been able to adjust for EWTD. Many early adopters have ‘settled in’ to new working patterns, other organisations are sustaining compliance through derogation, or use of internal locums and ‘opt-out’ amongst some trainees and other doctors (trainees may ‘opt-out’ of EWTD voluntarily and work up to 56 hours a week, but training must still be possible within 48 hours).
In some cases service reconfiguration has been necessary and taken place, in others that reconfiguration remains necessary if EWTD compliance is to be achieved and sustained but often cannot be pursued because the necessary political support is absent.

For smaller hospitals, with more limited activity levels or significant geographic coverage, the costs of EWTD compliance in some specialties (e.g., paediatrics) may significantly exceed the PbR income associated with the activity, and will therefore require ongoing subsidy if reconfiguration is not made possible.

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<th>4.</th>
<th>What lessons can be learned from national and international experience about the delivery of high quality training within time constraints?</th>
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<tr>
<td></td>
<td>Respondents may wish to present evidence on lessons learned from both positive and negative experiences, or from the experiences of colleagues and partners in other parts of the country or the world.</td>
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</table>

There has been a significant amount invested in looking at solutions. The SfH/WPT resources outline many approaches to implementation. The biggest problem has been getting organisations and doctors to consider and adopt them. This is a cultural challenge and one argued made harder by the continued negativity expressed by some Colleges and clinical leaders, which permeates through to trainees themselves.

NHS Employers has worked collaboratively with the Colleges and other stakeholders in all the national groups and support structures. We contributed to the Medical Programme Board’s 2008 examination and recommendations in relation to maximising training opportunities in a 48 hour working week. We have provided FAQs for employers outlining how the WTD can work locally and can continue to support service delivery.
3. Publications to be considered as evidence

Please list any published articles or research papers that you would like the group to consider as evidence. Please note that where the referenced article appears on a password-protected site, a copy should be submitted alongside your response. Given the limited timeframe of this consultation, if you are unable to provide a valid web-link, electronic or hard copy for all other articles/papers, your suggestion may not be considered.

<table>
<thead>
<tr>
<th>Article/paper title</th>
<th>Author(s)</th>
<th>Source</th>
<th>Web-link</th>
<th>Have you submitted a hard copy? (Applicable only where web-link is not provided)</th>
</tr>
</thead>
</table>

4. Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory code of practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you would explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

Medical Education England will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.