

The Less Than Full Time (LTFT(3)) working in Emergency Medicine Pilot. Final report.

Summary

- LTFT(3) is popular with those who choose it. They report an improved work life balance, job satisfaction and reported that they were more likely to remain in Emergency Medicine (EM) than if they had not been in the pilot.
- There has not been an excessive number entering LTFT (3) 17/607 (2.8%) in the first cohort, but more have entered the second cohort (25) which has been extended to CT3. The total currently LTFT(3) is 42/1143 (3.7%).
- All in the first cohort elected to work at 0.8 WTE.
- Impact on attrition from HST4-6: 1/17 (6%) of those in the pilot (2017-18) resigned from EM training. Within the overall EM HST 4-6 cohort 10/607(1.6%) resigned in 2016-17 and 21/737 (2.8%) in 2017-18. This difference is not statistically significant.
- It is likely that the majority, but not all of the vacant workload slots created by the 17 trainees working LTFT(3) were covered.
- For there to be a net reduction in the loss of the workforce through reduced attrition in the current year caused by working LTFT(3), the attrition rate of the group who joined the pilot would need to be greater than the percentage of time lost by working LTFT(3) (20%). Given the overall rate of 1.6% this is highly unlikely.
- There is a need for a clear description as to how slots created by LTFT(3) are covered. As this group grows the additional work that needs to be undertaken would need to be reflected in increased recruitment if the burden is not to fall on the already stretched existing workforce.
- Given the high levels of intensity of working both day and night identified by GMC NTS in EM, work is needed to review the structure and balance of training posts in general to ensure that they are manageable and deliver high quality training
- Consideration needs to be given to the implications for future workforce planning, specifically the expansion of LTFT(3) in training and potentially in consultant working.

Background

Service under pressure

Emergency departments are seeing more patients, who have more complex conditions and are likely to be sicker than before and more likely to need admission into a system with less beds and exit block. This pressure is reflected in the deterioration in the service metrics with more patients failing the four hour target, more waiting >12 hours and increasing reports of overcrowding. More patients, who are sicker and moving slowly through busy Emergency departments leads to the workforce being under greater pressure(1-3).

Although the medical workforce in training is the focus of this pilot evaluation, they are only part of the much larger team needed for departments to work successfully (nurses, HCAs, reception staff, managers, radiographers and other PAMs).

Trainees in Emergency Medicine have reported that the intensity of working is greater than other specialities, together with rota difficulties and frequent unsocial working (4,5).The GMC national training survey 2018 reported “long intense working hours, heavy work loads and the challenge of front line medical practice are affecting doctors training experiences and their personal well being....” . This is typified by Emergency Medicine.

These problems are impacting on the workforce. Recruitment has previously been reported as problematic and attrition of those who enter training in emergency medicine is currently 1:5 of all trainees. Many are choosing to leave the UK (171 trainees have left UK since 2015 (6). Attrition and failure to recruit are major threats to securing the EM medical workforce of the future that is needed to meet the increased demand for urgent and emergent care. This problem is also experienced by other specialities who provide front line care eg paediatrics and general practice. The consultant workforce is also under pressure evidenced by consultant locum usage and unfilled vacancies (despite increase in consultant numbers) and migration to other countries; 112 consultants have left the UK since 2015 (6).

The challenge

Interventions are required that can be rapidly implemented to improve the lives of EM trainees and reduce attrition . Such interventions should be positively regarded by existing trainees and attractive to those considering a career in the specialty. Such interventions should not disrupt existing service provision and should not be costly.

This intervention

It was anticipated that enabling trainees to choose to work less than full time (without the previously required reasons of child care, ill health, and training opportunity (Cat 1&2)) would improve their working lives, address the issues of

intensity and retain trainees in the specialty who might otherwise leave. Trainees could choose how much less they would work and 0.8 WTE was an option. It was expected that the existence of this option would improve the morale of existing trainees and be attractive to those considering a career in the specialty. Providing the offer was accepted by a small number of trainees then the impact on service provision and cost would be small. This intervention is referred to as LTFT (3) in this document.

What is the rationale of the intervention?

That working LTFT (3) would:

- Reduce exposure to intense working and unsociable rotas
- Allow trainees time to recover, be better rested and to do other non work related activities and regain an improved work life balance
- Potentially spend some of this time on training needs
- Potentially improve patient care (because trainees are better rested and may be more satisfied with their job)

This could lead to more satisfied trainees and potentially increased recruitment and retention.

NB This intervention was not designed to address the fundamental problem of increased demand on a service with the existing workforce. Other ways of improving the working lives of trainees such as restructuring the rotas or workplans of full time EM trainees to reduce the amount of direct patient care to allow more educational time or to change the balance of out of hours or unsociable rotas were not part of this intervention.

Risks of this intervention

1 There is a risk of a net reduction in the workforce (in an already stressed service) if large numbers go LTFT(3) and the slots created are unfilled (either by locums or more recruits) and if attrition is not reduced.

2. That those who work LTFT in training may be more likely to remain LTFT once their training is completed which will influence future workforce planning (more LTFT consultant posts).

The rationale of this option is recapped in table 1

The problem(s)	The resources for this intervention	The intervention	The expected outputs	The outcomes	Impact
1.Trainees report intense working, 2.Expression of work dissatisfaction in EMTA surveys 3.RCEM and HEE report poor recruitment and retention 4.Migration of those in EM training and those who have completed training	HEE creates the option of trainees to work less than full time by choice alone and offers flexibility in the amount of reduction of hours (Cat 3). 1.HR support for recruitment 2.Addtional rota working and ARCP work to accommodat e LTFT Cat 3 3.Support locum costs created by LTFT working	Trainees have reduced time at work leading to: 1.less exposure to the intense working environment 2.More time away from that setting to do – non training things- relaxation, time with family and friends 3.Spend time on training	1.Improved work life balance 2.Improved job satisfaction 3.Potentially improved clinical knowledge and performance	1.Improved recruitment and retention 2.More satisfied with work, and life outside work 3.Improved patient care and performance	Growth of the workforce within EM and the NHS

Table 1 Rationale for the intervention.

Key: EMTA (Emergency Medicine Trainees Association), RCEM (Royal College of Emergency Medicine)

Evaluation

Data sources

In order to evaluate the impact and effectiveness of this intervention, a number of approaches were used.

1. Qualitative

Interviews were undertaken with: trainees participating in the pilot both during and at the end of first year of the pilot; Heads of School of Emergency Medicine (responsible for training at a regional level); and the Chair of Training at RCEM, (during and at the end of the first year). Correspondence with consultants responsible for service delivery with LTFT (Cat 3)s and enquiries by NHS employers of the HR departments at LTFT(Cat 3) sites were also reviewed.

2. Quantitative data

ARCP outcomes and progression, recruitment and resignation (RCEM), GMC training survey data, EM trainees survey and questionnaire for LTFT pilot trainees.

Challenges of this evaluation

1. Self reporting

This study involves pilot trainees self reporting with its risk of bias. It was not possible to collect data on the potential impact of LTFT (3) on other EM trainees within the Departments in the pilot.

2. Comparison/Control group

Evaluating if an intervention has worked or not requires a comparison. We have used within group comparisons (the participants acting as their own controls) and comparison with larger groups (eg those working full time) using routinely collected data (see previous interim report).

3. Statistical comparison

Given the small number(17) in this pilot, unless the effect size is large, it will not be detected statistically.

Results

The results are reported under the headings of the *problem*, the *processes* around the intervention and its implementation, and the *outcomes* of those processes as outlined in Table 1. A summary for each heading is provided below together with a more detailed tables in Appendix 1

Participants

The option to work less than full time was made to English EM trainees in HST4-6 in Spring 2017. Of these, 18 expressed an interest and 17 ultimately took up the option of LTFT (2.8% of the total EM HST4-6 cohort). They were based in 15 hospitals in 7

deaneries. Of the 17 trainees 10 were male, predominantly in ST4 /5. All who entered the pilot choose to work 0.8WTE.

The response rate of trainees within the pilot to interview was 13/17 at 6 months. At 12 months, 13 were still in HST4-6 LTFT(3) training (of those who were not, 2 were OOP, one resigned and one post CCT). Of these 13,8 were interviewed and 10 completed the questionnaire.

The problem (Table 2 Appendix 1)

Trainees in EM report the highest intensity of working of any trainee group, high risk of burnout and rota difficulties and an attrition rate of 22% across the whole programme

The processes around the intervention and its implementation (Table 3)

The uptake of the pilot was straight forward but how the rota was delivered varied. Trainees mainly used the time to undertake non training activities but some used some of the time for training. It was difficult for trainees to report if all the slots created by LTFT(3) were covered or not- but their sense was that the majority were. Those LTFT(3) trainees who undertook locums did so at a frequency of <1/month.. Those within the pilot said they had peer support and this is supported by the EMTA 2018 survey.

The outcomes (Table 4)

Trainees within the pilot reported improved worklife balance, job satisfaction and increased likelihood of remaining in EM and the NHS . All who remained in HST stayed LTFT(3). They thought the quality of patient care they delivered was either similar or better. The attrition rate for the pilot trainees is not statically different from their peers and the ARCP outcomes are similar to that expected of all trainees (4). Where data is available for trainees of all specialities in the GMC survey(5), the responses to the Copenhagen questionnaire are similar or better for those in the pilot (see table 4).

Conclusions

- That LTFT(3) is popular with those who choose it. They report an improved work life balance and report that they are more likely to remain in EM than if they had not had the opportunity to take part in the pilot. All who are still in HST4-6 training have continued beyond the pilot year as LTFT(3)
- There has not been an excessive number entering LTFT (3), but more have entered the second cohort (25 vs 17). There has not been a mass exodus to LTFT (3) in this hard pressed speciality.
- Impact on attrition from HST 4-6: 1/17 (6%) of those in the pilot (2017-18) resigned from EM training. Overall for HST 4-6 10/607(1.6%) resigned in 2016-17 and 21/737 (2.8%) in 2017-18. This difference is not statistically significant, but the number in the pilot was small.

- That any detrimental impact on the service because of uncovered slots is likely to be absorbed because of the small numbers of LTFT(3) in this pilot all of whom were working 0.8WTE.
- For there to be a net reduction in the loss of the workforce *during the period of the pilot* through reduced attrition caused by working LTFT(3), the attrition rate of the trainees who joined the pilot would need to have been greater than 20 % , the proportion of time lost by working LTFT(3). Given the resignation rates in HST 4-6 this is extremely unlikely. The highest attrition rate is at CT3 and this year of training has been included for the second cohort (August 2018). *No account has been taken in this evaluation of the potentially large benefit of reduced attrition beyond the training period i.e retention in EM for the remainder of their working career of a trainee who might have left.*
- These LTFT(3) pilot trainees were prepared to take a wage cut in order to have more time within their own control. Does this mean the work is too intense and that emergency departments are too reliant on trainees?

Recommendations

- There is a need for a clear description as to how slots created by LTFT(3) are to be covered. As this group grows the additional work that needs to be undertaken would need to be reflected in increased recruitment *if the burden is not to fall on the already stretched existing workforce*. Any reduced attrition will not compensate for the reduction in trainee workforce secondary to working LTFT(3)
- The speciality of EM may benefit from the adoption of those strategies used by those specialities with greater experience in this area and a large proportion of trainees who are LTFT eg RCoA
- Consideration of the implications for future workforce planning , specifically the expansion of LTFT(Cat 3) in training and potentially in consultant working
- Given high levels of intensity of working both day and night identified by GMC NTS in EM (4,5), work is needed to review the structure and balance of training posts in general to ensure that they are manageable and deliver high quality training

In order to evaluate the future impact of LTFT (3) the following recommendations are made:

- The primary outcomes of interest are EM recruitment and attrition , GMC training survey and Copenhagen questionnaire
- Stratification of routinely collected data by LTFT (1&2) LTFT (3) and FT i.e GMC survey, HEE /RCEM data on progression/ARCP, EMTA survey
- Participation in survey/audit of LTFT(3) trainees should be required before progression or leaving the programme

Acknowledgements

Academic guidance- Professor Selena Gray
Those trainees in the pilot and Heads of School of Emergency Medicine
HEE- David Wilkinson, Julie Honsberger, Jackie Finn & Jon Hussain
RCEM- Maya Navari, Julia Harris, David Greening, Consultants involved in LTFT(3)
NHS Employers – Gordon Benson, Matt Aielio, Ellie Pattinson
Survey Questionnaire – Iain Beardsell

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Funded by HEE

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