



Royal College of
Paediatrics and Child Health

Leading the way in Children's Health

RCPCH response to the European Working Time Directive Taskforce

November 2013

1. Have you or your organisation encountered any problems relating to the Working Time Regulations and, if so, around what issue in particular?

The RCPCH reiterate our support for the EWTR as it was agreed by the European Council. The RCPCH is concerned about the safety issues related to high volume acute specialties and believes acute specialties are safer on 48 hour rotas.

The RCPCH gave evidence to Medical Education England in 2009, (MME EWTD Review – Written Evidence, Medical Education England, 2009) in which we stated that the RCPCH support the implementation of the EWTD (later referred to as Regulation) in the interests of both patient and staff safety as it provides a better work life balance for trained paediatric staff, and staff in training.

Furthermore we contributed to the evidence, conclusion and recommendations in the Temple report which was published in 2010 that Consultant delivered care can lead to higher quality care and allows mechanisms for better day time training and that service reconfiguration by concentrating senior staff and trainees on fewer sites can make implementation of the EWTR possible.

(Temple, J. (2010) Time for Training: A Review of the impact of the European Working Time Directive) on the Quality of Training, Medical Education England. [Online] Available at: www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf

In the lead up time to the implementation of the EWTR in 2009, there were gaps in the middle grade rotas but over time and by finding solutions, the vacancy rate has reduced in paediatrics, however middle grade vacancies are still higher, see: www.rcpch.ac.uk/rotas

However there are still numerous day to day difficulties that most units have faced in recent years supporting rotas - it can destroy morale, ruin training and probably impact on clinical care – the RCPCH winter compliance survey shows that 71.8% of paediatric clinical directors stated that they were either very or moderately concerned that their service would be able to cope with demands placed on it during the next 6 months.

The RCPCH fully supports the fact that the EWTR has been implemented as part of health and safety legislation and would not support any potential derogation beyond 48 hours. Such derogation will likely not be used to benefit training as the extra time could be used to maintain small district general hospital services where the trainees will be used for the

purposes of service provision, particularly out of hours rather than to maximise training opportunities.

By rescinding the EWTR so that different specialties can potentially work longer hours, will lead to unsafe services. It may prove impossible to implement service reconfigurations on fewer acute sites and it must be recognised that in such service reconfigurations, there are speciality interdependencies such as paediatric surgery and anaesthesia with paediatric medicine – in essence such a retrograde step from the recommendations in the Temple report would lead to a less safe and sustainable service

It also needs to be remembered that juniors' working practices are also governed by the "New Deal" as well; a voluntary agreement between Royal Colleges, BMA and DH and this is a constraint which would still exist given any change to EWTR.

2. What have you or your organisation been able to do to solve these problems?

The RCPCH fully supports the continuation of the EWTR and strongly advocates that other Royal Colleges take note of its solutions to implement the Regulation. By having the WTR in place, we are showing that standards of care can be improved and that by having safer and more sustainable services by concentrating acute inpatient services on fewer sites, and there is, in turn, a beneficial impact in training of junior doctors.

Solutions to implement the EWTD and improve standards of care, are highlighted in the publication Facing the Future (FTF) which lists 10 minimum service standards for acute paediatric services FTF gives the following interlocking recommendations (RCPCH, Facing the Future: A review of Paediatric Services, RCPCH, April 2011, <http://www.rcpch.ac.uk/facingthefuture>).

- Reconfiguration of acute services onto fewer specialised sites
- Expansion of consultant numbers and in consultant resident shift working
- Expansion of GP training
- Expansion of the extended and advanced role of nurses
- Reduction in the number of paediatric trainees.

These service standards were audited in 2012 and the results published in Back to Facing the Future <http://www.rcpch.ac.uk/facingthefuture>.

The RCPCH published in July 2009 advice to consultants to reflect the expected pressures on general and neonatal rotas when the directive comes into force in August 2009. http://www.rcpch.ac.uk/sites/default/files/asset_library/Research/Workforce/RCPCH%20Advice%20on%20WTD%20July%2009.pdf

In May 2009, the College published the document [RCPCH guidance on the role of the consultant paediatrician in providing acute care in hospital in the hospital](#) to disseminate information on new and innovative approaches to the role of the acute paediatrician in order to promote safe and sustainable services that meet the requirements of the 2009 Working Time Directive (WTD). This publication was quoted in the Temple Report (p44) as moving towards a consultant delivered service.

In response to this, the RCPCH expanded the models of consultant delivered care, particularly aimed at consultant resident shift working for the provision of acute paediatric services. This is a step toward meeting, in particular, Standard 8 of the RCPCH's FtF 10 acute service standards. Evidence from the 2009 and 2011 RCPCH workforce censuses has shown that the numbers of doctors participating in resident shift working in acute paediatric and neonatal care has increased.

The RCPCH contributed to the AMRoC report "The Benefits of Consultant Delivered Care. (January 2012).

The RCPCH also published the outcomes of its own project in 2012 entitled the Benefits of Consultant Delivered care which showed that this pattern of delivering acute care resulted in better day-time training, improved quality of care for patients, good quality handovers and better communication with parents (<http://www.rcpch.ac.uk/system/files/protected/page/CDC%20full%20report%2024%2004%2012%20V2.pdf>).

The RCPCH recognise the constraints of the consultant delivered care model in providing a complete solution to pressures exacerbated by the EWTR in that team job planning and an acknowledgement of the need for phased careers must all be balanced when implementing CDC systems. We also acknowledge the areas of uncertainty around the CDC model, including how to ensure you maintain the quality of independent decision making of the consultants is maintained by doctors trained in this environment. It is important that without further credible alternatives, more work needs to be done on CDC models. The uncertainty about future service delivery models means that it is difficult to plan realistically for the future number of trainees needed and the consequent effects that this will have on those in or wishing to enter training in the specialty.

The RCPCH have continued to work very closely with paediatric trainees in developing its policy in regard to EWTR and consultant delivered care. The following extract from the 1st Annual Trainees' Committee Survey Report – 2012:

"In April 2012 the RCPCH published its report on Consultant Delivered Care (CDC), which concluded that children would receive better care if they had 24/7 access to a consultant¹¹. CDC differs from Consultant Led Care (CLC), as in CDC models the consultant is clinically responsible for the care a patient receives (e.g. siting cannulas, writing drug charts) rather than supervising the delivery of this care by others. Resident Shift Working Consultants (RSWC) is those who are present in the hospital as part of a CDC model outside of normal working hours (i.e. in the evening, overnight or weekend). The provision of CDC and the development of the RSWC role provide an opportunity to improve the work-life balance in paediatrics. RSWC are limited to the 48-hour working week under the EWTD, so time working unsociable hours is rewarded by time in lieu at other times during the week. RSWC offer the opportunity to provide cover for gaps in middle grade rotas, improving opportunities for training and reducing the proportion of unsociable hours for trainees. Whilst evidence is limited, it would appear that the majority of RSWCs are positive about their role¹¹.

It is clear that ongoing trainee involvement is required in the development of the consultant role. 'No decision about me without me', a phrase to describe the need to involve patients in their own care should equally be applied in these circumstances. Changes made without the involvement of the doctors who are ultimately to work in these roles are unlikely to prove palatable to a body of trainees already expressing reservations about continuing in paediatric training, as our survey has revealed. It is essential that trainees entering into paediatric training in coming years are as well informed as possible about the changes that are likely to occur to the consultant role and do not feel misled about the type of career they have been recruited into. Conversely, it is important that paediatrics trainees entering into paediatrics have realistic expectations about what it is to be a paediatrician and understand that some antisocial hours are essentially inevitable, though this is likely to be compensated elsewhere during the working week."

Full report available at: <http://www.rcpch.ac.uk/training-examinations-professional-development/trainee-representation/trainees-committee-documents/t>

3. What more could be done to solve these problems?

The report of Back to Facing the Future referenced above, set out a series of recommendations which are relevant to solving any problems associated with the EWTR and to build a safe and sustainable service for paediatrics? These are set out below:

- *The College will work further to encourage units to provide better consultant (or equivalent) coverage when they are at their busiest. It is essential that paediatrics is a 24 hours a day, seven days a week specialty, and consequently the service should be organised around the child's needs.*
- *The RCPCH will continue to have discussions with the Care Quality Commission about how the standards might be applied within a regulatory framework*
- *The College will continue its invited reviews programme, using the standards published in Facing the Future to provide a framework in which quality and safety are maintained in the system. 18 of these reviews have taken place in the first 18 months of the programme and this exposes both difficulties, complexities and new ways of working.*
- *Individual units need to improve their data collection around outcomes, and how these are impacted upon by meeting the Facing the Future standards.*
- *The RCPCH will conduct further research on the impact of the standards upon quality, safety and outcomes. Facing the Future was built by consensus, and has been accepted by the service as the minimum standard. What is now required is to move beyond that consensus to demonstrate improved outcomes for children and young people.*
- *The RCPCH urges consultants and trainees to maintain a dialogue around the standards and their impact on training, and ensure that it is not adversely affected.*
- *Urgent reconfiguration and new models of provision need to be explored, and these interfaces may well form the basis of future College work in the Facing the Future series.*
- *The Strategic Clinical Networks for Children and Maternity in England should make it an urgent priority to reduce the unwarranted variation in care that may well result from such arrangements. Equally, in the other three home nations health trusts will need to work together to ensure that specialty advice is consistently accessible.*
- *The RCPCH will be following up with units where standard 10 is not being met to ensure that there are adequate child protection arrangements across the UK.*

- *The RCPCH will continue to look at more innovative models of service provision, providing more care in the community, whilst centralising expertise.*

Implement the recommendations of the Children and Young people's Health outcomes Forum, particularly those relating to Safe and Sustainable service (chapter 6) and Workforce, education and training (chapter 7). The College continue to work with the forum to ensure that these recommendations are followed through.

The College Scottish Committee works closely with the Scottish Government Workforce planning Board and Children and Young Peoples Support Group to look at how innovative models of care are developed and that staffing levels are maintained or increase to ensure working time compliance and the delivery of safe services

In paediatrics, we will use the data and information we collect from our regular workforce surveys and invited reviews to highlight and share areas of good practice, to ensure the lessons learned are disseminated more widely. The RCPCH has a workforce strategy which includes a number of elements which are designed to promote new ways of working such as organising events across the UK to focus on new ways of working, developing web based methods to share good practice, to undertake detailed modelling work for acute and neonatal rotas and to engage HEE/CfWI and other national workforce planning organisations to develop projects looking at new workforce models. We will also continue our annual surveys to monitor rota vacancies and compliance with the working time regulations.

Further, in paediatrics we will be looking at how primary and secondary care can work more closely to deliver a more flexible service, with more GPs trained in paediatrics and more paediatric consultants delivering care out of the hospital setting. This has the potential of creating a greater critical mass for acute rota cover and for graduated stepping down from acute roles.

The RCPCH has always been committed to ensuring paediatric doctors in training do not spend significant amounts of time undertaking inappropriate tasks in the workplace. With the introduction of the European Working Time Regulation (EWTR) it is important to ensure that junior doctors in training are exposed to the greatest training opportunities possible, the RCPCH Trainees' Committee has proposed that it is important to issue updated guidance.

4. Is there specific evidence (such as publications or studies) you would highlight to the taskforce?

In addition to the documents already referred to above:-

- a) Children's And Maternity Services In 2009: Working Time Solutions July 2008. Report of a joint project between RCOG and RCPCH http://www.rcpch.ac.uk/sites/default/files/asset_library/Research/Workforce/final%20version%20web.pdf
- b) Workforce models described as the 11 and 9 cell models for Tier 2 rotas (middle grade) have been designed to meet the EWTR and to include resident shift working patterns- Delivering Safe Services: Consultant Delivered Care for Maternity, Paediatric and Neonatal Services (Teamwork Management Services 2008).

http://www.rcpch.ac.uk/system/files/protected/page/EWTD%20-%20what%20does%20it%20mean%20for%20Paediatrics_.pdf

5. Are there any examples of ways in which the Working Time Directive has been successfully implemented that you would like to highlight?

In the NW of England a survey was undertaken to evaluate the introduction of consultant posts which would deliver resident emergency shifts at Tier 2 (middle grade) as a trained doctor solution to the EWTD and other standards (Edwards H, Ewing C, Bluck M, et al (2011). Evaluation of the introduction of resident shift working consultants across the North West Strategic Health Authority, copies available from halcyon@hrmenterprises.co.uk. Posts within a managed clinical network were developed in Greater Manchester as part of a large scale reconfiguration Making it Better (NHS, Making it Better For Children, Young People And Families, Greater Manchester CYPF Network www.makingitbetter.nhs.uk) which redesigned 12 to 8 paediatric and maternity units and 2 to 3 neonatal intensive care units to meet the EWTD standard, to concentrate service on fewer sites and to enhance senior clinical presence. 12 consultant paediatricians, 9 consultant neonatologists and 16 consultant obstetricians /gynaecologists were interviewed in 2009/10. The posts in the main were reported as having a net positive effect on the quality of service provided, patient safety and on the training of junior staff.

The College noted and fully supported this example of large scale service reconfiguration for obstetrics, paediatric and neonatal services combined with workforce models of consultant delivered care and Making it Better was highlighted as an example of good practice in the Temple report.

Other examples include:

Birmingham Children's Hospital innovative rotas in paediatric intensive care:

<http://careers.bmj.com/careers/advice/view-article.html?id=20008642>

Royal Free Hospital, describing consultant delivered models:

<http://careers.bmj.com/careers/advice/view-article.html?id=20013162>

Response collated by Martin McColgan, RCPCH Workforce Information Officer

27th November 2013.