

Association of Surgeons of Great Britain and Ireland

THE IMPACT OF EWTD ON DELIVERY OF SURGICAL SERVICES: A CONSENSUS STATEMENT



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A CONSENSUS STATEMENT



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*THE IMPACT OF EWTD ON DELIVERY OF
SURGICAL SERVICES: A CONSENSUS STATEMENT*



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This *Consensus Statement* is based on presentations delivered at a Consensus Conference held at the Royal Society of Medicine on Friday 30th May 2008, discussions arising from them and the final interactive session.

Video footage of the presentations, questions from the audience, discussion and the development of a consensus are available under “presentations” or “documentation” at:

www.asgbi.org.uk/EWTD-consensus

This *Consensus Statement* also includes feedback from those who contributed to the conference and those who were invited to comment on earlier drafts. The document is, therefore, a statement arising from a conference, rather than the proceedings of a conference. Thus, not everyone will agree with all the recommendations or conclusions. ASGBI have actively encouraged all stakeholders to submit individual responses to this document, and many have done so.

FOREWORD

In 1918, the International Labour Organisation, at its first conference, debated the forty-eight hour working week. Eighty years later the European Working Time Directive became law and ten years after that we continue to struggle with its implications and application.

Possibly no other legislation since 1948 has so challenged the conventions of service delivery and training, particularly for the craft specialties. Perhaps, not surprisingly, more effort has been put into resisting change rather than trying to work with it. Even the introduction of the “New Deal” in 2003 did not lead to the necessary changes in practice to enable the best opportunities for training and service delivery. Now, with the change in gender balance and a generation of doctors in training used to a shorter working week, there is a real need to understand the implications of the European Working Time Regulations. Failure to do this will lead to all the negatives; shifts that are so ineffective for training and continuity of care, and a huge new “lost tribe” bred by rota expansion seen by some as the only solution.

This Consensus Statement has begun to address the issues and dispel some of the myths; for instance, hours on call equalling training opportunity, as opposed to providing opportunity for emergency experience.

ASGBI should be congratulated for taking on this challenge and pointing the direction.

James Steers

President, Federation of Surgical Specialty Associations (FSSA)

INTRODUCTION

The *European “Working Time Directive (EWTD)*⁽¹⁾ has been enshrined in UK law since 1998 in *The Working Time Regulations*⁽²⁾ as part of Health and Safety Legislation. The principle was to gradually introduce a reduction in the working hours to a maximum average of 48 hours per week by August 2009. By August 2004 the Working Time Directive (WTD) had been reinforced to protect the health and safety of all doctors by restricting hours worked to a maximum of 58 hours per week and imposing minimum rest periods. This was followed by a phased introduction of further restriction of the hours to 56 hours per week by August 2007. The final implementation to a 48 hour working week is imminent and, although the deadline could be extended to 2012, such a delay is unlikely.

Rest requirements will be 11 hours of continuous rest in every 24 hour period with a minimum 20 minute break when a shift exceeds 6 hours. There is a minimum 24 hour rest period required in every 7 days or a minimum 48 hour rest period in every 14 days. All doctors in training are entitled to 4 weeks of annual leave.

Individuals can voluntarily opt out of the working hours limit, but they cannot opt out of the rest requirements. These restrictions also apply to Consultants and non-training grade staff in the NHS. The *European Working Time Directive* and the *Working Time Regulations* define working time as “*any period during which [the worker] is working at his employer’s disposal and carrying out his activity or duties*”. An important legal ruling, the SiMAP⁽³⁾ judgement of the European Court of Justice, confirmed that time spent on-call by doctors “... *must be regarded in its entirety as working time, ... if they are required to be at the health centre. If they must merely be contactable at all times when on call, only time linked to the actual provision of primary health care services must be regarded as working time.*” The effect of this was that doctors who are resident on-call but sleeping are adjudged to be working.

The WTD also stated that “*compensatory rest must be given when the daily/weekly rest requirements cannot be met. In each situation rest provided should make up for rest missed*”.

In another important judgment, Jaeger⁽⁴⁾, the European Court of Justice determined that rest periods must “*follow on immediately from the working time which they are supposed to counteract in order to prevent the worker from experiencing a state of fatigue or overload owing to the accumulation of consecutive periods of work*”. By August 2004, the effect of the reduction of hours from 100+ hours per week to 50+ hours per week, within the additional confines of SiMAP and Jaeger, meant that many junior doctors had to embrace unfamiliar work patterns such as full and partial shift working.

A survey undertaken by the Royal College of Surgeons of England in 2004 found that 75% of specialist registrars considered that continuity of care had worsened

following the implementation of full shift working. Furthermore, 50% of registrars considered the quality of care had also deteriorated and the vast majority of SHO's considered direct contact time with trainers had decreased in theatre, on the wards and in clinics. A survey of training log books demonstrated that there was a large reduction in operative experience before and after August 2004. At the same time Consultants were surveyed and 84% considered that continuity of care had worsened, many considered the quality of care deteriorated, and most found that direct contact time with trainees had decreased by up to one third.

A review of hours of experience and training by junior doctors has shown that the average exposure time of a trainee before 2004 was in the order of 21,000 hours during their six to eight year (depending on specialty) training programme. It is estimated that by August 2009, particularly with the added restrictions of Modernising Medical Careers, the average trainee will receive a total of only 6,000 hours during training. This means that a whole new approach is required to treating patients and to training the next generation of doctors.

The Surgical Royal Colleges and Specialty Associations continue to press for reconsideration of the European Working Time Directive, based on surgical specialties requiring specific craft skills, but it is unlikely that surgery will be treated as a special case. Under these circumstances, there will be huge pressure to ensure that surgeons have the knowledge and skills required to provide the best continuity of care by reconfiguration of surgical services and rotas designed to protect patient safety. Radical re-organisation of the delivery of healthcare in many areas will mandate a whole new approach to training the next generation of doctors. The surgical Specialty Associations, Societies and Royal Colleges have been working to help develop, implement and disseminate a range of potential solutions to maintain high quality patient care.

**Association of Surgeons of Great Britain and Ireland
November 2008**

KEY PRINCIPLES

- 1. The final phase of the EWTD is imminent and will be challenging to implement. It represents both opportunities and threats to the surgical profession in terms of patient care, training and quality of professional life. Currently EWTD compliance within surgery is poor across the UK. Reorganisation and investment are required to maintain patient safety.**
- 2. The UK has one of the lowest levels of trained surgeons per head of population in Europe. There is evidence of a mismatch between supply and demand for surgeons, which is likely to become increasingly acute with the implementation of EWTD. Government should encourage and enable Trusts to appoint more Consultants in order to address this issue.**
- 3. EWTD and the drive towards specialisation will inevitably lead to reconfiguration of surgical practice. Not all hospitals will be able to provide a full range of elective and emergency specialist services. Strategic planning will be required to deliver a compliant service through networks of clinical care. Unique and separate solutions for different geographical areas of the UK should be encouraged to maintain high standards of patient care.**
- 4. The introduction of EWTD and team working practices may threaten the quality of patient care unless communication and hand over are given the highest priority. Continuity is vital to patient care which should be supervised by a named Consultant Surgeon for the duration of any in-patient episode. Patient care should be delivered by trained surgeons or adequately supervised trainees.**
- 5. Elective and emergency surgical services should be separated. Care of emergency patients may be improved by the introduction of 'Hospital at Night' teams, provided they are properly resourced and managed and facilitate quality training and care.**
- 6. Skill mix initiatives to develop new roles for non-medically qualified (NMQ) staff may mitigate the pressure on the surgical team. The concept of a surgeon's assistant is attractive and is supported. However, this will not resolve the problems of EWTD.**
- 7. The Acute Care Surgical Team may be a solution in some hospitals. This should be developed with adequate resources. The emphasis for the acute care surgical team will be on diagnosis, clinical triage, resuscitation, and referral as necessary across a broad range of emergency conditions, including trauma. A number of major trauma centres are proposed but discussion is needed about location and service realignment prior to implementation.**
- 8. Full shifts and overnight duties for trainees result in a significant reduction in training opportunities. Training should, therefore, be more intensive and take advantage of multiple modalities of teaching and learning (simulators, e-learning, etc.). Surgical training must develop as a recognised focused activity which is managed and resourced independently. Not all departments or hospitals will have trainees.**
- 9. The Surgical Royal Colleges should continue to define levels of competence for pre-CCT grades. There should be a clearly defined career structure for post-CCT practice.**

SUMMARY OF CONSENSUS DISCUSSION

1. SERVICE DELIVERY

- 1.1 The introduction of the 48-hour working week in 2009 will have a significant impact on the delivery of service. At present, less than 20% of surgical training rotas are even 58 hour compliant. There is an urgent need for a marked reduction in the service commitment required of surgical trainees.
- 1.2 The future of full EWTD implementation is still not fully understood, but will result in a severe curtailment of Consultant working hours by 2010.
- 1.3 This will result in increased numbers of surgeons required to cover both daytime and on-call work. The workforce will be less experienced, there will be fewer rotatiers and cross cover between specialities will increase, resulting in further reductions in the delivery of service.
- 1.4 Reduction of trainee service provision will have implications for Consultant staff, and job plans should be adjusted to reflect this increased workload. These should include provision for adequate periods of compensatory rest and should reflect both clinical and supporting activities. Consultant expansion will be required to provide compliant 24-hour cover at Consultant level.
- 1.5 The provision of elective services is planned, predictable, measurable and profitable. Many surgical operations require a skilled assistant and dual Consultant operating will be required for more complex surgical procedures.
- 1.6 By contrast, emergency services are unplanned, unpredictable and less profitable. They require 24-hour cover and the patients are sicker. Best medical care requires the highest level of training and the need for specialist assistance. With the reduction in trainees, more Consultant input will be required to cover these emergencies. This increase in emergency workload should be reflected in individual Consultant job plans and met by increased Consultant numbers.
- 1.7 Increased Consultant involvement in the acute setting will necessitate the development of cross-site working patterns, greater Consultant team working and larger units to provide adequate cover for Consultant leave and sickness.
- 1.8 Further centralisation of both acute and elective services will be required, except in remote geographic areas where partnership schemes and networks should be encouraged.
- 1.9 In the current system, over 50% of surgical procedures are performed by Non-Consultant Career Grade Surgeons (eg. staff grade, hospital practitioner, clinical assistant, trust grade or clinical/research fellows). With the introduction of the 48-hour week, these posts will be developed and formalised and will allow hospitals to deliver effective elective service within the constraints of EWTD.

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- 1.10 The introduction of EWTD will inevitably result in the separation of elective and emergency surgical services.
- 1.11 Separation will require different models of surgical care depending on available resources and geographic location. Individual hospitals will need to determine how they are going to provide these services.
- 1.12 Failure to separate will have significant implications to patient care. Continuity will be lost, safety and outcome compromised and treatment will become depersonalised. Training opportunities will also be lost during the day and, at night, exposure to emergencies will be minimal. The training cycle will be disrupted and exposure to allocated Consultant trainers will be limited. This is already apparent with the introduction of shift working for surgical trainees.
- 1.13 Acute Care Surgical Teams could be developed to provide leadership for core emergency services and training opportunities to produce competent emergency surgeons.
- 1.14 SHAs and hospitals may need to develop a ‘hub and spoke’ system in order to generate a sufficient volume of emergency workload. This may involve the establishment of a national network of dedicated major trauma centres.
- 1.15 Emergency surgical work should be centralised in emergency and trauma centres run by experienced acute care surgeons. This would allow elective surgical teams to provide care effectively within the constraints of the 48-hour week.
- 1.16 Without significant expansion in Consultant numbers over the next five years, many current SPRs will either face unemployment or be encouraged to accept short-term “specialist post-CCT posts”.
- 1.17 The Consensus Conference strongly supported the continued expansion of Consultants to allow progression of the number of future surgical trainees and meet the demands of reduced working hours enforced by the EWTD.

2. TRAINING IN SURGERY

- 2.1 EWTD will have an immediate effect on both the breadth and depth of surgical training. The reduction to a 48-hour working week will reduce current elective training opportunities by 25% for trainees working a full shift system with night cover. Six years of training on current 56-hour full shift systems, will be equivalent to 7.5 years on 48-hour full shift systems.
- 2.2 The reduction in exposure to emergency procedures will compromise the ability of trainees to achieve the necessary competencies in emergency surgical practice. Training needs to become a focused activity, managed through the Schools of Surgery under the direction of the Surgical Royal Colleges and recognised as a specialised skill in its own right. It should be more intensive and take advantage of all modalities for teaching and learning including simulators and e-learning models.
- 2.3 Trainees will need to focus on their sub-specialty at an earlier stage in their training programme and will be challenged to achieve competence in the “generality” of Surgery in a designated time frame. The completion of surgical training must be competency based and not time based.
- 2.4 The Jaeger ruling⁽⁴⁾ found that a period of rest must follow immediately after the period of work which generated it. Partial shift or on-call rotas should include no, or limited, night cover to maximise the proportion of time available for daytime training.
- 2.5 Trainees (+/- Consultants) should avoid operating after midnight unless the patient requires emergency surgery (NCEPOD). A reduction in night shift working would result in daytime training opportunities being maximised for both elective and emergency surgery. Trusts should be encouraged to provide adequate ‘Hospital at Night’ cover and to allow surgical trainees and trainers to maximise daytime training opportunities.
- 2.6 Not all hospitals or departments will be involved in surgical training. Many may opt out and concentrate on the provision of service. This will have to be adequately resourced.
- 2.7 To date, surgical training numbers have reflected service needs rather than training needs. There is now an urgent need to separate training and service commitment so that hospitals and units are separated into those which train and those which don’t.
- 2.8 In many areas of the country, routine elective procedures will be provided by ISTCs, private hospitals and polyclinics. Surgical training programmes should be flexible enough to utilise all of these differing training opportunities, they are likely to centralise and they will move from being demand led to provider led.
- 2.9 The Workforce Review Team (November 2007) have forecast that, by 2012, both General Surgery and Trauma & Orthopaedics will be overproducing trainees. There is, therefore, either a need to increase Consultant numbers, or these specialities will need to reduce training numbers between 2008 and 2012. This reduction in trainees will have a major effect on the provision of service within hospitals and alternative arrangements will need to be implemented.

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- 2.10** The culture of “talent management” must be encouraged with the possibility of extra resources being targeted towards the gifted trainee. In addition, assessment and competency testing must be utilised to identify the failing trainee at a much earlier stage.
- 2.11** The introduction of MMC, MTAS and EWTD has significant consequences for surgical training. The abolition of the Associate Specialist grade, increasing numbers of UK medical graduates, the highly skilled migrant worker programme and the increased number of European Economic Area (EEA) applications, has resulted in considerable strain to UK surgical training programmes and significant uncertainty regarding the future of the end product of these programmes.
- 2.12** Many Trusts believe that much elective surgery can be carried out by fully trained surgeons who are not Consultants. This post CCT Specialist grade may be preferred by some trainees following completion of surgical training, but there should be an opportunity to compete for Consultant posts following the award of a CCT.

3. PROVIDER CHALLENGES

- 3.1 The introduction of the 48-hour working week in 2009 must address the welfare of both patients and doctors. It will be difficult enough in the larger specialities, such as General Surgery and T&O, but smaller specialties may really struggle to develop acceptable rota compliance. They will need different staffing ratios and there will be a major impact on the provision of emergency care.
- 3.2 Different solutions will be required for differing specialities. This may involve the separation of emergency and elective workload, the necessity for formal handovers, networking, night working and arrangements for specific cross cover either within or between specialities.
- 3.3 For the provision of elective services. Trusts may need to develop lists with more assistance from nurses and allied professionals. For the more complex procedures, teams of Consultants will be required to work together to provide ward based, operative and post-operative care for their patients.
- 3.4 It is likely that more elective work will be outsourced to Independent Sector Treatment Centres (ISTCs). It will be essential for more training to be transferred to these centres.
- 3.5 The compliant cover of emergency work will be more problematic. This may involve dedicated emergency teams with no other duties. Consultants may need to be on-call for 24-hours with no scheduled elective work requirement. There should be a readily available NCEPOD theatre in all hospitals providing acute care available from 08.00 hrs to 22.00 hrs. Only those procedures with a significant threat to life or limb should be performed after midnight.
- 3.6 Consultants may be required to work in shifts; there should, therefore, be the provision of adequate staffing levels to ensure that both elective and emergency sessions are covered and also that supervision and training of junior staff is fit for purpose. Adequate periods of compensatory rest must be built into these new Consultant job plans (eg. 8 hours rest after every 24-hour episode of on-call).
- 3.7 Night emergency cover may be provided by a dedicated ‘Hospital at Night’ team. Only patients with life or limb threatening conditions will be considered for “out of hours” surgery and all others should be investigated and stabilised prior to possible surgical intervention on the dedicated NCEPOD list the next day.
- 3.8 The introduction of formal team working practices will require mandatory development and implementation of formal handover procedures, both at Consultant and trainee level.
- 3.9 The strength of the implementation of EWTD is that it may result in a less exhausted workforce and, consequently, a better work/life balance. Those surgeons presently working in isolation should become part of surgical teams, thus enhancing professional practice.

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- 3.10** There is, however, the potential for surgical care to become disjointed and fragmented, resulting in patient confusion, chaotic rotas and inadequate night cover arrangements for both elective and emergency patients. It is, therefore, essential that adequate numbers of Consultants and trainees are employed to prevent such deterioration in service provision.
- 3.11** The introduction of the 48-hour working week can provide significant opportunities to the provision of surgical care. The concept of ‘ancillary theatre assistants’ and ‘emergency physicians’ should be developed, as these individuals may be able to play an important role in the initial identification, resuscitation, stabilisation, investigation and preparation of surgical patients for theatre.
- 3.12** All Trusts must ensure that the changes in working practices designed to deal with the implications of EWTD are associated with an acceptable level of risk. Work schedules should be specifically designed to minimise such risk and all hospitals and hospital networks need to make urgent plans to accommodate such changes.

4. WORKFORCE PLANNING

- 4.1 Co-ordinated planning for the change is essential and EWTD should be seen as an opportunity to transform the quality of surgical training and patient care. There is an urgent need to align specialty training and service needs. With many specialties becoming highly competitive, better workforce planning systems are required.
- 4.2 The Workforce Review Team provides expert advice on workforce planning for the NHS and works in partnership with NWP to predict compliance for EWTD 2009. Their estimated compliance is between 40% and 60% and has a significant variation dependant upon region and specialty.
- 4.3 Those specialities with an essentially elective service provision are expected to reach between 90% and 100% compliance (eg. General Practice and Public Health).
- 4.4 The estimated compliance for Surgery by SHA is poor, ranging from 17% (West Midlands) to 63% (North East). *See Figure 4.1*

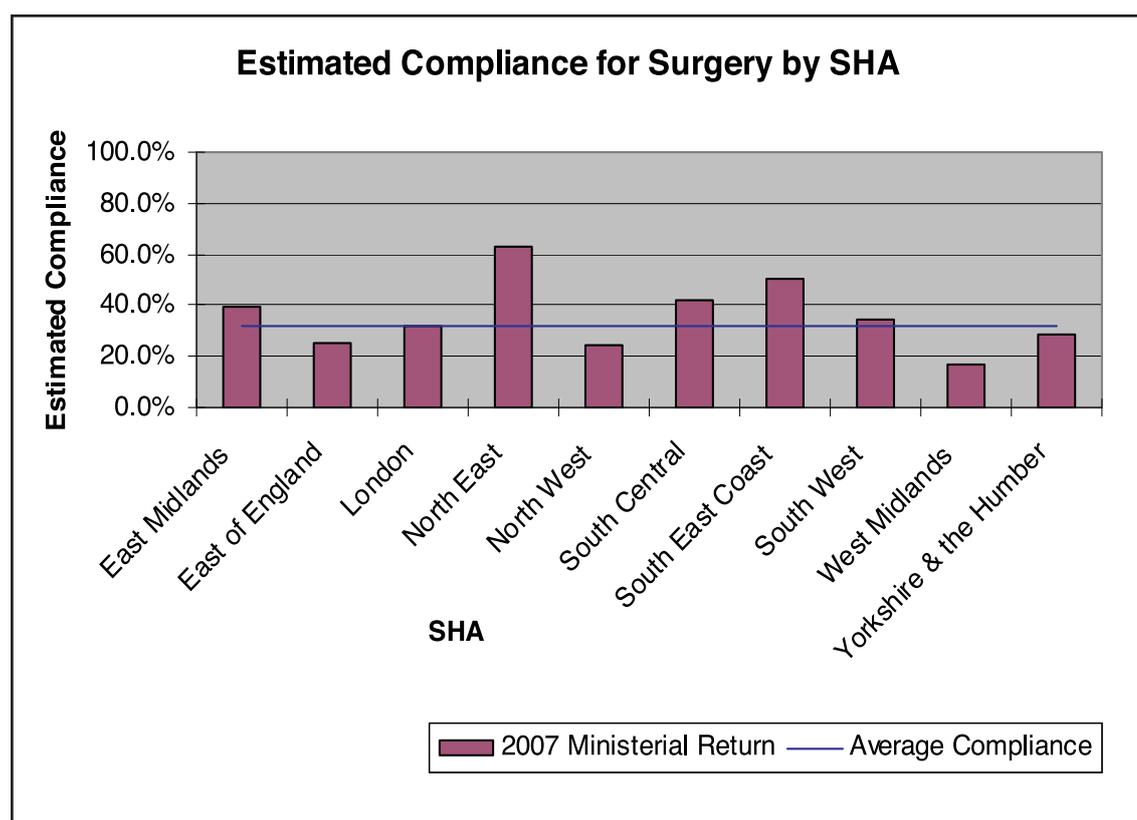


Figure 4.1: Estimated EWTD Compliance for Surgery by SHA

- 4.5 Estimated compliance by surgical trainees indicates an average of 50%, 40% and 20% at F1, F2 and SPR level. Urgent work is required if Surgery is to reach the required EWTD compliance levels by implementation in 2009.

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- 4.6 There is much existing evidence that rested doctors provide safer care for patients. Trusts must be committed to supporting work/life balance.
- 4.7 It is recognised that the NHS will need more trained doctors in the long-term and medical school numbers have, therefore, increased. The Workforce Planning Review found specialty training numbers are currently at suitable levels, but the specialty mix needs reviewing, with more GP trainees and fewer surgeons accepted for training.
- 4.8 EWTD is challenging but presents real opportunities for transforming patient services. The focus must be on quality of care, training and coordinated planning. It is essential that planners and surgeons work together to maintain quality of care in the wider NHS.

5. THE FUTURE OF THE DISTRICT GENERAL HOSPITAL

- 5.1 A District General Hospital (DGH) provides a spectrum of clinical services primarily directed at the health needs of its local population.
- 5.2 The delivery of future healthcare will involve a balance between “accessibility” and “expertise”. Centralisation of services will threaten the viability of many smaller DGHs and require patients to travel to obtain specialised surgical services.
- 5.3 There is a growing body of evidence that outcome is related to caseload. This caseload is not always available in DGHs and further data is required with respect to optimal volume and outcome. There is strong evidence that Consultants (specialists) have better outcomes for specialist procedures.
- 5.4 Excellent outcomes are not only dependent on institutions or individuals *per se*, but also rely on service design, adequate resourcing, teamwork and promulgation of high standards.
- 5.5 At present, 63% of NHS workload is carried out in DGHs, 31% in teaching hospitals and only 5.5% and 0.5% in specialty hospitals and ISTCs respectively (Data source HES 2006-7). Centralisation of service will not be possible without major investment in both real-estate and personnel. This is unlikely to occur within the next decade.
- 5.6 The greatest percentage of emergency procedures is performed in DGHs, with many University and specialist hospitals preferring to concentrate on elective and more complex procedures. ISTCs primarily provide elective services. Any move towards closing DGHs will need to address the re-provision of emergency surgical services.
- 5.7 The introduction of the 48-hour week will be a significant threat to the DGHs who often do not have adequate staffing levels to continue to offer both elective and emergency care under EWTD requirements. This may drive ‘centralisation of service’ but, in the interim, the development of ‘Networks of Care’ may be a stepping stone to full centralisation and will be essential for the delivery of compliant Consultant and trainee rotas.
- 5.8 Politically and socially it will be possible to maintain many DGHs within EWTD guidelines, but this will inevitably involve change in working practices and “networking” of both elective and emergency services with neighbouring providers.

6. SOLUTIONS FROM EUROPE

- 6.1** The Scandinavians recognise that EWTD is an issue of “work; stress and health”. Stress is known to be associated with an increased risk of coronary heart disease⁽⁵⁾ and it is the employers' obligation to minimise this risk. There is, therefore, recognition from both doctors and employers to the practical implementation of EWTD.
- 6.2** The Scandinavian countries have more practicing physicians per 100,000 head of population (Norway 362; Sweden 348; Denmark 308; Finland 245) than the UK⁽⁶⁾.
- 6.3** In Sweden, there is no shortage of doctors and each works an average of 40 hours a week. The average annual number of operations per surgeon (150 to 200) is less than in the UK and most large units are highly specialised. There are generous compensation schemes for being on-call (2 hours for every 1 hour) and each surgeon would normally take 8 to 10 weeks off duty per year. Academic surgeons tend to use this time for research. This makes EWTD compliance much less of a problem for Sweden.
- 6.4** Finland, however, has a shortage of doctors (> 1000 doctors), a shortage of specialists and a reduction in the number of hospitals able to offer a 24-hour emergency service. Finland does not, at present, comply with EWTD.
- 6.5** Norway is not a member of EU (only EES). There is a relatively high number of doctors who are already working a 48-hour week. Only minor problems exist regarding their on-call service and training and it is unlikely that the EWTD will have a significant impact on their practice. A similar situation exists in Denmark, where doctors work a strict 40-hour week and have no problems with the delivery of emergency services or training.
- 6.6** Anecdotal evidence suggests that implementation of EWTD in Ireland has been very slow, and totally ignored in many surgical units. Full implementation would likely result in the closure of many small hospitals which would impact significantly on surgical training.
- 6.7** If shift work was introduced to ensure compliance, the number of hours worked would reduce, but patient care would deteriorate as would the quality of training.
- 6.8** Possible solutions for EWTD in Ireland would be to separate the elective and emergency service provision and to increase the number of Consultants (which is the stated policy of the Health Service Executive). There are proposals to introduce physician assistants who would carry out much of the “non-training” aspects of the current trainee surgeon’s work.
- 6.9** The Royal College of Surgeons in Ireland has a strong pedigree in e-learning, web-based surgical education, mobile skills courses and simulation of critical clinical scenarios. These activities are developing and expanding and will supplement ‘in hospital’ training.
- 6.10** The development of elective only hospitals would provide excellent caseloads for trainees, whilst one surgeon (surgical team) providing emergency care on a weekly basis would result in trainees receiving good training in emergency procedures during the normal working day.

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**CONSENSUS CONFERENCE ON THE IMPACT OF EWTD
ON DELIVERY OF SURGICAL SERVICES**

30th May 2008

ATTENDANCE LIST

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Mr Sunil Bhudia	Society of Cardiothoracic Surgeons
Mr Stephen Blair	Wirral University Teaching Hospital NHS Foundation Trust
Mr Richard Bliss	Honorary Secretary, British Association of Endocrine and Thyroid Surgeons (BAETS)
Mr Abrie Botha	Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland (AUGIS)
Mr Nigel Burgess	WTD Programme Lead, NHS National Workforce Project
Professor Kevin Burnand	President, Society of Academic and Research Surgery (SARS)
Professor Richard Canter	Associate Dean and Head, Severn Postgraduate School of Surgery
Mr Peter Chong	Western Infirmary and Gartnavel General, Glasgow
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Mr Jonothan Eamshaw	Honorary Secretary, Vascular Society of Great Britain and Ireland (VS)
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