BMA

Medical rota gaps in England

August 2018

British Medical Association
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Contents

Executive Summary

1. Rota gaps, long-term staff vacancies and intensifying workload are major issues across the NHS. Hospitals across England must juggle patient demand without a full complement of medical and clinical staff; in part, because the root causes of rota gaps have not been adequately addressed. Wider difficulties recruiting and retaining staff, the inadequacy of national workforce planning, the pressure employers feel to mask staff shortages and the impact of the under-funding and under-resourcing of the health service are having both direct and indirect impacts on doctors' wellbeing and patient care.

2. Our members have consistently told us about the negative impact rota gaps have on training, morale, work-life balance and quality of care. Resident doctors describe their role as 'firefighting' due to the widespread gaps in the medical workforce. These gaps can put doctors in situations when they are forced to act above their competencies, putting patient safety at risk.

3. Most interventions related to rota gaps have been viewed negatively or as punitive by resident doctors. Rotas have been shrunk to reduce the number of doctors without reducing the workload, therefore obscuring the rota gap. The consequences of reducing the number of doctors on the rota are wide reaching, with doctors reporting increased workload, worsening mental health and stress, fatigue and reduced morale. Some doctors feel they have been bullied or intimidated into taking on extra work to fill rota gaps, and are routinely discouraged from raising concerns about their treatment or workload.

4. Few trusts appear to have taken positive steps to improve the situation and need to think more carefully about the way they treat staff in terms of their wellbeing, their training and education needs and how they communicate with them.

5. In this report, we recommend practical steps that can be taken to mitigate some of the negative impacts of rota gaps in the relative short-term. We have not focused on large-scale solutions, such as adequate funding for the NHS or genuine, well-considered UK-wide workforce planning and policies that allow for non-UK trained staff migration to supplement workforce supply without arbitrary limits, as these will require significant and long-term changes in Government policy. Rather, we have focused our recommendations at interventions that can produce immediate benefit and be implemented without delay.

6. We recommend solutions that should help to significantly improve staff wellbeing, increase morale and increase medical and clinical staff capacity. Areas of focus include culture, planning and responsiveness, engaging with the medical workforce, guardians of safe working, data accuracy, exception reporting, tackling bullying and harassment and better incentives, policies and processes to support locums.

7. In addition to the problems caused by rota gaps, we explored with doctors their motivations and approaches to taking on additional work. Doctors value a supportive and welcoming environment and the desire for senior support and training opportunities remains a strong motivator to take on additional shifts, particularly for those doctors in the early years of postgraduate training.

8. We know that rota gaps and their associated problems need the focus of the entire system. We are calling on all interested stakeholders, from the Secretary of State for Health and Social Care to rota co-ordinators, to work with the BMA to tackle the root causes of rota gaps. Consistent improvements need to be made across employing trusts to start to tackle the workload burden. Otherwise, current national and regional recruitment and retention policies will prove fruitless and we will fail to adequately train the senior clinicians of the future. This has potentially serious implications for the quality and safety of patient care.

Introduction

Project purpose

The aim of this project has been to gain a better understanding of the problems caused by rota gaps so that we can make effective recommendations for practical remedies. Following the protracted negotiations and dispute that arose from the 2016 doctor in training contract discussions, the BMA RDC (resident doctors committee) took stock of the feedback from members regarding their working environment and training. Members shared their experiences of intense workload, missed training opportunities, low morale, considerable emotional and physical strain and fears about the safety and quality of care they could provide to patients under such pressures.

Methodology

Both qualitative and quantitative methods were used to gather feedback from secondary care doctors, including resident doctors, SAS (staff, associate specialist and specialty) doctors and consultants. We held a series of focus groups to gain a deeper understanding of the impact rota gaps have on doctors' working lives and patient care and more than 1,000 members responded to an online survey in January 2018.

Context

In the face of rising patient demand, hospitals have been left chronically understaffed as a result of long-standing recruitment and retention problems. 70% of resident doctors report working on a rota with a permanent gap, and eight in ten consultants report gaps in resident doctor rotas; more than one in four reported that the gaps are so serious and frequent that they cause significant problems for patient safety.[a] Between 2013 and 2015, the number of doctor vacancies increased by 60% and an estimated 10% of all medical posts are currently vacant.[b] The UK has 2.8 doctors per 1,000 population compared to the average of 3.4 across the OECD.[c] While medical school places will increase by 25% in 2018/19, the impact on the workforce will not be immediately realised as it takes more than a decade to train a senior doctor.

Staff shortages and rota gaps result in increased workload for doctors and workload is a significant factor in the attractiveness of NHS roles. The GMC's 2017 NTS (National Training Survey)[d] confirmed that just over 40% rated the intensity of their work by day as 'heavy' or 'very heavy'. Medical trainers are also reporting high workloads – with almost 80% working beyond their rostered hours at least once a week, which is impacting on training. Around a third say they don't have enough time in their job plan (or equivalent) for education.[e]

Doctors' unmanageable workloads impact on their morale, motivation, well-being and on the quality of care they can offer to patients. Almost 25% of resident doctors feel short of sleep while at work on a daily or weekly basis.[f] Consultants in England work on average an extra 4.5 unpaid hours per week outside their contracted time, according to a recent BMA survey.[g] They describe their current workload as 'consistently unmanageable' and nearly half of those responding to the survey (49%) had felt unwell over the last 12 months because of work related stress. Unsurprisingly, 61% of respondents went on to describe their morale as low or very low. In addition, half said that their current workload has a negative or significantly negative impact on the quality of care that their patients receive.

a Royal College of Physicians (2017), *Underfunded. Underdoctored. Overstretched. The NHS in 2016.*
b *Facing the Facts, Shaping the Future A draft health and care workforce strategy for England to 2027* (2017).
c https://data.oecd.org/healthres/doctors.htm
d https://www.gmc-uk.org/education/surveys.asp
e *Training environments 2017: Key findings from the national training surveys* (November 2017), General Medical Council
f GMC 2017 National Training Survey.
g British Medical Association (2017) *Survey of consultants in England.*

Similarly, nearly three quarters of SAS doctors reported that they had worked more hours than in their job plan in the past year, according to a 2015 BMA survey[h]. Roughly the same proportion reported giving up SPA (supporting professional activities) time to fulfil clinical duties. Perhaps even more worryingly, 27% reported that they intended to leave medicine within the next five years, whilst 45% said they would not recommend an SAS grade career to resident doctor colleagues.

h BMA (2016) *SAS Doctor Survey*

Key findings

Impact of rota gaps on workload and patient care

1. The results of our survey show a medical profession under significant and worrying strain. **More than three in four respondents (80%) said that individuals are encouraged to take on the workload of multiple staff**. This is an alarming indication that both medical and clinical staff are working to and, in some cases, beyond their physical and emotional limitations. The negative implications for the quality of care delivered, individual staff wellbeing and morale are clear. Doctors at our focus groups spoke of the difficulty in trying to balance delivering high quality patient care with the demands of an impossible workload.

2. In addition to asking doctors to take on the work of multiple colleagues, **over two thirds of survey respondents (68%) had been asked to act up into more senior roles or cover for more less senior colleagues**. At our focus groups, foundation doctors reported undertaking work that should have been performed by a senior registrar or a consultant. This indicates staff shortages, raises concerns about the responsibility placed on inexperienced resident doctors and increases the risk of errors when diagnosing, treating and caring for patients. Those doctors who are acting down are likely to be taking on additional workload, which may well impact on their wellbeing. There is also likely to be reduced training opportunities for medical trainees whilst they fulfil service provision requirements instead.

3. **Over half of respondents (56%) said that SAS doctors were asked to both act up and act down to cover rota gaps. Just over one third of respondents (37%) said their employer asked consultants to act down to cover shifts**. This shows that rota gaps impact on other areas of the medical workforce, not just resident doctors.

4. **Two in three (65%) respondents said medical trainees are pressured to take on extra shifts**. Participants at our focus groups discussed how doctors covering rota gaps are being pressured to work unsafe shifts, putting them at risk of making mistakes. Covering a rota gap was described as 'firefighting'. Not only is this an indication of a culture of bullying, but it also highlights a desperation on the part of employers to find staff to plug rota gaps. This is unlikely to lead to a favourable training experience, maintain morale or harbour a working environment that encourages medical trainees to remain working in the NHS. Crucially, it is also likely to have an impact on the quality of care doctors can provide for their patients.

5. **Around one in three respondents (32%) stated that**, where resident doctors have undertaken additional hours at the end of their shifts, **their employer, their educational supervisor or their clinical supervisor has discouraged exception reporting**. This reinforces anecdotal evidence from BMA members of a failure to develop a positive culture shift since the introduction of exception reporting and is further evidence of a culture of bullying persisting within the NHS.

6. The SAS doctors who participated in our focus groups also raised concerns about the fact that the Associate Specialist doctor workforce is an ageing one, is overstretched and frequently works considerably more than specified contractual hours, particularly since the introduction of strict safety limits for resident doctors that are not matched for SAS doctors. They also report high levels of bullying and harassment. This is not good for wellbeing, morale, supporting the education of medical trainees, or, where exhausted doctors continue working long hours, for patient care or safety.

7. **Two in five survey respondents (40%) reported that employers had employed Medical Associate Professions or Advanced Clinical Practitioners to help support existing clinical staff with workload demands**. Expanding the doctor-led multi-disciplinary team can help to ensure more manageable workload for individual doctors. However, such roles should supplement the medical workforce rather than act as a solution to medical recruitment difficulties, as these practitioners cannot replace the expertise, skills and knowledge of doctors. The educational impact on training doctors working alongside these clinicians must also be carefully considered to avoid undermining medical training time.

Impact of rota gaps on medical training

8. Participants in our focus groups felt strongly that rota gaps have significant consequences for training quality. Vital training opportunities are lost due to a requirement to maintain minimum standards of service provision. Participants believed that this was a major contributing factor in medical trainees choosing not to complete their specialty training pathway, either to take non-training roles or to leave the profession altogether. Likewise, senior doctors expressed concerns that rota gaps and vacancies lead to a lack of time to train other doctors.

9. Clinical fellowships are becoming an increasingly popular option among doctors. This is possibly due to the pressure of being in a formal training programme. Some participants at our focus groups felt that clinical fellows get better protected opportunities to train and learn, and can be offered incentives that are not available as part of the formal training programme, such as medical education, subspecialty training or additional qualifications. Some participants expressed concern that clinical fellows were being prioritised for training opportunities above those in formal training programmes. This reinforces findings in the BMA career trends survey, which suggest that lack of training in over-worked service posts means some are leaving for career grade jobs that also provide protected teaching time.

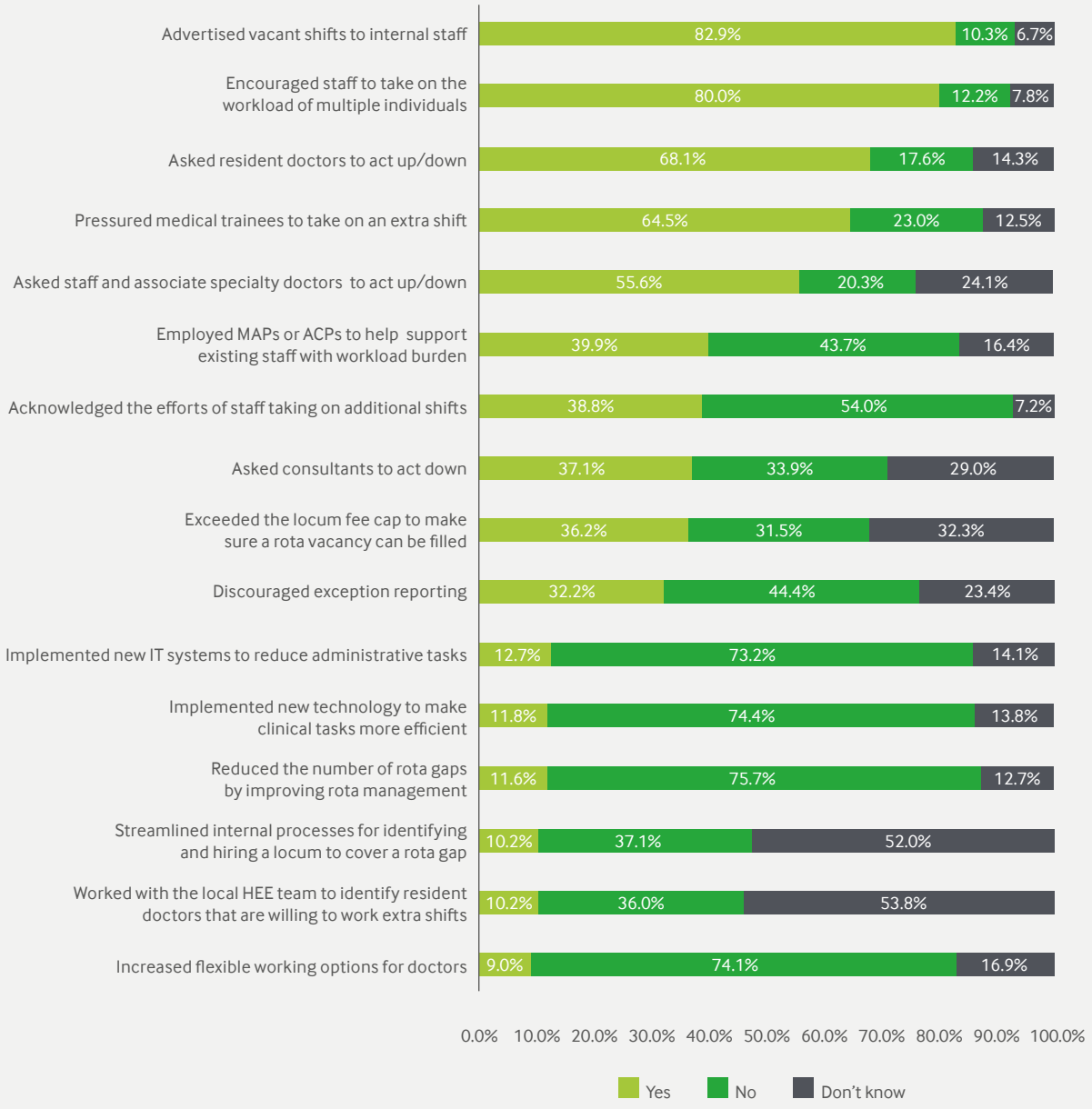
Use of locums to cover rota gaps

10. Participants at our focus groups reported frequent use of locum doctors to fill rota gaps. There was a view that poor inductions and lack of adequate training are part of the reason some trusts struggle to retain locums. Similarly, participants felt that time should be invested in preparing locum staff for their shifts to help avoid potential problems, e.g. providing IT login access and making sure they know where to find emergency equipment.

11. **Just over one third of survey respondents (36%) said their employer has had to exceed the locum cap to attract staff to fill a rota gap.** This indicates that any efforts that the employer has made to fill the gap via internal staffing solutions have been fruitless. What this response does not tell us is how frequently employers must breach agency fee caps or if trusts are failing to fill rota gaps because they will not breach the cap. The BMA has always maintained that the locum cap does not work and should be removed.

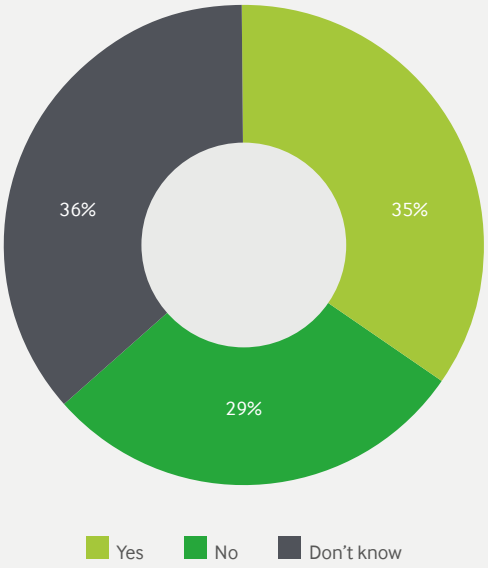
Online survey

Has your employer done any of the following? (most to least common)

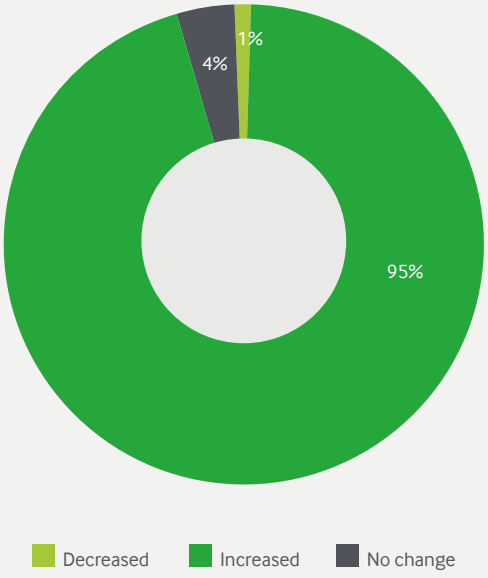


Redesigning rotas and obscuring gaps

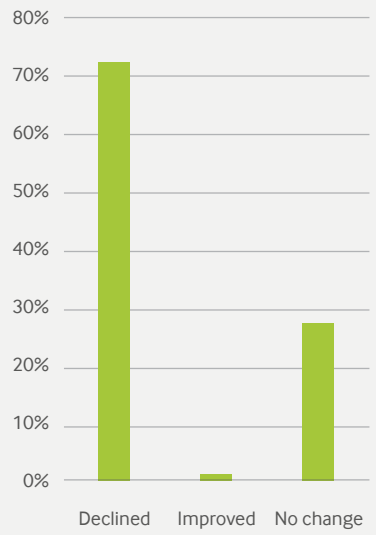
Has your employer ever redesigned a rota you work on so that it includes fewer doctors?



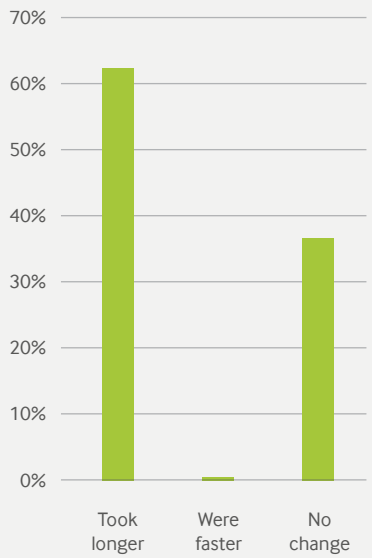
(If yes) What were the consequences regarding individual workload?



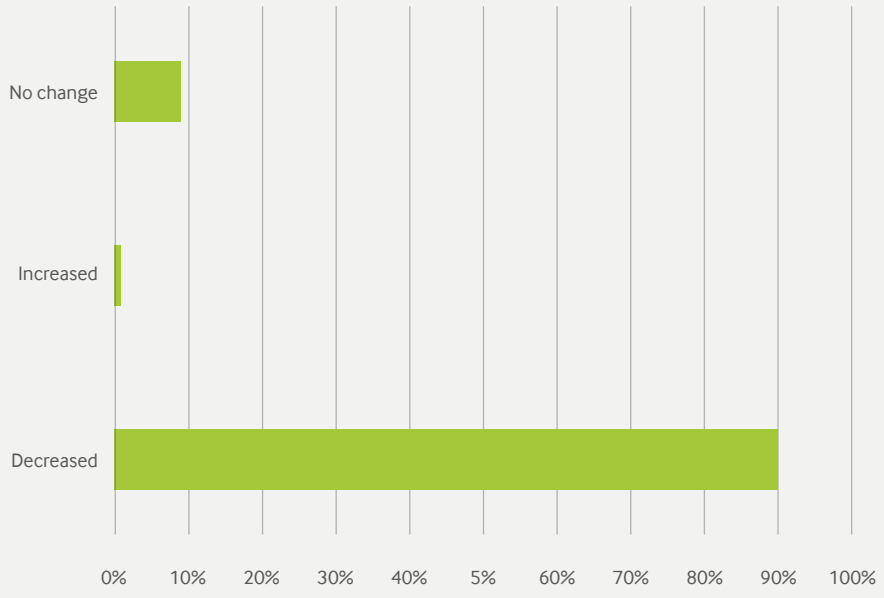
What were the consequences regarding patient care?



What were the consequences regarding patient admissions?



What were the consequences regarding training opportunities?



12. **More than a third (34.6%) of respondents reported that their employers had re-designed rotas to include fewer doctors,** thereby obscuring the rota gap problem. This echoes our focus groups where many participants talked about employers 'collapsing', 'combining' or 'contracting down' the rota, whereby vacant posts are removed and the number of doctors on the original rota is decreased, making the new rota appear full.

    We can also see that there is a correlation between obscuring rota gaps and other negative behaviours. Respondents who answered 'yes' were:

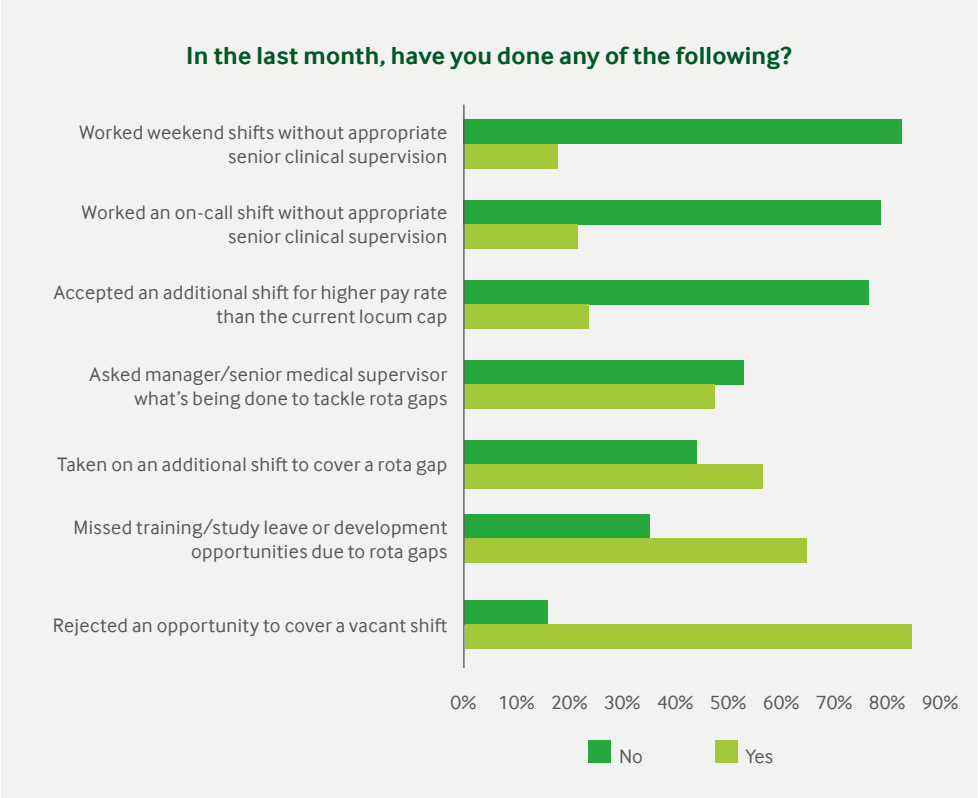
    – more likely to state that their employer had pressured them to take an extra shift; 74.4% compared to 64% of all respondents
    – more likely to state that their employer had encourage individuals to take on the work of multiple individuals; 86.6% compared to 78.9%.

Obscuring the problem may simply be the result of bad practice, but it is clear from our findings that it does not lead to good practice in other areas, with possible relationships between one form of bad practice and another.

It is also clear that the consequences of reducing the number of doctors on the rota are wide reaching and worrying. Respondents reported negative consequences for individual workload, patient care, patient admissions and training opportunities.

140 (13.7%) respondents provided further information about the personal consequences of redesigning rotas to reduce the number of doctors. Common themes were increased sickness, worsening mental health and stress, fatigue and reduced morale.

Experience of working extra shifts to cover rota gaps



13. **The clear majority of respondents (84.2%) had turned down the opportunity to cover a vacant shift in the past month**, while **more than half of respondents (56.3%) had** also **taken on an additional shift to cover a rota gap**. This is a clear demonstration of how widespread rota gaps have become. While there is an obvious willingness to help, it is clear the resident doctor workforce does not feel able to bear the entire burden of the shortfall in doctors.

14. There is evidence of a significant problem with cover being provided by doctors **working without the appropriate senior clinical supervision**, with **21.8% reporting having worked an on-call shift and 17.7% reporting having worked a weekend shift** in this way.

    It is encouraging that **nearly half of residents (47.2%) have asked a manager or senior medical supervisor what is being done to tackle rota gap problems**. The engagement of residents will be an important factor in making improvements.

15. We also asked doctors about their motivations when undertaking additional work. **Pay, the presence of a senior doctor** and **training opportunities** ranked as the top three considerations if asked to take on an extra shift at **their** place of work.

    FY1/2s, CT1/2s and ST1/2s all regarded the presence of a senior doctor as their highest priority at this stage of their medical training, but as doctors gained experience less emphasis was put on the presence of a senior doctor, with pay and training opportunities taking increasing priority.

16. **Appropriate induction**, **presence of a senior doctor** and **pay** ranked as the top three considerations when doctors were asked to take on an extra shift at a **different** place of work.

    Without senior supervision for FY1/2s and CT/ST1-2s and appropriate inductions for doctors in other medical training grades, they will not want to take up an additional shift in an unfamiliar place of work. These results were echoed in the focus groups where doctors talked of the need for a welcoming and positive environment in order to consider taking on additional work.

17. **Almost three in four survey respondents (71%) do not believe they get enough notice from their employer about available shifts**. This reflected findings from our focus groups where it was often felt that planning for known vacancies and rota gaps was poor. One participant gave an example of a rota where 'twilight registrars' are included for an evening shift and often asked to work days or nights depending on where rota gaps exists.

Action to tackle workload and mitigate the effects of rota gaps

18. **Almost three in four respondents (73%) stated that their employer had not implemented new technology to help reduce administrative tasks for their staff. Similarly, 74% of respondents did not believe their employer had implemented new technology to make clinical tasks more efficient. Three out of four respondents (76%) also believed that their employer had not reduced rota gaps by taking steps to improve rota management**. There are a range of time saving benefits that can be brought about by the adoption of modern technology innovations. For example, see recommendations 17 and 18 on page 16.

19. **Just over one in 10 respondents (11%) were aware of employers streamlining processes for identifying and hiring a locum to cover a rota gap. One in 10 (10%) respondents also stated that they were aware that their employer was working with the local HEE team to help identify resident doctors who were willing to undertake additional shifts. Around three in four respondents (74%) stated that their employer had not increased flexible working options for medical staff.**

Recommendations

Our research shows how far the problems caused by rota gaps resonate throughout the NHS and the lives of doctors. While rota gaps result primarily from a lack of doctors, alongside our call for more doctors and our evidence of the consequences of rota gaps, we must identify practical solutions and examples of good practice to help mitigate against the negative results.

It is concerning that a third of survey respondents confirmed that their employers have taken measures to obscure the rota gap problem, but it is equally worrying that a similar number did not know whether this was the case. Transparency about safe staffing levels and how rotas work is an essential element of establishing an open, honest and fulfilling workplace. With that in mind, we make the following recommendations:

Local Solutions

1. **Trusts should minimise the impact of rota gaps by effective forward planning by rota coordinators/planners.**

   Some gaps can be anticipated, such as those resulting from long term vacancies, maternity, long-term sick or annual leave. Seeking cover well in advance will help lessen the problems caused by rota gaps that arise with little warning. While this may sound like straightforward advice, the failure of some employers to plan has been a consistent theme throughout our research. Clear policies are required to enable trusts to escalate problems arising from unfilled shifts to ensure that timely resolutions can be found that do not put unnecessary pressure on staff.

"Rota gaps are the biggest issue in terms of exception reporting"

2. **Each LNC should set up a subgroup specifically to consider rota gaps and the problems arising in their locality.**

   The LNC is an invaluable tool for dealing with the problems arising from rota gaps. The subgroup can provide the LNC with ideas for improvements and reform, e.g. step-down policies enacted for registrars, which can be discussed between doctors and management through joint-LNC meetings.

3. **Employers should have policies agreed with the LNC subgroup for how to deal with and manage rotas, rostering and gaps that arise to allow for clear and transparent processes.**

   The joint BMA/NHS Employers rostering guidance should be implemented in full. There must be sufficient headroom in all rotas to allow doctors to take their full leave entitlements and have adequate education and training opportunities.

4. **Each hospital department should appoint a resident doctor to be actively involved with rota design, planning and rostering.**

   A recognised management role with sufficient protected time away from clinical commitments and appropriate remuneration would ultimately have significant benefits for the operation of the department. The policies agreed with the LNC subgroup should also govern the roles of the resident doctors appointed to be actively involved in rota design, planning and rostering.

5. **All trusts must ensure that exception reporting is supported with clear standardised processes for reporting excess hours worked, missed breaks or training opportunities.**

   One in three respondents to our survey stated that their employer, educational or clinical supervisor has discouraged exception reporting. This not only obscures true workforce need and hinders workforce planning and projections, but will inevitably impact on morale and wellbeing. A functioning exception reporting system will also enable educational and clinical supervisors to monitor areas where doctors are not able to access required opportunities to meet their training needs.

6. **All trusts must commit to tackling bullying and harassment.**

   The English workforce strategy consultation document refers specifically to 'human factors in healthcare' and 'understanding the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities'. There is now widespread acceptance of the need for culture change across the NHS workforce, and this needs to be swiftly turned into positive action. The workforce is the NHS' most valuable asset and staff need to be treated with respect to feel both motivated and valued.

7. **Trusts should implement better and consistent incentives, policies and processes to support locums.**

   Locum shifts, whether in a doctor's primary place of work or in another trust, must be attractive. Whether by providing assurances of senior medical supervision, a thorough induction, working IT infrastructure, clear training opportunities to develop specific competencies or increased remuneration, trusts need to be more cognisant of the needs of their medical workforce.

   By offering high quality inductions, employers can make a good start with their new doctors by creating good will and improving the experience for everyone working in the department.

8. **Health Education England and employers should offer clinical fellow and staff grade posts that are tied to extra-clinical benefits, e.g. foundation three (F3) year.**

   This can make roles more attractive, provide greater educational benefit, enable professional development and widen the skills of the doctor. These roles exist in a variety of formats and different employers are using them in different ways. They are growing in number and are becoming increasingly attractive to doctors who no longer find the formal training programme appealing. Such posts offer increased flexibility, training opportunities and support, e.g. clinical/educational supervision. Examples of other potential benefits include:

   - attracting doctors to stand alone posts with promises of more developmental time within their working pattern
   - linking them to postgraduate qualifications in a wide range of areas
   - providing opportunities for developing medical education
   - specific sub-specialty training
   - providing a bespoke alternative to the training programme through the certificate of eligibility for specialist registration (CESR) route.

National Solutions

9. **Government must place more value in the locum workforce and end the cap on locum spend.**

   Locums are a valuable part of the medical workforce. We recognise high levels of locum spend as the result of the inability of trusts to retain sufficient numbers of doctors in substantive employment. Doctors will be more willing to take on additional shifts if there are obvious benefits and they are remunerated for this work appropriately. Policies and rhetoric that undermine this staffing group only harm the organisational resilience of the NHS.

   The locum clause (schedule 3, paragraph 43 of the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) imposed as part of the 2016 contract for resident doctors in England, which insists that a doctor intending to 'undertake hours of paid work as a locum' initially offers them 'exclusively to the service of the NHS via an NHS staff bank', has proved deeply unpopular with resident doctors. It potentially accentuates the problems smaller trusts have with recruitment by making the pool of potential doctors willing to take on these shifts even smaller.

   There are better ways of encouraging doctors to undertake less costly NHS staff bank shifts and, as part of our work to value and respect the locum workforce, we should recognise this by removing this clause from the contract. The alternative is that many will simply stop doing additional work.

10. **Government, NHS Improvement, NHS Confederation, NHS Employers and commissioners must support employers to place renewed focus on the health and wellbeing of permanent full and part-time staff.**

    A focus on health and wellbeing would positively impact on sickness absence rates, which should help reduce rota gaps and individual workload. This will help employers to reduce agency costs and use those efficiency gains to invest in employers' permanent workforce.

"Are trusts clear about the difference between a gap and a medical vacancy?"

11. **Government, national workforce planners and commissioners should establish and enforce safe medical staffing levels alongside a national standardised definition of a rota gap.**

    If the role of guardians of safe working is to be meaningful, they must have sufficient freedom to report on the situation in their trust. Part of the problem for guardians is the lack of a clear definition of what constitutes a rota gap, with approaches varying in different parts of England.

    For a rota gap to be defined there needs to be a clearer understanding of how many doctors are required to staff a particular rota to provide adequate safety for patients and to ensure that resident doctors are receiving high quality training. There should be published and enforced safe staffing levels applicable to doctors and more work must be done to enable consistent and high-quality workforce planning. It is likely that current estimates of vacancy rates for doctors are significantly lower than the actual number of doctors needed to provide high quality patient care.

12. **Employers must introduce annualised working patterns and self-rostering by implementing transparent e-rostering systems across all trusts.**

    This will improve flexibility and should lead to improved job satisfaction and therefore better retention and recruitment. It will allow enhanced patterns of LTFT (less than full time) working, which may in turn enable doctors to take up additional shifts where they choose to do so.

Improving the medical training experience

13. **Health Education England and employers to ensure that the senior doctors of the future do not have their competence compromised because of missed training opportunities due to service provision pressures.**

    We urge all those with a stake in the education and training of doctors to work with us to address this situation. We need guarantees that employers will prioritise the training needs of our future senior doctors and that they will ensure:

    - protected training time within work schedules
      - accurate calculation of education and training time required in rotas and rosters to ensure they are not subsumed by service provision
      - rotas built to provide adequate training
      - full implementation of the joint BMA / NHS Employers rostering guidance;
    - protected teaching time within consultants' job plans; and
    - Educational and Clinical Supervisors have enough Programmed Activities to ensure quality training time with resident doctors.

"I fear for patient and personal safety. All out of hours shifts have gaps, I'm concerned about the level of care and I'm worried that residents will be blamed for this"

14. **Employers should structure all rotas to allow easy access to a senior doctor for training and supervision at all times on each shift.**

    Resident doctors are wary of accepting offers to cover rota gaps when they believe that there will be limited access to senior doctors. Our research suggests that offering this guarantee has the potential to result in more resident doctors taking up additional shifts. Similarly, ensuring each additional shift has value in terms of medical training could also make them more attractive to doctors.

15. **Health Education England, Public Health England, regional/local workforce planners and commissioners to place a strong focus on making sure annual medical training cohorts are adequate for service need and are filled for each specialty.**

    The forthcoming national workforce strategy must clearly outline how workforce planning will be improved to ensure sufficient workforce supply to meet current patient demand and the needs of the future will be adequately resourced.

16. **Health Education England, royal colleges and employers should improve the flexibility of the medical training programme.**

    Many doctors throughout this project have spoken about the current inflexibilities of the medical training programme. Recent initiatives such as the pilot to allow more Emergency Medicine Registrars access to less than full time training have been very well received. Initiatives like this, plus the ability to step on and off training without penalty, combined with secure long-term training pathways – such as run through training schemes – allow a balance between flexibility and long-term workforce planning, which will help improve recruitment and retention.

    Currently, only work prospectively approved by the GMC is allowed to count as time towards a doctors CCT (Certificate of Completion of Training). We support moves towards competency based progression in training and the ability to count all work as evidence towards meeting those competencies.

Time saving IT Improvements

17. **Commissioners should ensure full implementation of the NHS e-Referral Service and the advice and guidance functionality within it.**

    This can offer rapid (under 48 hours) virtual direct communication between clinicians in primary and secondary care, which will ultimately reduce workload for doctors and improve patient care. Trusts also receive more CQUIN (commissioning for quality and innovation) income for setting up this electronic pathway.

18. **Commissioners to ensure all employers have properly implemented e-Rostering systems.**

    These systems can significantly reduce the time taken to develop the staff roster, reduce agency staff use, provide more flexible and less stressful working patterns and support automatic monitoring of workforce activity. Taken one step further, this software can also allocate workload, track tasks and match staffing-levels to acuity levels in real time.

Case Study – Clinical Fellowships

Dr. Rob Galloway, A&E Consultant Brighton and Sussex University Hospital NHS Trust (BSUH NHS Trust) and year five sub–Dean, Lead for Undergraduate Emergency Medicine Training and Honorary Senior Lecturer at Brighton and Sussex Medical School (BSMS)

Outside of training programmes, we often struggle to get resident doctors to work in A&E departments. We lose staff due to unsustainable rotas and we can fail to teach our medical students due to the intensity of the environment we work in. Consequently, locum bills skyrocket, students are put off A&E as a career and workforce strategists resort to introducing non-medically trained staff as a solution rather than trying to get to the root cause of the problem.

At BSMS and BSUH NHS Trust we were faced with these problems – historically low input of A&E training into the curriculum, massive staff shortages and an inability to recruit to non-training clinical fellow posts. We also had a £950,000 per annum resident doctor locum budget and a reduction in SHO weekend availability resulting from the new doctor in training contract.

A 'blue sky thinking solution' was devised, which many people initially thought was overly optimistic and unrealistic. However, as the traditional models of A&E teaching and recruiting were failing, the time was right for considering more radical approaches. Our new approach would involve:

- new doctors having their time divided between 66% clinical and 33% special interest work
- a weekend frequency of 1 in 2.5 weekends clinical work
- the same amount of night-time working as our other doctors
- Medical SIFT (Service Increment for Teaching) funding to help with financing the non-clinical special interest work
- the clinical hours these doctors provided for the department were annualised
- annual leave, study leave, all bank holidays plus three hours a week of private study were incorporated into the rota
- their time working for the department was then divided into two thirds clinical and one third educational for student teaching and to take a PGC in Medical Education
- supervision from an A&E consultant with a PGC in Medical Education who is also one of the sub-Deans at BSMS
- posts for a minimum of a year as opposed to the constant 4 month 'churn' of other residents, which is often hard to manage both for trainees and departments.

The impact was dramatic. When in the educational portion of their time, the fellows were dedicated to education. They wore different colour scrubs, concentrating on 'shop floor' teaching and did not get involved with patient throughput. The students had inductions, received timely feedback and came to develop a good understanding of the A&E process. When they came to do shifts without educational fellows in the clinical setting, they were able to really fit into the team. Having final year medical students in the department was advantageous as they helped clerk and provided clinical care as well as benefiting from an educational perspective.

The impact on the students was impressive too. Our new approach helped get A&E the best feedback within the medical school and in turn helped the medical school get some of the best feedback in the country for student satisfaction. The fellows also got involved with the medical school outside of A&E – helping on skills days, examining and helping to run the 'preparation for practice' course.

The resident doctors were either SHO or registrar level – including people taking an Out of Programme Experience. Many of our fellows have gone on to specialist training and in the future, given their formal educational qualification, will be able to look for consultant jobs with teaching elements attached.

Within BSMS other hospitals are now using this approach as it is a great use of SIFT funding. Registrars and SHOs can often provide the required teaching if they are supervised appropriately. The value of SIFT money put into educational fellows is often greater than if the money is simply put into department budgets and time sought for consultant SPAs to teach.

Within the BSUH A&E department, the trial was considered a success and we have continued to make appointments, including many new posts, e.g. 22 SHOs. Not all of them do education; we also have fellows in simulator training, trauma fellows, toxicology fellows, leadership fellows and major incident fellows. In addition, we have used the same 66/33 approach for middle grade clinical fellows, with some using one third of their time to work towards their Certificate of Eligibility for Specialist Registration.

Staffing departments is about not just increasing the supply, but stopping our doctors from leaving. This system has helped because so many resident doctors want to work in jobs that are sustainable and flexible, where they can pursue special interests and can see career progression without jumping so quickly onto the treadmill of a formal training programme.

Our programme is helping to create a new generation of doctors who realise the importance of general and acute skills, and know how to manage undifferentiated patients in a holistic way. At the same time, we are improving the running of the A&E department. It is a win-win for all.

Conclusion

To address the root causes of rota gaps, the NHS must recruit and retain more medical staff, make significant improvements to workforce planning and rostering, improve the attractiveness of posts and offer greater flexibilty within careers and employment. Individual employers must do more to support resident doctors who take up additional shifts and to mitigate the worst impacts of workforce shortages.

Resident doctors have experienced bullying and harassment from rota managers who are under pressure to fill gaps. Masking rota gaps exacerbates workload and stress and fuels job dissatisfaction and low morale. The current training pathways and rostering of resident doctors are too rigid, the elements of their work that are service provision under recognised. The continued lack of training will have an inevitable impact on morale and lead to more doctors leaving training programmes in search of flexibility, a better working environment, a work-life balance and, perversely, training opportunities.

It can no longer be acceptable to cover for inadequate staffing and workforce planning by placing responsibility on doctors already working to their limits in an overstretched system. The inevitable burnout and its harmful effects on trainees have devastating long-term implications for the workforce. The risks to quality of care and patient safety are too great to ignore.

We have made straightforward recommendations that both Government and employers can take forward that would generate real results. However, we need to be honest about the scale of the problem before we can genuinely start to plan our workforce needs for the future. We look forward to working with doctors, employers, Government and other key stakeholders to make real improvements for those working on the NHS frontline.

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