The Royal College of Anaesthetists
Educating, Training and Setting Standards in Anaesthesia, Critical Care and Pain Management

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**REPORT ON ROYAL COLLEGE OF ANAESTHETISTS LIAISON VISITS TO STRATEGIC HEALTH AUTHORITIES – 21st APRIL – 7th MAY 2009**

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## EXECUTIVE SUMMARY

- **Background.** An RCoA working party was formed to visit all 10 SHAs in England to assist and make recommendations for EWTD planning in accordance with direction from DH. The visits took place from 21 Apr-7 May

- **Aims.** The Aims of the liaison visits were:

    - To share with the SHAs areas of concern to the RCoA.
    - To compare SHA data and RCoA data on compliance and reconcile any differences.
    - To identify compliance to EWTD at 48 hours by 1 Aug 09.
    - To identify compliance to EWTD at 52 hours by 1 Aug 09.
    - To identify non-compliance to EWTD by 1 Aug 09.
    - To identify the shortfalls in standards set against the 3 main areas.
    - To help the SHAs to plan any necessary action to meet EWTD challenges including the possibility of derogation as an interim measure.

- **Key Issues.** Key issues were:

    - Novice anaesthetists are unable to contribute to service for a minimum of 3 months.
    - Adherence to notional compliance without due consideration to level of experience and training.
    - Omission of ICM rotas in planning.
    - Potential of unfilled posts to cause additional problems for compliance.
    - Concerns over planned medical staffing solutions.
    - Reconfiguration of services requiring involvement at all levels of management.
    - Realistic approach from SHAs regarding state of readiness returns to DH.

- **Recommendations.** The following recommendations were made:

    - The impact on training is given a higher priority.
    - Any 24 hour rota more onerous than 1 in 8 with prospective cover should be considered RED.
    - Any 24 hours rota that is 1 in 8 with prospective cover will not be compliant if there is one gap in the rota. Where this is recognised as likely to happen the rota should be considered to be AMBER
    - Further investigation should be carried out on ICM rotas
    - Contingencies should be the put in place if planned recruitment and MTI solutions fail, through lack of numbers. DH must be aware that many SHAs have planned on recruitment and MTI to alleviate the shortfalls and this may not come to fruition.
    - Continued liaison is recommended between the SHAs and RCoA as a continued dialogue will enable SHAs the ability to gain clarity on specialty specific issues that may not be immediately apparent.
    - Longer term planning by all key stakeholders including DH, RCoA and SHAs to ensure Hospitals remain compliant following the initial deadline of 1 Aug.

TRG/EWTD/05/09

20 May 09

**REPORT ON ROYAL COLLEGE OF ANAESTHETISTS LIAISON VISITS TO STRATEGIC HEALTH AUTHORITIES – 21st APRIL – 7th MAY 2009**

## BACKGROUND

1. **Concept.** Following increasing concern on the impending requirement for all Strategic Health Authorities (SHAs) to ensure that all hospitals in their area of responsibility are European Working Time Directive (EWTD) compliant by 1 Aug 09 the Department of Health (DH) accepted the offer of assistance from a number of the Royal Colleges of acute specialties to conduct a detailed investigation into the state of compliance for their specific specialty.

2. **Approach.** In response to a request from Wendy Reid, working in her capacity as the DH EWTD lead, the Royal College of Anaesthetists (RCoA) agreed to conduct detailed liaison visits to each SHA, in England, to assess compliance against the criteria as laid down below:

    a. Service.
    b. Patient Safety.
    c. Effect on Training.

3. **Aims.** The aims of the liaison visits were:

    a. To share with the SHAs areas of concern to the RCoA.
    b. To compare SHA data and RCoA data on compliance and reconcile any differences.
    c. To identify compliance to EWTD at 48 hours by 1 Aug 09.
    d. To identify compliance to EWTD at 52 hours by 1 Aug 09.
    e. To identify non-compliance to EWTD by 1 Aug 09.
    f. To identify the shortfalls in standards set against the 3 main areas.
    g. To help the SHAs to plan any necessary action to meet EWTD challenges including the possibility of derogation as an interim measure.

## PROJECT METHODOLOGY

4. **RCoA plan**. The DH requested that this project was carried out with some urgency. An RCoA plan was developed and implemented (Annex A) within the very short timescale requested. This resulted in a programme of visits conducted between 21 Apr – 7 May (Annex B).

5. **Funding.** Funding to facilitate the visits was provided by DH to RCoA. This was specifically to cover the costs of the working party and no provision was made in the business case presented to DH by RCoA to cover clinicians' time away from their Hospitals.

6. **Working Party.** The RCoA working party consisted of 7 experienced consultants who were either in post as a Regional Advisor or had recently

demitted office, supported by a team of 3 administrative staff of the RCoA. The working party lead was the Deputy Medical Secretary and one of the RCoA Vice Presidents acted as Chairman. The Director of Training led the administrative team. A list of working party members is included in Annex C.

7. **Visit Preparation.**

    a. **RCoA.** A detailed questionnaire was sent to the College Regional Advisors who were asked to complete it with as much detail as possible for each hospital in their area (Annex D). The results were collated by RCoA and were used by the working party to analyse the specialty specific issues within each SHA. Where possible the RCoA data was sent to the SHA in advance. Prior to each visit the designated working party members met to discuss the questionnaires and any other data available. Clarification of any information or lack of information provided was sought by telephone prior to the final meetings.

    b. **SHAs.** SHAs have conducted detailed planning into EWTD compliance and had data on most Hospitals. A number of SHAs provided copies of their March Statement of Readiness Returns to the College in advance. SHA leads were proactive in enabling the visits and ensuring that key personalities were available during the arranged meetings. The most beneficial meetings were where there was an anaesthetist representing the specialty interest on behalf of the SHA and representation from a local deanery.

8. **Visit Format.** The visits generally conformed to a similar format where the RCoA working party visitors were able to discuss anaesthesia issues with the key SHA EWTD personalities. In some cases RCoA visitors also sat in on steering group meeting and although not hugely beneficial did provide a clear overview and insight in the situation within the SHA.

**OUTCOME OF VISITS**

9. With one or two exceptions SHAs have been well focused on the issues, very amenable to discussion of the training, staffing and safety issues concerned with EWTD, and receptive to input from others; these meetings resulted in a mutually advantageous exchange of information and views.

**KEY ISSUES DISCUSSED**

10. Although by no means exhaustive the key issues were as follows:

    a. **Intensive Care Medicine (ICM) Rotas.** In some cases SHAs have omitted any detail on ICM rotas. The cross specialty nature of ICM cover may be the cause of lack of engagement with this group. This was of particular concern when the ICU is run independently from Anaesthetic Departments. This must be addressed in subsequent Readiness Returns and plans put in place to address staffing issues and training on ICM rotas.

b. **Notional compliance.** There was evidence that some rotas that appear to be fully staffed and compliant actually include novice anaesthetists or "locum" slots. Not all SHAs appreciated that novice anaesthetists are unable to provide any service on their own until they have completed their Initial Assessment of Competence after a minimum of 3 months experience. The impact on individual hospitals depends on the distribution of CT1s and ACCS doctors within a school. Some spread recruits evenly, some concentrate them in the Teaching Hospital where the out of hours service contribution is insignificant, some concentrate them in the DGH with presumably the most intense service impact. This is compounded by almost all posts starting in August resulting in a significant number of predictable gaps in the rotas in August, September and October and those with a significant number of ACCS trainees experience a second wave in February, March and April. Plans for covering CT1/ACCS starters were rarely given.

c. **Unfilled posts.** A number of reasons were identified for additional gaps in the rotas

    i. **Recruitment.** Most Hospitals have not had a 100% fill in the first round of recruitment and the National Recruitment round led by the West Midlands will not guarantee fill rates. SHAs are generally unaware of CT/ST fill rates. There are therefore likely to be significant gaps in training posts across all points of entry. Some returns to DH by SHAs reflect a 100% fill rate come 1 Aug. These figures should be reviewed with caution. It is almost impossible to assess the impact of an unsuccessful fill rate.

    ii. **OOPEs, Maternity Leave and Trainees Leaving the Program.** In the last years of training trainees may be scattered according to individual needs or preference, or concentrated in the Teaching Hospital for end stage subspecialty training. The impact on EWTD of leavers, OOPE or 'acting up' as locum consultant will vary accordingly. Specialist, teaching and some major district hospitals offer Fellowship posts which make it relatively straightforward to expand rota cells at the same time offering doctors additional expertise. As a result these are popular. Unless these doctors are from overseas or are post-CCT, more gaps are introduced in the overall programme of training. Rotas that only just comply with EWTD and training targets will always be vulnerable to gaps from maternity leave.

    iii. The SHA returns for March are the first to count the number of unfilled posts and present alarming statistics. In 5 SHAs where the figures were analysed it has been estimated that on average every hospital has between 1.5 and 2 vacancies with 50% of the rotas within each hospital "one down". Although recruitment in August will fill some of the training gaps they will be filled with novices who will not be able to contribute until at least November or until they have passed their initial test of competence.

d. **Medical Staffing solutions**

i. **Locums.** An RCoA survey carried out in Dec 2008 – Feb 2009 reported 72.6% of hospitals regularly rely on locums to fill these gaps, 72.2% reported they used internal trainee locums with 43.7% reporting the use of trainees through a locum agency. SHAs are aware of this activity and concerned that trainees may not appreciate they could be in breach of contract.

iv. **MTI.** Some Deaneries are relying on MTI to fill gaps in rotas. It is imperative that doctors employed through this scheme are offered training opportunities appropriate to their individual needs. While this may alleviate some of the issues SHAs should conduct more strategic planning on how these gaps will be filled should MTI not provide the solutions. It should also be considered that this problem will arise again in 2 years following the end of the IMG's contract. Unless already in negotiations it is unlikely that new MTI will be recruited in time to assist hospitals by August 2009.

v. **Specialty Doctors.** At Trust level there is a significant reliance on specialty doctors, some in exclusive non-compliant rotas with agreed personal opt out of EWTD. A large proportion of gaps are currently filled by specialty doctors working additional locum shifts. Many hospitals report they are actively recruiting to this grade. It is not clear how the pool of available candidates will satisfy the national demand, and almost all hospitals taking this route report difficulties with recruitment. Doctors eligible for these posts are likely to be required to give a period of notice from their current employment before taking up a new position and so unless they are currently unemployed any further recruitment is unlikely to get individuals in post by August.

vi. **Consultant expansion.** Identified as a long term solution and is taking place but is considered an expensive option, particularly if consultants are required to fill gaps by acting down. The full impact on the provision of anaesthetic services may not be appreciated until this occurs.

e. **Reconfiguration of services.** Some hospitals are in the process of amalgamating sites, and some of these changes will not have happened in full by Aug 09. However there is a plan in progress. A few are assuming they will still be able to offer a full range of clinical service on too many sites or in too many rotas, for the number of doctors available but have no plan to address either service distribution, redesign or altered staffing structures. It is unlikely that these hospitals will have this resolved by 2011 without a serious change in mindset. The RCoA visitors stressed a key finding of the RCS/ RCoA WTD – *Implications and Practical Suggestions to Achieve Compliance* report, published in November 2008 was that successful hospitals showed evidence of active engagement of senior management within a WTD planning group, involving senior clinicians from all acute specialties and requested SHA support for this principle where it is missing.

f. **State of Readiness Return Fidelity.** There were a number of examples where returns to DH reflected an emphasis on legality of theoretical rotas without consideration of requirements for training. The RCoA minimum standard to maintain adequate training is 3 sessions per week of hands-on training (in theatre or ITU) and provision of a structured program of classroom (protected) teaching. The College view is that any rota more onerous than 1 in 8 with prospective cover will not provide adequate training. Initial returns from some hospitals to SHAs implied that they would be compliant with rotas of 1 in 7 or less and this had been accepted. It was not obvious that discussions concerning the impact of the other issues such as training, fill rate, novice placement, and full recruitment of specialty doctors was received and digested in a meaningful way by all SHAs. It is the view of the RCoA that any rota that covers 24 hours and is 1 in 7 with prospective cover or worse should be considered RED.

g. **Implementation review.** Compliance is over a 26 week reference period. By omitting the period Aug – Nov from any survey the impact of the worst of the staffing issues will not be recognised. If a post EWTD implementation survey were to be conducted 6 weeks of this period must be included. A period mid-Sep to mid-Mar might be more representative than Nov to May if the impact of CT1 particularly were to be properly recognised as a recurrent yearly issue.

**CONCLUSIONS**

11. From the RCoA perspective the vital ground regarding the implementation of EWTD across all SHAs is the threat to training. The true impact of this may not be seen within the first few months after 1 Aug. Although SHAs are aware of this on the surface there are key areas where it has not been addressed. This has short, medium and long term consequences to both service and, most importantly patient safety.

12. It is clear considerable work is being done at SHA level to meet the requirements of EWTD and rotas are becoming increasingly compliant as the 1 Aug deadline approaches but such compliance is reliant on many uncertainties, including recruitment, MTI and an assumption that consultants will cover the shortfall. The degree of engagement with different hospitals has been variable. Some SHAs have identified where these shortfalls are and have taken proactive steps to resolve them, others have been taking a more passive role and have not questioned the returns submitted.

**RECOMMENDATIONS**

13. The RCoA visitors found the visits to be constructive and valued the opportunity to raise their concerns and came to the following recommendations:

- **The impact on training is given a higher priority.**

- **Any 24 hour rota more onerous than 1 in 8 with prospective cover should be considered RED.**

- **Any 24 hours rota that is 1 in 8 with prospective cover will not be compliant if there is one gap in the rota. Where this is recognised as likely to happen the rota should be considered to be AMBER**

- **Further investigation should be carried out on ICM rotas**

- **Contingencies should be the put in place if planned recruitment and MTI solutions fail, through lack of numbers. DH must be aware that many SHAs have planned on recruitment and MTI to alleviate the shortfalls and this may not come to fruition.**

- **Continued liaison is recommended between the SHAs and RCoA as a continued dialogue will enable SHAs the ability to gain clarity on specialty specific issues that may not be immediately apparent.**

- **Longer term planning by all key stakeholders including DH, RCoA and SHAs to ensure Hospitals remain compliant following the initial deadline of 1 Aug.**

**POINTS OF CONTACT**

14. RCoA EWTD Points of Contact are as follows:

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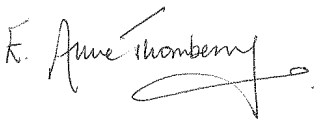

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