



Sustainable future for diagnostic radiology: less than full-time (LTFT) working

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Key points

- Less than full-time working (LTFT) enables improvement in recruitment and retention by facilitating a better work–life balance and reducing the risk of stress and burnout.
- It also produces a flexible workforce to allow delivery of service over an extended working pattern.
- It enables flexibility in the delivery of professional requirements, such as training and education, research and management.
- LTFT working requires careful and flexible job planning to facilitate retention/development of skills, team working, mentoring and continuing professional development (CPD).

Background

The hours and times radiologists work have been variable among individuals and institutions for many years; however, the need to change the way radiologists work is now more urgent than ever because of:

- Individuals wishing to achieve a better balance between work and home life
- Healthcare trusts and private organisations wanting to match their service, training, management and research needs with the way their employees work
- Organisations needing to produce services of the right quality and within the right budgets, as and when patients want them – creating pressures to use staff and other resources optimally
- Accommodating working practice (as highlighted in the Keogh and Stevens reports) enabling patients to access care and services outside of traditional working hours.^{1,2}

Less than full-time (LTFT) working is increasingly seen as part of the solution to this problem – maximising the available workforce of radiologists who may not be able to work full time for a variety of reasons (child care; dependent care; ill health; management or research outside their NHS role; private work and so on) – while improving patient care.

LTFT and flexible working can also help to reduce absenteeism and increase productivity, while offering intangible benefits such as maintaining a sense of professional development and commitment to the profession that 'full time or nothing' solutions negate.³ Additional information about flexible home working and implications for training and trainees can be found elsewhere in the *Sustainable future for diagnostic radiology* series which supersedes the previous 2005 Royal College of Radiologists (RCR) document *Changing working lives*.⁴

Definition and current LTFT working

Less than full-time (LTFT) working is when radiologists are contracted to work for anything less than the normal basic full-time hours, typically less than 10 sessions per week. The *Clinical radiology UK workforce census 2014 report* identified that 23% of consultant radiologists in the UK already work LTFT.⁵

'Approximately one-third of the consultant clinical radiology workforce is female. However, this figure is set to increase as 42% of current trainees are female. In

*2012, one-in-five consultants worked part time (this figure rises to one in four in London). With the feminisation of the workforce, part-time working looks set to increase.'*⁶

Between 2012 and 2014, the percentage of the consultant radiologist workforce working LTFT increased from 20% to 23% indicating further expansion.⁵ As a specialty, radiology reflects the national averages, where part-time workers make up 25% of all workers in Britain with 80% of them women.³

Better work–life balance for all

The reduction in working hours enforced by the *European Working Time Directive*, while seen as improving the traditional highly pressurised culture affecting clinicians, has not solved all the problems associated with work–life balance.⁷ Indeed, the most recent January 2015 British Medical Association (BMA) quarterly report indicated that 45% of 512 respondents have made or are in the process of making changes to their work-life balance.⁸

In line with these general trends, there has been an increase in the percentage of healthcare professionals who are suffering from stress, depression or other

morbidities, with issues such as ‘compassion fatigue’ and ‘burnout’ highlighted in recent research.^{9–11} Additionally, increasingly anti-social hours have led to a number of consultants seeking recognition for the difficulty in maintaining a positive work–life balance. These NHS consultants are not looking for increased rates of pay to compensate for anti-social hours, rather ‘fair equality of leisure time’ that is lost due to extended working practices for consultants across specialties without a commensurate increase in consultant numbers.¹² LTFT working may help to redress this imbalance.

More men and women working less than full time

Up to 75% of women doctors wish to work less than full time or more flexibly at some stage in their career, usually to care for a young family.¹³ The 2014 RCR census indicated that women are still much more likely than men to work LTFT in all age groups, with 42% of female consultants versus 12% of male consultants choosing to work LTFT.⁵ Although the less-than-full-time role has traditionally be seen as a prerogative for working

mothers, there has been increasing interest from male consultants to work more flexibly. From 30 June 2014, every employee has the statutory right to request flexible working, which includes LTFT practices, after 26 weeks employment service. Previously, the right only applied to parents of children under the age of 17 (or 18 if the child is disabled) and certain carers.¹⁴

Increasing proportion of female doctors

The number of women entering medical school has been increased significantly since 2000 – and the Junior Radiologists' Forum (JRF) March 2015 survey showed that approximately 46% of current clinical radiology trainees are now female.^{15,16}

In the *Changing working lives* document (now withdrawn), the increasing tendency to both train and work LTFT, combined with periods of maternity leave, estimated that the total contribution to work in a lifetime is approximately 25 years for a female doctor as opposed to 35 years for a male. The increase in the proportion of female doctors and the corresponding decrease in lifetime contribution to

the field have increased the required number of radiology consultants. Not taking gender differences into account, based on the number of clinical radiology trainees in 2003, the RCR estimated that approximately 3,200 trainees would be needed by the year 2010 to keep pace with the current workload.¹⁷ The diagnostic radiology workload has increased by 10.3% year on year in computed tomography (CT) and 12% in magnetic resonance (MR) studies in recent years.¹⁸ Taking into account the increase in the proportion of female doctors, the need for increased training numbers was calculated to be an additional 15% (equating to, 480 trainees).

Increase in the demand for LTFT training

Despite three radiology academies opening in 2005 with the aim of increasing the number of radiologists significantly over the last decade, there remains an overall shortage of radiologists in post, with considerable variation throughout the UK.¹⁹ Despite more than 250 trainees entering the radiology workforce between 2005 and 2007 and further additional posts funded since then, this welcome investment has, to date, not eliminated the consultant shortages. Nationally, 12% of consultant posts remain unfilled.⁵ There are particular shortages in Scotland and the North of England, whereas in the South of England the shortages are less apparent. Expansion involving new consultant posts is hindered by financial constraints in acute trusts.

In 2005, only 7% of clinical radiologists trained flexibly; the average is now 10.3% (2015 JRF Survey).¹⁵ LTFT training prolongs the time required to obtain a Certificate of Completion of Training (CCT). Based on current trends, if more than 10% of the 2015 expansion train LTFT, this will equate to <1% increase on the established 3,200 consultant radiologists by 2020.^{15,20} LTFT trainees occupying a full-time posts have already had critical impacts on service provision as it has effectively decreased the number of national training numbers available. Indeed, service capacity has become such an issue nationally that some training schemes are attempting to introduce compulsory slot sharing with two trainees occupying a single national training number working 60% of full-time equivalent each. In England,

Tariffs for Training were introduced in April 2014. Central funding of 50% of salary and a training levy was devolved to trusts where trainees were placed, the impact of this is unclear.¹⁹ Currently, the extra costs of handover for two trainees in a single post are absorbed to meet the service components of rotas.

Additionally, educational supervision repeatedly rates lower on *the General Medical Council (GMC) National Training Survey* for LTFT trainees in radiology compared with their full-time counterparts (2012, 2013 and 2014 GMC NTS).²¹⁻²³ Most LTFT trainees prefer to work more than 60% because it is extremely difficult to meet FRCR Level 2 specialty training requirements in six sessions per week. After essential teaching sessions, service commitment sessions (for example, inpatient CT/plain film/ultrasound lists and a multidisciplinary team meeting with preparation time) as well as mandatory rest sessions after overnight on call on some rotas, specialty training opportunities can be extremely variable. This may reflect missing lists or meetings that occur on fixed days that are not routinely worked, but also reduced momentum (such as rapport and confidence in skills) due to extended intervals between cases with the same supervising consultant. There is concern that subspecialties requiring more practical apprenticeships, such as interventional work, may be seen as unachievable by LTFT trainees if 60% becomes the norm. Indeed, some feel that a Fellowship will be mandatory to fulfil the interventional consultant role, especially on call.

Special interests

It is unlikely that any clinical radiologist working a limited number of hours will be able to maintain skills in both special interests and general areas, particularly if the specialist role has little overlap with emergency radiology (for example breast or radionuclide). This may be particularly critical on call, where team support is less likely to be available. A secondary effect of less than full-time working may be that more effort needs to be put into building rapport with referring clinicians and establishing protocols to assist radiographers and technicians, especially as timely requests may need expediting by team members in the LTFT consultant's absence.

Clinical roles evolve throughout each radiologist's career. Thus, a period of retraining may be warranted if a LTFT consultant is asked to renew or expand practice in an area neglected in previous job plans. Ideally, trusts should give all consultants the opportunity to review their job plan when a new post or change in role is being developed, to give all consultants in the department an opportunity to change their own working lives. This can be extremely difficult to balance in the current climate of financial austerity. For further information, the *NHS Job Evaluation Handbook* may be a useful resource when assessing hybrid roles, such as those encompassing shared management positions.²⁴

Continuing professional development (CPD) and revalidation

Supporting professional activities (SPA) sessions in job-plans are already reducing in many departments away from the Academy of Medical Royal Colleges recommendation of 2.5 per ten sessions.²⁵ It is recognised that LTFT consultants need to devote proportionately more of their time to SPAs due to the need to participate in continuing professional development (CPD) to the same extent as their full-time colleagues.

Current British Medical Association (BMA) advice (matching other bodies, for example, the Association of Medical Royal Colleges) is that all doctors are required to undertake the same work for revalidation, and thus need the same basic SPA allocation (AoMRC/RCR 1–1.5 PA) before any other SPA activity is calculated.^{26,27} There is an increasing indication that LTFT doctors may need more SPAs than full-time equivalents to achieve revalidation. Further advice is available in the RCR document *A Guide to Job Planning in Clinical Radiology*.²⁸

Total number of PAs	Number of SPAs
<5.5	1.5
6–7.5	2
8 or more	2.5

Evolution of team working

Successful clinical teams commit their complementary skills to the common goal of excellent patient care while holding themselves mutually accountable. Most organisations, including clinical radiology departments, intrinsically prefer individual to group (team) accountability.²⁹ However, different ways of working, including novel forms of team working, depend upon the development of effective communication networks and evolving shared responsibilities.

Team working also relies upon better communication between colleagues; cross cover for leave and on call should be facilitated. It may be possible (but not compulsory) for one consultant to increase the hours of

work to cover some of the sessions of other team members during periods of leave, with the options of being reimbursed, taking time back in lieu or working on an annualised hour contract. Designated time built into the job plan to take account of the need for a greater degree of flexibility, which would facilitate consultation with both clinical and radiological colleagues not formally timetabled to be at work, should be considered. A degree of flexibility built into the job plan should also enable individuals to take a more active part in teaching and management activities. With good teamwork, arrangements can be made for the team to be fully represented at clinical, management and research meetings with individuals reporting back to colleagues.

Summary of benefits and challenges to working LTFT

Benefits

- LTFT/flexible working allows doctors to take time out to train or learn new skills, volunteer or simply to avoid travelling at rush hour to transform their work–life balance.
- In turn this has been shown, across many industries including medicine, to boost productivity and staff morale.
- LTFT staff have greater resilience including reduced sick leave.
- LTFT doctors initiate and facilitate team working through necessity. For example, experienced LTFT clinicians with management responsibilities may need to delegate, but may develop co-management or shared responsibility roles, supporting clinical leadership, perhaps earlier in their careers than might otherwise have been feasible.
- Individually negotiated job plans mean that there are as many different patterns to LTFT working as there are reasons for working reduced hours.
 - Some consultants choose to work four or five days per week during the school terms, but are off during the school holidays.
 - Others choose to work three long days and essentially commit to providing 80% of a whole-time equivalent radiologist over those days.
 - Extended working days encompassing three programmed activity sessions per day are becoming more commonplace in imaging departments. LTFT 80% might be six sessions over two days in the department, 0.25 sessions for department management/audit meetings, 0.5 sessions designated on call and 1.25 SPAs from home.
- Specialist skills deemed critical to local services can be met and maintained (although more general skills may be lost).

Scenario from a large teaching hospital:

If you want a job done, give it to someone who is already busy ...

Dr W: previous Royal College examiner; President of a national Special Interest Group (SIG) and keen sailor, wishes to reduce his hours to travel more widely at the weekends for competitions.

His clinical director approves 80% LTFT working with Friday afternoon and Monday morning sessions dropped, although he remains on the on-call rota. It's a win–win for the department. Though impossible to replace his breadth and depth of experience, his seniority makes him an expensive member off staff and there are 5% savings to be made across the trust.

When Dr W audits his reporting figures, despite working only eight sessions per week, he continues to report the same number of studies, with increasingly complex MR and CT replacing plain-film reporting.

His experience resonates with a number of LTFT women consultants with years of similar experience. It is indeed possible to cram five days' work into four, but there is now very little time for teaching and he must actively protect his quiet reporting time. As he may not be the one vetting his CT list, he feels more inappropriate requests are getting through and regrets that both the patients and department resources are not best served. It is one consequence of the new way of working that has been very difficult to rectify.

Challenges:

- Breakdowns in communication can have longer intervals before coming to light which may significantly impact on patient care; thus, handover plans may have to be 'personalised' and considered in greater detail than for full-time workers, possibly involving a team approach.
- Due to limited sessions, many LTFT radiologists must accept that some skill sets will be lost due to insufficient volume of work. New plans for shared responsibility on call (for example, separate diagnostic and [non-vascular] intervention rotas) may need to be developed. This may also imply suitable cross-cover arrangements for other skill sets that are outside the LTFT clinicians' competencies.
 - Inversely, if a LTFT radiologist wishes to return to full-time working, there may be an expectation to retrain to regain lost competencies. Generally, departments are very keen to recruit extra sessions from known colleagues, but the process will depend upon the assessment of individual needs and negotiation to deliver the required training and support within a suitable timescale.
- Maintaining CPD, including attending educational or clinical governance meetings on days outside routine working, requires additional negotiation. Although the RCR *Radiology Events and Discrepancies* (READ) newsletter does not obviate the need to attend departmental meetings, it is a useful tool to promote safety in radiological practice and stimulus for personal reflective practice.³⁰
- Lifelong learning is also facilitated by frequent, workflow-efficient electronic text feedback. This is particularly relevant for LTFT radiologists who may be less available to attend multidisciplinary team meetings (MDTs), receive informal verbal feedback or to learn from audit, educational and learning from discrepancies meetings.^{31,32}
- Mentoring, although sometimes a formal arrangement, often develops organically. Anecdotal evidence suggests that some of the doctors who are most nurturing and supportive in their working/teaching practice are exactly the people who are in the department the least to act as a role model, encouraging new colleagues to develop an interest in their specialty.
- LTFT radiologists' contribution to department-wide leave cross cover may be reduced; however, their requests for same are reduced.

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The Royal College of Radiologists. *Sustainable future for diagnostic radiology: less than full-time (LTFT) working*. London: The Royal College of Radiologists, 2015.
Ref No. BFCR(15)10
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