# 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 POST 1st AUGUST 2009 SURVEY**

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**Executive Summary**

- **Background.** RCoA carried out a second survey to follow up on the information gathered from the Jan 09 survey and visits to SHAs conducted in May. The survey was conducted in October 09 and the response rate was 58%.

- **Aims.**

    - To assess the impact of WTR implementation post 1 Aug 09 on anaesthetic departments.
    - To identify key issues concerning the delivery of training across all anaesthetic departments.
    - To identify key areas of concern and areas of best practice

In order to inform all key stakeholders and provide evidence to support further work into providing workable solutions.

- **Key Issues.**

    - Rotas appear complaint on paper but are not sufficiently robust to survive in reality
    - Difficulties in recruiting both consultants and specialty doctors affected planned solutions to fill rota gaps.
    - International recruitment continues to be complicated and elongated
    - Completion of the Initial Assessment of Competence, required before an anaesthetist provides any service, is regularly taking longer than the indicative 3 months previously considered the norm,
    - Core trainees are failing to gain enough obstetric competencies to contribute to an obstetric anaesthetic on call rota within the expected timeframe, increasing the burden on more senior trainees.
    - Some trainees are not gaining sufficient exposure to specialist cases to complete their competencies within allocated training units and are required to return for further experience in due course.
    - To provide effective training tutors need to micromanage the deployment of trainees on a daily basis, to protect them from service demands and ensure access to the most relevant training opportunities. This requires dedication and time.
    - Trainees who opt out and provide locum cover are spending a disproportionate amount of time providing out of hours cover at the expense of daytime training opportunities
    - Specialist doctors and consultants are absorbing extra work to fills gaps in both the on call rotas and service provision
    - Support and realistic job planning for career grades and consultants is insufficient.

- **Recommendations and Actions.**

    - RCoA working alongside PMETB to assess the impact on training as a result of WTR implementation.
    - RCoA providing evidence to MEE report WTR impact on training.
    - Further RCoA work to be conducted on areas of best practice.
    - Further RCoA work to assess the time taken to pass the Initial Assessment of Competence and compare this to data pre-WTR in order to ascertain how training is being affected at CT1.
    - Continued engagement with all key stakeholders including SHAs through the continued framework already in place.

**Introduction & Background**

- Following the full introduction of WTR on 1 Aug 09, RCoA carried out a second survey to follow up on the information gathered from the Jan 09 survey and visits to SHAs conducted in May. All College Tutors across the 4 nations were asked to complete the survey which was carried out in October to help identify issues since the introduction of the new WTR. The response rate was 58%.

- The detailed results were sent to the College SHA liaison representatives and discussed at an RCoA WTR strategy meeting on 15 Dec 2009 to identify issues that need addressing and recommend further action as appropriate.

- The report includes details on

  a. Derogation
  b. Compliance of rotas with WTR and RCoA standards
  c. Patterns of recruitment
  d. The impact on training
  e. The impact on consultants
  f. The impact on specialty doctors

- The data is separated into the subject areas above and by nation. The data from England and Wales is further subdivided by SHA.

**Derogation**

- A total of 54 Anaesthesia and ICM rotas applied for derogation (42 in June and 12 in October). The RCoA state of readiness survey carried out in March 2009 suggested that many more hospitals in England would have benefited from derogation than those that applied in June. The RCoA results for the devolved nations also contradicted the stated view that derogation was not necessary. This survey shows that the option to make a late application for derogation in September was not common knowledge within the anaesthetic community and few hospitals took advantage of it.

- A number of College Tutors reported resistance to requests to apply for derogation coming from HR departments, Medical Directors, Chief Executives or reportedly from SHAs. Where rotas were legally compliant tutors felt there was a lack of understanding and support to meet the minimum standard set by the RCoA to protect training and a lack of flexibility to cope with any gaps in the rotas.

- Support from Trusts frequently came in the form of funding for new anaesthetic posts without appreciation of the difficulties recruiting. This promise of financial support was given as the reason for not applying for derogation.

- Derogation was frequently seen as undesirable because if simply delayed the implementation of the solutions. Of the 15% of hospitals in England that reported applying for derogation only half have put it into practice.

**Representative samples of free text concerning derogation**

- Derogation was given to us late at which time we could not do much for our August/September rotas
- No information about derogation. Not consulted
- Trust policy not to apply for derogation. Rotas considered to be compliant but no account of gender shift, midterm consultant appointments, inability to recruit and illness factored into numbers.
- Short term “quick fix” only. Doesn’t address the recruitment issues.
- I was informed by the HR manager at the LNC meeting that the SHA would not have liked us to apply for derogation
- No derogation in Scotland
- As far as I can see derogation has not been applied in Wales
- There has been some confusion about the derogation issue in our Trust. HR decided we did not need to apply for derogation.

**England**

DEROGATION

| SHA | No hospitals that replied | No. applied for derogation in June (%) | % knew about September derogation | No. that applied in September | % reporting resistance to derogation | No. of those given derogation that are using it (%) | % of hospitals reporting concerns about training |
|---|---|---|---|---|---|---|---|
| East Midlands | 8 | 2<br>25% | 37.5% | 0 | 37.5% | 0 | 87.5% |
| North West | 26 | 1<br>4% | 23.0% | 0 | 12.0% | 1<br>100% | 69.0% |
| South East | 14 | 3<br>21% | 21.0% | 1 | 14.0% | 1<br>33% | 78.0% |
| Yorkshire and Humber | 22 | 1<br>4.50% | 23.0% | 0 | 23.0% | 0 | 82.0% |
| East of England | 17 | 3<br>18% | 47.0% | 1 | 12.0% | 2*<br>66% | 65.0% |
| North East | 9 | 1<br>11% | 11.0% | 0 | 0.0% | 1<br>100% | 33.0% |
| South Central | 13 | 3<br>23% | 7.7% | 0 | 7.7% | 1<br>33% | 92.0% |
| South West | 17 | 5<br>29% | 47.0% | 2 | 5.8% | 4<br>80% | 70.0% |
| London | 35 | 0 | 28.5% | 1 | 17.0% | 1<br>100% | 68.5% |
| West Midlands | 19 | 3<br>16% | 37.0% | 2 | 21.0% | 2*<br>50% | 84.0% |
| **Totals/avgs** | **180** | **22**<br>**15%** | **28.3%** | ~~6~~**7** | **15.0%** | **13**<br>**56%** | **72.9%** |

**Northern Ireland**
DEROGATION

| SHA | No hospitals that replied | No. applied for derogation in June (%) | % knew about September derogation | No. that applied in September | % reporting resistance to derogation | No. of those given derogation that are using it (%) | % of hospitals reporting concerns about training |
|---|---|---|---|---|---|---|---|
| | 6 | 0<br>0% | 16.6% | 0 | 0.0% | nr | 66% |

**Scotland**
DEROGATION

| SHA | No hospitals that replied | No. applied for derogation in June (%) | % knew about September derogation | No. that applied in September | % reporting resistance to derogation | No. of those given derogation that are using it (%) | % of hospitals reporting concerns about training |
|---|---|---|---|---|---|---|---|
| | 27 | 0<br>0% | 18.5% | 0 | 7.4% | nr | 74% |

**Wales**
DERAGATION

| SHA | No hospitals that replied | No. applied for derogation in June (%) | % knew about September derogation | No. that applied in September | % reporting resistance to derogation | No. of those given derogation that are using it (%) | % of hospitals reporting concerns about training |
|---|---|---|---|---|---|---|---|
| North Wales | 3 | 1<br>33% | 33.0% | 0 | 33.0% | 100.0% | 100% |
| Mid and West Wales | 9 | 0<br>0% | 0.0% | 0 | 0.0% | nr | 56% |
| South East Wales | 5 | 0<br>0% | 20.0% | 0 | 40.0% | nr | 40% |
| **Totals/avgs** | **17** | **1**<br>**6%** | **17.7%** | **0** | **24.3%** | **1**<br>**100%** | **65.2%** |

**Compliance with WTR and RCoA Rota recommendations**

- Compliance with the WTR is not complete. 97.5% of hospitals report that they are compliant with a 52 hour week but only 77% report compliance with the 48 hour week. Only 7.5% of hospitals working a 52 hours week have formal derogation. Compliance was lowest in Northern Ireland where only 50% reported compliance but no requests had been made for derogation. Returns from Scotland suggested that they were 100% compliant but their WTR liaison representatives informed the strategy group that a Scottish Academy survey has recently reported 93% of their rotas are compliant on paper but only 83% are actually compliant.

- In order to ensure a balanced training program, including structured teaching and exposure to an appropriate mix of elective and emergency cases, the RCoA has published guidance stating that a rota that covers 24 hours should be no more onerous than 1 in 8[1]. Only 59% of hospitals reported that their planned rotas met this target.

- 63% report additional gaps in the rotas. Evidence suggests that compliance is breached as soon as there are gaps[2]. In order to support the WTR rotas these gaps are being filled by consultants, specialty doctors and by locums.

- There is not a large pool of suitable doctors available for locums and so most are internal or provided by career grade and training grade anaesthetists from neighbouring hospitals. 14.9% report that some trainees have formally opted out. 10.7% have reported counseling their trainees on their personal responsibility to obey the law. There is evidence that trainees who do internal locums are complying with all the requirements of the WTR but are spending more time providing service cover out of hours, losing valuable training opportunities and failing to meet the RCoA targets for daytime supervised teaching.

- CTs expressed concern over the difficulty policing trainees doing additional locums elsewhere.

**Representative samples of free text in response to the question**

*If there are gaps in the rota, what is the reason?*

- We have 2 novice trainees in the theatre rota. They are included in the numbers but actually are supernumerary currently.
- ICM is most difficult to fill up because of lack of competency (our medical trainees are not deemed competent to go solo on call for 3 months out of their 6 and our F2s are never deemed to be competent to be solo on call) and trainees coming to us at a time when they have done ICM elsewhere so need maximum theatre time.
- Currently 2 trainees who have not got obstetric competencies have been taken off rota and are being replaced by locum cover or resident on call consultant.
- Both ICM and theatre rotas went from 1 in 8 to 1 in 7 as we had 3 novice CT1s who started in August
- Insufficient experience of CT2s means they are on first call, leaving gaps in rota on 2nd call.

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[1] The report states the following *'As an absolute minimum, trainees shift working must not be more onerous than 1 night in 8 to ensure there is sufficient "in-hours" training time and then only if all nominal day time on call sessions are utilised for training when prospective cover included'*. For more details see page 5 of *Working Time Directive 2009 and shift working: ways forward for anaesthetic services, training, doctor and patient safety. Royal College of Anaesthetists: Updated September 2007* at http://www.rcoa.ac.uk/docs/WTD2009_shift-working.pdf.

[2] http://www.rcoa.ac.uk/docs/RCoA-EWTD-FinalReport-MainBody.pdf

- WTR compliance caused gaps in the senior anaesthetic rota which has resulted in a consultant/trainee hybrid rota.  ICM trainee rota also has significant gaps due to recruitment and funding issues.
- Sick leave
- LTFT trainee
- Not enough trainees in the region to fill the posts
- Mid-term accreditation and unfilled posts
- 1 long term sick, 4 recently recruited not suitable for the obstetric rota
- Senior trainees getting locum consultant posts
- CT1 and ACCS not completed initial assessment of competency
- Unable to recruit substantive specialist doctors
- Eastern European doctors leaving
- OOPE/Ts and maternity leave

**England**
ROTAS

| SHA or equivalent | No hospitals that replied | % 48 hour compliant | % 52 hour compliant | % with gaps in the rota | % reporting gaps because of recruitment | % with reporting gaps because of maternity leave | % reporting gaps for other reasons | % with one or more 24 hr. rotas **not** meeting RCoA 1 in 8 recommendation |
|---|---|---|---|---|---|---|---|---|
| East Midlands | 8 | 100% | 100% | 75% | 100% | 33% | 33% | 36% |
| North West | 26 | 92% | 94% | 83% | 85% | 40% | 45% | 33% |
| South East | 14 | 79% | 100% | 79% | 91% | 18% | 64% | 16% |
| Yorkshire and Humber | 22 | 90% | 100% | 86% | 94% | 33% | 39% | 43% |
| East of England | 17 | 81% | 92% | 63% | 90% | 20% | 50% | 35% |
| North East | 9 | 89% | 100% | 89% | 67% | 17% | 50% | 13% |
| South Central | 13 | 92% | 92% | 77% | 90% | 40% | 30% | 15% |
| South West | 17 | 80% | 100% | 73% | 73% | 36% | 74% | 22% |
| London | 35 | 94% | 100% | 62% | 76% | 19% | 57% | 5% |
| West Midlands | 19 | 80% | 93% | 90% | 89% | 17% | 55% | 10% |
| **Totals/avgs** | **180** | **88%** | **97%** | **78%** | **86%** | **27%** | **50%** | **23%** |

**Northern Ireland**

ROTAS

| SHA or equivalent | No hospitals that replied | % 48 hour compliant | % 52 hour compliant | % with gaps in the rota | % reporting gaps because of recruitment | % with reporting gaps because of maternity leave | % reporting gaps for other reasons | % with one or more 24 hr. rotas **not** meeting RCoA 1 in 8 recommendation |
|---|---|---|---|---|---|---|---|---|
| All | 6 | 50% | 100% | 50% | 67% | 0% | 33% | 52% |

**Scotland**

ROTAS

| SHA or equivalent | No hospitals that replied | % 48 hour compliant | % 52 hour compliant | % with gaps in the rota | % reporting gaps because of recruitment | % with reporting gaps because of maternity leave | % reporting gaps for other reasons | % with one or more 24 hr. rotas **not** meeting RCoA 1 in 8 recommendation |
|---|---|---|---|---|---|---|---|---|
| All | 27 | 100% | 100% | 46% | 67% | 50% | 75% | 45% |

**Wales**

ROTAS

| SHA or equivalent | No hospitals that replied | % 48 hour compliant | % 52 hour compliant | % with gaps in the rota | % reporting gaps because of recruitment | % with reporting gaps because of maternity leave | % reporting gaps for other reasons | % with one or more 24 hr. rotas **not** meeting RCoA 1 in 8 recommendation |
|---|---|---|---|---|---|---|---|---|
| North Wales | 3 | 67% | 100% | 33% | 100% | 0% | 0% | 62% |
| Mid and West Wales | 9 | 71% | 80% | 100% | 100% | 0% | 29% | 12% |
| South East Wales | 5 | 75% | 100% | 100% | 100% | 50% | 25% | 55% |
| **Totals/avgs** | **17** | **71%** | **93%** | **78%** | **100%** | **17%** | **18%** | **43%** |

**Patterns of Recruitment**

- 26% of hospitals reported some consultant expansion to meet the WTR challenges. 17% have tried to appoint IMG or MTI doctors. 57% reported planning to recruit middle grade specialist doctors, either in SAS posts of Trust or Fellowship posts. Unfortunately middle grade posts are very difficult to fill and as a result 40% also report the need to employ locums. 33% report failure to fill all the training posts in August.

- There is evidence[3] that more successful trusts are poaching staff from the "less attractive" trusts which is making it more difficult for these hospitals. Northern Ireland has reported a 100% increase in the number of CT1s recruited causing a significant reduction in service provision and disrupting rota compliance.

- Registration and visa difficulties are delaying the employment of IMG or MTI doctors often taking up to 6 months between appointment and starting a post.

**Representative samples of free text providing additional comments on recruitment**

- We still have unfilled SAS grade gaps
- We await overseas middle grade arrival but so far they have not completed Home Office/ GMC paperwork.
- Posts filled on paper but not all the doctors are able to work yet
- There is an issue with FTSTA's/LATS. Towards the end of the year the trainees have no obligation to complete the year. Some leave early to extra leave.
- Recruiting to UK/EU ST3-7 is very difficult – the standard is almost universally "un-appointable". Recruiting from overseas into LAT posts is also difficult due to red tape- expensive for Australians showing they can speak English, for example. A consequence of this is that many excellent doctors are going to the USA to do their Fellowship years who would previously have come to the UK.
- The NI training scheme has inflated the training scheme this year by over recruiting CT1's by approx 100%. So while we don't have many gaps, we have entire rotas full of brand new trainees. Imagine the manpower implications for consultants!
- We have sufficient numbers but not the experience as previously as we are top heavy with CT1/2 with no ICM or Obs experience
- FTSTA jobs advertised but no applicants
- There is no competition for career grade jobs at all. Recruitment will be difficult and standards will be low.
- Unable to recruit to posts that are available from October onwards
- We have been unable to fill 2 clinical fellow posts.
- There are no decent staff grades to recruit and we have tried to fill our vacancies on a number of occasions.
- We have advertised multiple times for specialty doctors and clinical fellows. We had only one appointment as a result and he was dismissed after 6 months as incapable of working safely. He was of course immediately recruited by another hospital
- We did fill 2 of our posts with Sri Lankan anaesthetists but we have had to take one off the on call rota after a month for safety fears and are currently offering a closely supervised period of retraining.

[3] EWTD Working Party Strategic Meeting Minutes of the meeting held on Wednesday 16 December 2009, comment from NW SHA liaison representative.

**England**
RECRUITMENT

| SHA or equivalent | No. of hospitals that replied | No. of hospitals that used recruitment as a solution | % using IMG/MTI | % appointing middle grade/SAS doctors | % appointing locums | % appointing consultants | % who failed to fill all training posts in August |
|---|---|---|---|---|---|---|---|
| East Midlands | 8 | 8 | 0% | 75% | 50% | 37% | 50% |
| North West | 26 | 17 | 12% | 70% | 70% | 35% | 62% |
| South East | 14 | 11 | 9% | 91% | 55% | 45% | 71% |
| Yorkshire and Humber | 22 | 15 | 0% | 73% | 60% | 20% | 73% |
| East of England | 17 | 14 | 21% | 71% | 64% | 43% | 29% |
| North East | 9 | 7 | 14% | 71% | 28% | 43% | 77% |
| South Central | 13 | 13 | 15% | 85% | 69% | 15% | 46% |
| South West | 17 | 14 | 0% | 86% | 50% | 36% | 35% |
| London | 35 | 25 | 16% | 84% | 60% | 28% | 26% |
| West Midlands | 19 | 15 | 13% | 80% | 73% | 27% | 26% |
| **Totals/avgs** | **180** | **139** | **10%** | **79%** | **58%** | **33%** | **50%** |

**Northern Ireland**
RECRUITMENT

| SHA or equivalent | No hospitals that replied | No. of hospitals that used recruitment as a solution | % using IMG/MTI | % appointing middle grade/SAS doctors | % appointing locums | % appointing consultants | % who failed to fill all training posts in August |
|---|---|---|---|---|---|---|---|
| | 6 | 3 | 17% | 17% | 17% | 33% | 33% |

**Scotland**
RECRUITMENT

| SHA or equivalent | No hospitals that replied | No. of hospitals that used recruitment as a solution | % using IMG/MTI | % appointing middle grade/SAS doctors | % appointing locums | % appointing consultants | % who failed to fill all training posts in August |
|---|---|---|---|---|---|---|---|
| | 27 | 18 | 11% | 48% | 15% | 0% | 19% |

**Wales**

RECRUITMENT

| SHA or equivalent | No hospitals that replied | No. of hospitals that used recruitment as a solution | % using IMG/MTI | % appointing middle grade/SAS doctors | % appointing locums | % appointing consultants | % who failed to fill all training posts in August |
|---|---|---|---|---|---|---|---|
| North Wales | 3 | 1 | 0% | 100% | 100% | 100% | 0% |
| Mid and West Wales | 9 | 5 | 40% | 60% | 60% | 10% | 66% |
| South East Wales | 5 | 2 | 50% | 100% | 50% | 0% | 20% |
| **Totals/avgs** | **17** | **8** | **30%** | **87%** | **70%** | **37%** | **29%** |

**Impact on training**

- 88% hospitals report they are meeting the RCoA target of 3 supervised teaching lists/sessions a week. There is concern that trainees are getting the correct number of lists but the balance is not appropriate. An increase in consultants working evening and weekend trauma and emergency lists provides additional training opportunities but trainees are lacking a broad experience in elective surgery. Trainees are allocated training lists when the trainees are available to work rather than the most appropriate lists for their training needs.

- Hospitals that are reporting that training is **not** affected by WTR point out that this is achieved by micro managing the daily allocation of list and rotas and that this is very time consuming. There is also a need for the tutor to resist requests to move trainees to fill gaps or provide internal locums.

- Novice anaesthetists cannot provide any service until they have passed the Initial Assessment of Competence (IAC) which is usually taken after 3 months training. These novices have frequently been counted for the purposes of WTR compliance. Since the introduction of a universal starting date in August this has led to a significant reduction in the number of trainees contributing to the rotas for a minimum of three months. In addition hospitals with a number of ACCS trainees experience this challenge again in February. This results in a wide variation in access to training opportunities for the more experienced trainees throughout the year.

- There is evidence that novice trainees are not achieving their initial assessment of competence and obstetric assessment of competence certificates as early as previous cohorts of trainees, this is apparent through 3 sources of reporting; PMETB training survey, training committee and previous SHA visits conducted in May 09. Both of these are required before a trainee is considered suitable to join an on call rota. Some novice anaesthetists have been given a 40 hour contract and only attend during the week for attached lists. Novices are no longer shadowing more senior trainees both because of reduced hours and because the tiers of on call have been removed and the more senior trainees are required to contribute to middle grade rotas. CT1s are not being introduced to obstetrics because they need the time to complete their general anaesthetic competences and this is having a knock on effect delaying their obstetric training as CT2s. The delay in CT2s starting on the obstetric on call rotas results in an excessive amount of obstetric service provision by ST trainees to the detriment of their general anaesthetic experience.

- There is concern about the reduction in number of solo lists trainees are undertaking, leading to a lack of confidence, particularly managing a whole list and interacting with the surgical team. The main reason for this is that trainees are required to have the 3 training lists and this may be all the daytime sessions they are present. In some instances consultant expansion has left very few lists available for trainees to undertake on their own.

- Intensive Care is generally able to maintain teaching because of a high level of consultant presence 24 hours a day. This is achieved at the expense of a considerable increase in consultant workload. All grades of trainees are providing service cover for ICM over and above their training modules to the detriment of their experience providing anaesthesia for both emergency and elective cases.

- Tutors report that trainees are having difficulty completing enough cases to gain the necessary competencies within the normal specialty training modules. They are being asked to return at a later date for more training. Those who undertake specialty interest fellowships are having their training opportunities eroded by service responsibilities.

**Representative samples of free text in response to the questions**

*Has EWTD compliance affected training?*
*Are trainees seeing sufficient cases at a suitable level?*

- When their annual leave, study leave entitlements and days off after nights on are taken each trainee works with any consultant for such a brief period of time, and spends such a reduced time gaining clinical anaesthetic experience that in the short attachments at any one hospital they are getting very limited training and experience, in my opinion (and several trainees i have spoken to).

**CT 1s**

- CT1s taking longer to achieve initial assessment of competency
- Recruitment causes more problems as we now have 4 novices in August which we struggle to get solo by 4 months due to a lack of suitable training lists.

**CT 2s**

- CT2 struggle to get sufficient obs experience to equip them to join an Obs rota at ST3 level
- We are having to allocate a longer period of time for each of our CT2 to get competency training in Obstetrics. I do not know if I can fit them all in before they rotate on.
- Training for obstetrics almost impossible to achieve within the two month block we normally allow.
- Sometimes not getting Obs competencies done
- CT2 trainees finding it difficult to obtain competence in maternity anaesthesia within 2 years.
- I have had requests from the programme director about CT2/ST2 trainees who have had their obs competencies signed off in other hospitals, to have further exposure to obs in my hospital as they did not feel ready to progress to ST3
- There is debate in the department about when the CT1 equivalents go onto the obstetric rota. There is a service pressure to put them on at the usual time, which has majority support, but there is resistance from those of involved in their assessments that they are not ready. This is merely a specific example of the difficulties which we are facing.
- In my hospital - obstetrics. Pre MMC a typical SHO trainee would do 6 months and achieve 40-50 epidurals, 40-50 spinals and about 6-10 GAs. The figures now are approx 20/20/1-2

**ST 3 and above**

- Variable across all levels. Eg. ST3 and above trainees get lots of experience (mostly unsupervised) in obstetrics outside of normal working hours due to the high case load but find it hard to gain enough exposure to some elective specialties such as vascular as a result of less hours and limited daytime caseload.
- Senior Trainees are struggling to get minimum case numbers for advanced training modules.
- Unable to gain all neuro competencies in ST3-4 years
- Some trainees being delayed in progression through to next ST year, because of inadequate numbers of cases
- No hard evidence yet in terms of crude numbers of cases per year as presented at RITA's but anecdotal evidence that trainees do not feel they are getting same training. Some good trainees have failed to complete all their competencies in a given module as they were not present often enough!
- Some trainees have had extra time in some modules to allow them to complete all their modules
- Pain week is sometimes removed completely to address rota shortages. Vascular training is affected simply because of reduction in hours which reduces training opportunities.
- I have refused to sign some trainees off because they haven't felt competent in certain areas. Also, there may have been some aspects of training that haven't been addressed eg. With vascular for example trainees may have done a number of AAA repair but no carotid artery surgery.
- Trainees return (using study leave in DGH years / come in on days off) to complete modules.
- It is proving difficult to offer modular training. It is taking longer to complete a satisfactory number of lists for a given surgical specialty (eg Colorectal) as the trainee may do a list only every other week.

- We have noticed a progressive and worrying decrease in the number of patients anaesthetised per year by trainees as hours of work have decreased. Is there a minimum acceptable level? We are probably at that level for some of the less confident or "natural" anaesthetists.
- One trainee was not able to achieve the number of cases in the module because of annual leave, day offs , on calls etc
- Senior trainees have fewer opportunities for advance skills in complex anaesthetic cases. especially all day lists, so have less experience by end of the training
- They often see a low volume of specialist cases but don't spend enough hours seeing the 'bread and butter' work that makes up much of a DGH workload.
- Cardiothoracic rotation too short and they have less experience than previously. Our trainees have to cover CICU and go to theatre on a hybrid rota.
- There are deficiencies in skill mix arising and it is more difficult to absorb the trainee in difficult

**England**

| SHA or equivalent | No hospitals that replied | % of hospitals reporting concerns about training | Number of hospitals reporting individual grades that are affected | | | | | | | % reporting that progression with gaining competencies is being affected | % reporting that some trainees have formally opted out | % reporting they have had to counsel trainees about flouting EWTR rules |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CT1 | CT2 | ST3 | ST4 | ST5 | ST6 | ST7 | | | |
| East Midlands | 8 | 87.5% | 4 | 7 | 7 | 7 | 6 | 4 | 2 | 50.0% | 25.0% | 25.0% |
| North West | 26 | 69.0% | 8 | 13 | 12 | 15 | 15 | 17 | 17 | 15.3% | 11.5% | 19.2% |
| South East | 14 | 78.0% | 7 | 7 | 11 | 6 | 7 | 4 | 3 | 28.6% | 14.2% | 0.0% |
| Yorkshire and Humber | 22 | 82.0% | 10 | 13 | 18 | 15 | 14 | 16 | 16 | 22.7% | 31.8% | 9.0% |
| East of England | 17 | 65.0% | 4 | 6 | 9 | 9 | 8 | 6 | 7 | 35.0% | 5.8% | 17.6% |
| North East | 9 | 33.0% | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 11.1% | 22.2% | 11.1% |
| South Central | 13 | 92.0% | 6 | 9 | 7 | 9 | 7 | 5 | 5 | 23.0% | 15.3% | 7.6% |
| South West | 17 | 70.0% | 5 | 9 | 7 | 7 | 10 | 10 | 10 | 29.4% | 11.7% | 0.0% |
| London | 35 | 68.5% | 8 | 14 | 18 | 16 | 19 | 15 | 17 | 25.7% | 11.4% | 17.1% |
| West Midlands | 19 | 84.0% | 13 | 14 | 12 | 8 | 7 | 7 | 8 | 31.5% | 0.0% | 0.0% |
| **Totals/avgs** | **180** | **72.9%** | **67** | **94** | **104** | **95** | **96** | **87** | **88** | **27.2%** | **14.9%** | **10.7%** |

**Northern Ireland**
TRAINING

| SHA or equivalent | No hospitals that replied | % of hospitals reporting concerns about training | Number of hospitals reporting individual grades that are affected | | | | | | | % reporting that progression with gaining competencies is being affected | % reporting that some trainees have formally opted out | % reporting they have had to counsel trainees about flouting EWTR rules |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CT1 | CT2 | ST3 | ST4 | ST5 | ST6 | ST7 | | | |
| All | 6 | 66.0% | 4 | 4 | 4 | 4 | 4 | 3 | 2 | 33.0% | 0.0% | 0.0% |

**Scotland**
TRAINING

| SHA or equivalent | No hospitals that replied | % of hospitals reporting concerns about training | Number of hospitals reporting individual grades that are affected | | | | | | | % reporting that progression with gaining competencies is being affected | % reporting that some trainees have formally opted out | % reporting they have had to counsel trainees about flouting EWTR rules |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CT1 | CT2 | ST3 | ST4 | ST5 | ST6 | ST7 | | | |
| | 27 | 77.8% | 15 | 14 | 14 | 15 | 15 | 13 | 14 | 29.6% | 3.7% | 7.4% |

**Wales**
TRAINING

| SHA or equivalent | No hospitals that replied | % of hospitals reporting concerns about training | Number of hospitals reporting individual grades that are affected | | | | | | | % reporting that progression with gaining competencies is being affected | % reporting that some trainees have formally opted out | % reporting they have had to counsel trainees about flouting EWTR rules |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | CT1 | CT2 | ST3 | ST4 | ST5 | ST6 | ST7 | | | |
| North Wales | 3 | 100.0% | 5 | 5 | 5 | 5 | 5 | 2 | 1 | 33.3% | 0.0% | 0.0% |
| Mid and West Wales | 9 | 55.6% | 4 | 5 | 5 | 4 | 4 | 4 | 4 | 22.2% | 0.0% | 0.0% |
| South East Wales | 5 | 40.0% | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 0.0% | 0.0% | 0.0% |
| **Totals/avgs** | **17** | **65.2%** | **10** | **11** | **12** | **11** | **11** | **8** | **6** | **19%** | **0%** | **0%** |

**Impact on Consultants**

- Consultants are increasingly being asked to fill the gaps in service provision and in junior rotas. Only 6% of hospitals report that job plans have been renegotiated to accommodate this. 66% of hospitals report consultants are doing additional work outside their job plan. Not all of this is because of WTR; a proportion is because of waiting list targets. Remuneration can be time back or financial but in some circumstances voluntary unpaid contributions have been requested. The level of satisfaction with these arrangements reflects the reward but the consensus is that none of these arrangements are sustainable.

- Only 21% of tutors reported that consultant expansion had been employed to meet the demands of the WTR.

- ICM consultants report a significant increase in their workload carrying out duties of junior doctors because of a reduction in the skill mix of trainees on the rotas. Consultants covering the anaesthetic on call rota report an increase in the numbers of calls for advice and an increased frequency of returning to work to support trainees out of hours.

- During the day consultants often work single handed on major cases in theatre, wasting training opportunities and increasing the stress levels of the consultant. Similarly consultants are working single handed on the labour wards with no backup if there is increased demand. Consultants have expressed concerns that they are being used to maintain service within the constraints of WTR to the detriment of their own compliance.

- The current economic climate means that SPA allocations to consultants are under threat. Tutors that are successfully meeting the training targets and providing a balanced training program report the need to micro manage both the rotas and the allocation of lists and how time consuming this is. The increase in the number of consultants and reduced time trainees are present is making it more difficult for consultants to get to know the trainees in depth.

**Representative samples of free text providing additional comments on the impact on consultants.**

- We have had to deploy the acting down policy for consultants….which obviously adds to Trust expenditure and takes them away from day time sessions
- Consultants are covering resident on-call sessions (approx 8/month) for financial remuneration. Time in lieu has not been negotiated as an alternative. This position is not sustainable.
- There is a great disparity between the consultants as to how acceptable/ sustainable all this is
- Increasingly consultants provide out of hours trauma and emergency cover
- The 18 week targets are even more important than the EWTD
- The consultant body is generally very unhappy with the heavy increase in workload and expectations of more work for no pay.
- Consultants are acting down because no locums available to cover gaps in the rota. Dispute as to remuneration.
- The rotas have increasingly junior people as we are forced to use novice ACCS people as first call as soon as they achieve initial competencies. People who should be first call are then moved up to senior second call and the consultant workload becomes more onerous
- Less experienced staff unable to deal with things they would have easily handled in the past
- We need more consultants but managerial reluctance to appoint due to financial constraints and contractual wrangles over 9+1 contract.

Impact on Consultants

- Extremely fed up with constant crisis management and being expected to backfill and cover at short notice even if it is paid for. Despondent about the lack of will to appoint extra consultant anaesthetists.
- Fears that we will be forced to be resident etc.

**England**
CONSULTANTS

| SHA or equivalent | No hospitals that replied | No of new consultants appointed | % of hospitals where some consultants have formally opted out | % hospitals where consultants breach the EWTR rest requirements | % hospitals where job plans have been renegotiated to accommodate EWTR | % of hospitals where the consultants are being asked to do additional work outside their job plans | % of hospitals where consultants report they are unhappy with these arrangements | % of hospitals where elective work is being compromised |
|---|---|---|---|---|---|---|---|---|
| East Midlands | 8 | 6 | 25.0% | 37.5% | 37.5% | 100.0% | 62.5% | 37.5% |
| North West | 26 | 25 | 26.9% | 42.3% | 11.5% | 57.6% | 19.2% | 11.5% |
| South East | 14 | 15 | 28.6% | 28.6% | 0.0% | 78.6% | 35.7% | 0.0% |
| Yorkshire and Humber | 22 | 7 | 4.5% | 45.4% | 18.1% | 95.4% | 18.1% | 40.9% |
| East of England | 17 | 11 | 41.0% | 64.7% | 11.7% | 82.3% | 29.4% | 17.6% |
| North East | 9 | 7 | 44.4% | 44.4% | 33.3% | 100.0% | 33.3% | 11.0% |
| South Central | 13 | 13 | 7.6% | 84.6% | 7.6% | 69.2% | 61.5% | 23.0% |
| South West | 17 | 13 | 29.4% | 47.0% | 0.0% | 76.5% | 23.5% | 0.0% |
| London | 35 | 23 | 17.1% | 51.4% | 5.7% | 88.5% | 34.2% | 14.2% |
| West Midlands | 19 | 2 | 0.0% | 47.3% | 10.5% | 89.4% | 26.3% | 21.0% |
| **Totals/avgs** | **180** | **122** | **22.5%** | **49.3%** | **13.6%** | **83.8%** | **34.4%** | **17.7%** |

**Northern Ireland**
CONSULTANTS

| SHA or equivalent | No hospitals that replied | No of new consultants appointed | % of hospitals where some consultants have formally opted out | % hospitals where consultants breach the EWTR rest requirements | % hospitals where job plans have been renegotiated to accommodate EWTR | % of hospitals where the consultants are being asked to do additional work outside their job plans | % of hospitals where consultants report they are unhappy with these arrangements | % of hospitals where elective work is being compromised |
|---|---|---|---|---|---|---|---|---|
| | 6 | 4 | 0.0% | 100.0% | 0.0% | 83.0% | 33.0% | 16.6% |

**Scotland**
CONSULTANTS

| SHA or equivalent | No hospitals that replied | No of new consultants appointed | % of hospitals where some consultants have formally opted out | % hospitals where consultants breach the EWTR rest requirements | % hospitals where job plans have been renegotiated to accommodate EWTR | % of hospitals where the consultants are being asked to do additional work outside their job plans | % of hospitals where consultants report they are unhappy with these arrangements | % of hospitals where elective work is being compromised |
|---|---|---|---|---|---|---|---|---|
| | 27 | 8+ | 3.7% | 37.0% | 11.1% | 48.1% | 18.5% | 14.8% |

**Wales**
CONSULTANTS

| SHA or equivalent | No hospitals that replied | No of new consultants appointed | % of hospitals where some consultants have formally opted out | % hospitals where consultants breach the EWTR rest requirements | % hospitals where job plans have been renegotiated to accommodate EWTR | % of hospitals where the consultants are being asked to do additional work outside their job plans | % of hospitals where consultants report they are unhappy with these arrangements | % of hospitals where elective work is being compromised |
|---|---|---|---|---|---|---|---|---|
| North Wales | 3 | 0 | 0.0% | 33.3% | 0.0% | 66.6% | 33.3% | 66.6% |
| Mid and West Wales | 9 | Y | 11.1% | 22.2% | 11.1% | 55.5% | 11.1% | 0.0% |
| South East Wales | 5 | >5 | 0.0% | 0.0% | 0.0% | 60.0% | 33.3% | 0.0% |
| **Totals/avgs** | **17** | **>5** | **3.7%** | **18.5%** | **3.7%** | **60.7%** | **25.9%** | **22.2%** |

**Impact on specialty doctors**

- Specialty doctors, including Staff Grades, Associate Specialists, Trust Doctors and Clinical Fellows, are filling a significant number of gaps in the rota. They are not all complying with the WTR limit of hours although the majority of them are complying with the rest requirements between shifts. Only 5% have formally opted out.

- Rigid job plans have added to difficulties within departments when planning rotas that include specialty doctors and trainees. Some specialty doctors do no on call or out of hours duties.

**Representative samples of free text providing additional comments on the impact on specialty doctors**

- Our staff grades are picking up all the internal locums to cover on call. I think that they must be breaching their EWTD rest requirements, but do not know this for certain. The service would fall apart if they were not prepared to do this. Hence we have not asked the question.
- Specialty doctors often fill the gaps in the rota. This is paid and voluntary, but there are many gaps so it seems like they do a lot of extra work.
- Low morale, rapid turnover.
- They still do 24 hour obstetric on call
- Being asked to do multiple locums. Ratio of night time to day time work increasing
- Previously our SAS doctors did no on call now they are stepping in – on a voluntary basis.
- Asked to cover more shifts and be more flexible in their job plans
- Again a very unhappy bunch. We have redesigned their rotas to be EWTD compliant and more efficient. They are not happy with the increased workload with little change in pay.
- They have been asked to voluntarily opt out but the request was refused
- We are unsuccessful in recruiting specialty doctors for about 10 months

**England**

SPECIALTY DOCTOR

| SHA or equivalent | No hospitals that replied | % reporting speciality doctors have formally opted out | % reporting specialty doctors are non-compliant with rest requirements |
|---|---|---|---|
| East Midlands | 8 | 4.5% | 4.5% |
| North West | 26 | 7.7% | 7.7% |
| South East | 14 | 28.5% | 0.0% |
| Yorkshire and Humber | 22 | 4.5% | 4.5% |
| East of England | 17 | 11.7% | 0.0% |
| North East | 9 | 33.3% | 0.0% |
| South Central | 13 | 0.0% | 7.6% |
| South West | 17 | 5.8% | 11.7% |
| London | 35 | 11.4% | 11.4% |
| West Midlands | 19 | 5.2% | 10.5% |
| **Totals/avgs** | **180** | **11.3%** | **5.8%** |

**Northern Ireland**

SPECIALTY DOCTOR

| SHA or equivalent | No hospitals that replied | % reporting speciality doctors have formally opted out | % reporting specialty doctors are non-compliant with rest requirements |
|---|---|---|---|
| | 6 | 0.0% | 16.6% |

**Scotland**

SPECIALTY DOCTOR

| SHA or equivalent | No hospitals that replied | % reporting speciality doctors have formally opted out | % reporting specialty doctors are non-compliant with rest requirements |
|---|---|---|---|
| | 27 | 7.7% | 11.5% |

**Wales**

SPECIALTY DOCTORS

| SHA or equivalent | No hospitals that replied | % reporting speciality doctors have formally opted out | % reporting specialty doctors are non-compliant with rest requirements |
|---|---|---|---|
| North Wales | 3 | 0.0% | 0.0% |
| Mid and West Wales | 9 | 0.0% | 22.2% |
| South East Wales | 5 | 0.0% | 0.0% |
| **Totals/avgs** | **17** | **0.0%** | **7.4%** |

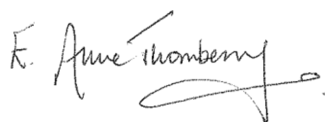
**Recommendations and Actions.**

- RCoA working alongside PMETB to assess the impact on training as a result of WTR implementation.
- RCoA providing evidence to MEE report WTR impact on training.
- Further RCoA work to be conducted on areas of best practice.
- Further RCoA work to assess the time taken to pass the Initial Assessment of Competence and compare this to data pre-WTR in order to ascertain how training is being affected at CT1 by asking CTs extent of the problem with anaesthesia and ACCS.
- Continued engagement with all key stakeholders including SHAs through the continued framework already in place.
- Continue to provide support and advice to all anaesthesia practitioners in regards to WTR.

**Points of Contact**

- RCoA WTR Points of Contact are as follows:

| | | |
|---|---|---|
| Dr E A Thornberry | Deputy Medical Secretary and EWTD lead | eanne@doctors.org.uk |
| Mr Richard Bryant | Director of Training & Examinations | rbryant@rcoa.ac.uk |



Dr E A Thornberry
Medical Secretary and WTR Lead
25 Jan 10

Distribution:

External:

DH - Steve Buggle
DH - Dr Wendy Reid
East Mids SHA EWTD lead - Simon Markille-Mallinson
East of England SHA EWTD lead - Dr Martin Goddard
East of England Workforce Planning - Cheryl Thornhill
London SHA EWTD lead - Sue Hitching
North East SHA EWTD lead - Jill Smith
North West SHA EWTD lead - Debbie Kendall
South Central SHA EWTD lead - Caroline Chipperfield
South East Coast SHA EWTD lead - Eleanor Bell
South West SHA EWTD lead - Rachel Wylie
West Midlands SHA EWTD lead - Maggie Bayley

| | | |
|---|---|---|
| Yorks & Humber SHA EWTD lead | - | Jonathan Brown |
| AoMRC President | - | Professor Neil Douglas |
| RCOG | - | Dr Maggie Blott |
| RCP | - | Dr Clive Constable |
| RCPCH | - | Dr Mary McGraw |

Internal:

| | | |
|---|---|---|
| President | | |
| Vice Presidents | | |
| Medical Secretary | | |
| EWTD Working Party | - | Dr Ian Geraghty |
| EWTD Working Party | - | Dr Ernie Grundy |
| EWTD Working Party | - | Dr John Peacock |
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| EWTD Working Party | - | Dr Paul Spargo |
| All Regional Advisors | | |
| Training Manager | - | Craig Williamson |
| Senior Training Administrator | - | Claudia Moran |