Impact of the European Working Time Directive (EWTD) on Postgraduate Medical Education

Report summary on the Primary Research Phase
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Introduction

The implementation of the European Working Time Directive (EWTD) in the UK, which has required both a reduction in the working hours and a change in the working patterns of doctors, has created challenges around meeting the needs of clinical service and of postgraduate medical training.

The EWTD, which became effective from August 2004, currently places a working time limit of 56 hours per week which will decrease to 48 hours from August 2009.

The Directive was introduced at a time of fundamental and extensive organisational changes in the NHS when the sharpened financial focus of Trusts, and the accompanying refinements of job plans of consultants, have impacted on the delivery of education and training of both undergraduates and postgraduates.

This study, whose results should be considered in that context, aimed to assess the progress being achieved in balancing service and training needs as the EWTD becomes progressively more time-restrictive. It also sets out to provide a tool by which Trusts and other organisations might monitor the training climate in their institutions.

The report considered the views of approximately 1000 trainees and 500 trainers (consultants) in secondary care, from three postgraduate deaneries, on the impact of EWTD on doctors’ training.

The study also offers some recommendations to assist the further development of training, including the use of tools in the management of postgraduate medical education.

Key findings

1. The study found that around 70% of all trainees report their training as “excellent” and there is evidence of widespread engagement by consultants in matters relating to training.

2. Almost 80% of trainees said they had sufficient contact time with their supervising consultants.

3. The report suggests that 60% of trainees’ training needs are being met within the current 56 hours of the EWTD and approximately 50% of rotas are thought by both trainees and trainers to take account of training needs.

4. It revealed that many trainees appear to distinguish between ‘training’ and ‘learning from clinical experience’. The study also concluded that the engagement with trusts on training issues needs enhancing.

5. It found that EWTD might be considered to represent a success in the context of change that has been implemented in the NHS. Careful supportive and sustained education input and advice is needed to help trainees who are sufficiently aware of the nature and purpose of the Directive and of how they might best benefit from clinical experience as part of their training.
A questionnaire was developed by Sheffield University, in line with accepted academic standards, and was divided into three areas.

- The postgraduate training environment
- Rotas, working time and organisation
- Curriculum and assessment

### Training environment

Between 60-80% of trainees said their training environment provided them with good support.

Between 70-80% of trainees stated that their training support was excellent and there was a high level of satisfaction with non-ward or non-clinic based resources available to support training.

A large majority of trainees felt their consultants were competent teachers, although about a third of consultants acknowledged they would value more training in teaching.

Around 65% of trainees said they felt they were receiving feedback on their performance sufficiently frequently, although almost all trainers said they were providing such feedback. As feedback is such a vital part of educational development, this difference needs to be resolved.

Over 50% of trainees believed their clinical activities with their teams provided learning opportunities, whereas almost all the trainers felt they did.

![Figure 1: Training environment (% respondents agreeing)](image)
Rotas, Working Time and organisation

It was agreed by all groups that about 50% of rotas took account of training needs.

Almost 80% of trainees said they had sufficient contact time with their consultants but only about 40% of trainers felt that their job plans allowed them enough time with their trainees.

Almost all trainees felt that they actively sought learning opportunities, although that view was not shared by their trainers. Around 60% of both trainees and trainers said that the training needs of trainees were met within the 56-hour rotas.

Some trainees and trainers have implemented good rota design and others could benefit from learning from their methods.

About 60% of respondents felt that their Trust gave sufficient priority for training.

![Figure 2: Rotas, Working Time and organisation (% respondents agreeing)](image-url)
Curriculum and assessment

Between 60-70% of trainees and trainers thought that the majority of training, which is aligned to the requirements of the Royal Colleges and of the Postgraduate Medical Education Training Board, linked with relevant curricula.

Less than 50% of trainees felt that workplace-based assessments were of value, which, considering its importance in judging the performance of doctors and providing them with feedback, requires further investigation. A slightly higher proportion of trainers felt they were valuable.

Themes which emerged from the data

Results showed that many trainees conceptually separate formal training sessions from the educational experience gained by contact with patients.

Between 40-50% of trainees did not recognise that their clinical team’s clinical activities provided a potential wealth of learning opportunities - the implication being that ‘training’ occurs away from wards and clinics and therefore patients.

Between 30-40% of trainees reported that they were unable to attend formal training sessions due to their clinical commitments.

The report concludes it would be helpful to review all learning opportunities in order to assess their purpose and value.

It would also be of benefit if trainees were enabled to exploit all possible learning opportunities to include formal training sessions and informal learning. It may be that the word ‘training’ is a hindrance with its implications of something which will be delivered, compared with ‘education’ or ‘development’ for which the individual takes responsibility.

But it is unlikely that trainees’ entire development and educational needs can be met by only attending the workplace and it would be helpful if these points were discussed with trainees as part of their induction.

Conclusions and recommendations from the questionnaire

A high level of EWTD compliance has been achieved in terms of hours worked by doctors in training and periods of rest in a relatively short time. There is now an urgent need to promote and protect medical training within the context of a 48-hour week. It is also necessary to ensure that training is appropriate in content and purpose.

The study recommends that:

1. The workforce is thanked for the degree of success in changing work patterns to date and given an explanation of what still needs to be achieved and why

2. Trusts are congratulated for what has already been achieved towards EWTD compliance and where rotas are already delivering training needs within the Directive. More still needs to be done as medical training remains a priority.

3. Trainees understand the reasoning and purpose of the EWTD

4. Trainees appreciate how best to learn while on duty, what constitutes feedback and how it can be obtained if more is necessary

5. A review of the provision of didactic training is undertaken to assess its efficacy, extent and timing

6. Trusts are partners in the development and provision of training.
Training activity

Audit of ‘on the job’ training activity and development of trainee booklet

The aim of this work was to address the concerns that EWTD will result in a squeeze on ‘on the job’ training and the organisational trend to hand over more responsibility to employees for their own learning and development (e.g., e-learning) - a responsibility for which trainees are not often prepared. Many trainees do not therefore recognise and capitalise on informal learning opportunities which arise as part of service delivery.

An online questionnaire sent to 202 trainees from one large UK deanery revealed that they found informal discussions and being on-call very helpful and that training was frequently occurring in such situations.

The findings also indicated that there are a number of under-utilised training opportunities, including specialist nurse clinics and inter-professional training, which are very effective when they do occur.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Frequency Mean Rating</th>
<th>Usefulness Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handover</td>
<td>2.72</td>
<td>3.10</td>
</tr>
<tr>
<td>Post take ward round</td>
<td>2.93</td>
<td>3.38</td>
</tr>
<tr>
<td>Consultant led clinics</td>
<td>2.39</td>
<td>3.36</td>
</tr>
<tr>
<td>Specialist nurse clinics</td>
<td>0.83</td>
<td>2.07</td>
</tr>
<tr>
<td>On call</td>
<td>3.18</td>
<td>3.74</td>
</tr>
<tr>
<td>Multi-disciplinary team meetings</td>
<td>2.01</td>
<td>2.82</td>
</tr>
<tr>
<td>X ray conferences</td>
<td>1.92</td>
<td>2.91</td>
</tr>
<tr>
<td>Shadowing senior doctors</td>
<td>2.22</td>
<td>3.31</td>
</tr>
<tr>
<td>Formal assessments</td>
<td>2.68</td>
<td>2.81</td>
</tr>
<tr>
<td>Operative procedures</td>
<td>1.92</td>
<td>3.11</td>
</tr>
<tr>
<td>Inter-professional training</td>
<td>1.81</td>
<td>2.64</td>
</tr>
<tr>
<td>Teaching and training others</td>
<td>2.86</td>
<td>3.45</td>
</tr>
<tr>
<td>Completion of personal learning log</td>
<td>2.60</td>
<td>2.61</td>
</tr>
<tr>
<td>Informal ad hoc discussions with senior colleagues</td>
<td>3.43</td>
<td>3.82</td>
</tr>
</tbody>
</table>

The results indicated the feasibility of conducting an audit of ‘on the job’ training. The field tests of the trainee booklet found it was thought to be a useful tool, particularly for new trainees.
Recommendations

1. Determine how to increase the involvement of specialist nurses and elements of interprofessional training in the support of junior doctors’ training
2. At induction, highlight training opportunities and hope to optimise learning based on the trainee booklet and audit data
3. Provide trainers with training sessions on how to optimise ‘on the job’ training
4. Regular audits of ‘on the job’ training, as part of trainees’ exit procedure or on an annual basis for those in run-through training
Training outcomes - evaluation of learning and training

With the increasing trend for training to be supplemented by methods away from clinical practice - external courses, wet labs, simulation, distance and e-learning - a pilot study was undertaken to evaluate the learning and changes in clinical practice following external courses.

Trainees attending two of the Royal College of Surgeons of England courses provided self-assessments of knowledge, skills and abilities relating to each of the course objectives at four timescales: pre-course, post-course, retrospective pre-course and one month post-course.

In addition, the one month post-course assessment asked whether it had changed their clinical practice and how, how easy it had been to put learning into practice and what factors helped and hindered the process.

The results demonstrated that learning had occurred across all course objectives, with post-course ratings significantly higher than pre-course ratings.

In determining the results, the difference in rating (pre-course vs post-course) for each course objective was examined using paired sample t tests. The results demonstrated that learning had occurred across all course objectives, with post-course ratings being significantly higher than pre-course ratings. The smallest difference in mean ratings was 4.86 vs 4.18 ($t = 4.4$, $p<0.0001$) and the largest difference was 5.04 vs 3.70 ($t =11.2$, $p<0.0001$).

There was also evidence of response shift bias (with significantly higher rating pre-course vs retrospective pre-course, maximum $t =3.4$, $p<0.005$), indicating that, prior to the course, trainees were over confident in their abilities.
All respondents who completed the one month post-course evaluation indicated that the course had changed their clinical practice and the training transfer was fairly easy. The opportunity to practice the skills they had learned and support from seniors were key factors in facilitating the transfer.

However, trainees identified time pressures, workload and service demands as barriers to training transfer. As the management of training transfer is critical to improved work-based performances, the early identification of barriers will help to maximise the benefit of training to individuals and organisations.

The process described in this pilot study provides a mechanism by which those who finance or organise postgraduate training courses may evaluate learning and training transfer. The use of self-reporting is a cost-effective method of evaluating training programmes.

**Recommendations**

1. That Trusts and Deaneries consider implementing an evaluation process for learning transfer from training courses to identify and address any barriers. One month post-course trainees could either meet their educational supervisors to discuss training transfer or complete an evaluation. Feedback to be given to trainers on identified transfer barriers for consideration to support sessions.

2. That Trusts implement the following process of evaluation:
   - identify training objectives
   - assess learning
   - examine impact of learning on practice
   - identify and address any barriers to training transfer
   - provide feedback on training transfer to course provider
   - include a session on strategies to cope with training transfer in future courses.

3. That best practice guidelines are implemented to ensure the training is successfully transferred to clinical practice, the critical link from learning to improved performance. Trusts should implement the self-report process of evaluation and consider short-term support for trainees immediately after training to ensure that long-term gains are realised.
Acknowledgements

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