Health Education England listening exercise: junior doctor morale
Understanding best practice working environments
Background
An unprecedented year for junior doctors: 2016

The annual GMC report found the levels of dissatisfaction across the profession has reached a different order\textsuperscript{1}. The morale of the medical workforce has a direct impact on patient safety, the quality of care delivered and productivity.\textsuperscript{1,2,3} The manifestation of low morale, culminated in the first junior doctors’ strike in 40 years. Subsequent studies have demonstrated deep-seated issues around burnout, a lack of support, and not feeling valued.\textsuperscript{1,3}

The number of trainees applying directly into core training after the foundation programme is dropping steadily\textsuperscript{1}. Junior doctors are taking breaks from training citing burnout (50%) and need for a work-life balance (87%) as the reasons. There are similar trends occurring between core and higher specialty training. The Royal College of Physicians’ (RCP) report comprehensively described the sentiment amongst their junior doctor membership in 2016\textsuperscript{3}.

80% felt excessive stress because of their job \textsuperscript{3}

Factors affecting low morale were distilled into four themes including: excessive workforce pressures, poorly managed working environments, lack of interest in wellbeing of staff, and restricted access to good training opportunities. Fifty per cent felt that the on-going low staff morale was having a detrimental effect on patient safety. Despite these pressures, the relationship between junior doctors and patients is largely unchanged, with 96% feeling valued by them.\textsuperscript{3} Relationships with consultants range widely between very good and poor. However, the relationship between trainees and Trust leadership is unequivocal; there is a clear disconnect \textsuperscript{3,4}.

A qualitative study in the British Medical Journal, described a sense of junior doctors feeling ‘dehumanised’ by employers, who increased workload demands without regard for their personal lives.\textsuperscript{5}

25% reported a serious impact on their mental health \textsuperscript{3}

The work set out in this document was initiated by a working group between the BMA, NHS Employers and HEE Deans that sought to address non-contractual issues that arose during the junior doctors’ contract negotiation. HEE describe what they have heard from junior doctors around morale, as well as their experiences of best practice in training environments. In addition to this, some of the Arm’s Length Bodies (ALBs), Health organisations and the Royal Colleges outline their existing and future work and together demonstrate commitment to a collaborative effort to improve the working lives of doctors in training.

NHS Constitution’s 3\textsuperscript{rd} principle

Respect, dignity, compassion and care should be at the core of how patients and staff are treated- not only because that is the right thing to do, but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.
Where have things gone wrong?
Negative themes from a listening exercise

HEE undertook a brief listening exercise to establish whether the negative themes previously identified by other organisations remained\textsuperscript{1,3,4,5,6}.

Two focus groups were held with junior doctors during Autumn 2016. Subsequently the Postgraduate Deans were asked to corroborate the views through their local trainee networks. Alignment existed between the evidence from focus groups, existing literature and Postgraduate Deans. Findings were particularly similar to a listening exercise undertaken by the RCP Edinburgh in 2016\textsuperscript{6}.

The negative themes below persist, despite the Academy of Medical Royal College’s charter for postgraduate medical training which was developed in 2014\textsuperscript{7}.

- **Supported**
  - I am not...“I don’t have a personal relationship with a team or consultant”
  - No one is interested in my personal development”
  - “My training time is unprotected; there is no one to hold the bleep to attend teaching”
  - “Consultants need to be more outwardly supportive of juniors”
  - “Loss of the ‘firm’ means there is no longer a feel of being in it together”

- **Valued**
  - I do not feel...“The work is relentless but no one shows appreciation”
  - “I don’t feel valued or respected anymore”
  - “Rotations are too short so it’s not worth people getting to know my name”
  - “A lot of perks of the jobs have been removed, like the mess and free accommodation”
  - “There is little engagement of the managers; induction should include the directorate and rota manager”

- **Autonomy**
  - I do not feel...“The rota is rigid and poorly managed”
  - “My personal life is significantly disrupted”
  - “I don’t feel protected if I raise a concern”
  - “I am pushed from one ward to another, there is no continuity”
  - “I am treated like a worthless commodity”
  - “I can’t give anonymous feedback”
Good: the exception not the rule
What is working well?

Around the country there are already excellent training environments offering positive role models and developmental work experiences. The listening exercise sought to explore the common features of the best working environments.

Below is a summary of the results:

<table>
<thead>
<tr>
<th>Supervision</th>
<th>Rota management</th>
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<tbody>
<tr>
<td>A named consultant</td>
<td>Co-design between HR and clinician</td>
</tr>
<tr>
<td>Weekly designated contact</td>
<td>Accountable to a clinical director</td>
</tr>
<tr>
<td>Contact details for emergencies</td>
<td>At least 6 weeks advance notice</td>
</tr>
<tr>
<td>Regular feedback on performance</td>
<td>System for illness or life events</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Protected time</th>
<th>Valued by employer</th>
</tr>
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<tbody>
<tr>
<td>Clinical work structured to gain maximum experience (e.g. designated clinic week)</td>
<td>Attention paid to environment (e.g. 24-hour food access)</td>
</tr>
<tr>
<td>Training time allows for study leave and reflective supervision</td>
<td>CEO presence at induction</td>
</tr>
<tr>
<td>Personal life respected</td>
<td>Invested in learning (e.g. QI projects)</td>
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<td></td>
<td>Educational representation at board level</td>
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<tr>
<th>Team working</th>
<th>Support systems</th>
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<tr>
<td>Name badges and introductions</td>
<td>Concise and well-organised HR processes</td>
</tr>
<tr>
<td>Weekly team forum</td>
<td>Simple IT solutions to order investigations and book leave</td>
</tr>
<tr>
<td>Working closely with other disciplines</td>
<td>Integrated secretarial support</td>
</tr>
<tr>
<td>Social relationship building</td>
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**Expectations of junior doctors**
**Themes in best practice environments**

As well as eliciting examples of good practice, the listening exercise produced ideas about junior doctors’ expectations. Themes emerged about the visions they had for themselves, of their employer and how they expect to be supported by regional/national organisations.

Most junior doctors felt disconnected from their employers and this extended beyond trusts, to the regional and national organisations that impact on their working conditions.

A summary of the expectations of junior doctors are depicted below:

<table>
<thead>
<tr>
<th><strong>Doctor</strong></th>
<th><strong>Employer</strong></th>
<th><strong>National and Regional</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Career</strong></td>
<td><strong>Trust</strong></td>
<td><strong>Regional</strong></td>
</tr>
<tr>
<td>• Good training environment</td>
<td>• Considerate rota coordination</td>
<td>• Presence of Postgraduate Deans and Directors of Medical Education</td>
</tr>
<tr>
<td>• Positive work relationships</td>
<td>• Visible CEO and senior management</td>
<td><strong>HEE National</strong></td>
</tr>
<tr>
<td>• Balance of administrative and clinical work</td>
<td>• Shared culture of respect</td>
<td>• Ensure high quality and supportive training environment</td>
</tr>
<tr>
<td><strong>Personal life</strong></td>
<td><strong>Consultant</strong></td>
<td><strong>All National Bodies</strong></td>
</tr>
<tr>
<td>• Acceptable work-life balance</td>
<td>• Present</td>
<td>• Listen to the voice of doctors in training</td>
</tr>
<tr>
<td>• Access to annual leave</td>
<td>• Approachable</td>
<td>• Create accountability</td>
</tr>
<tr>
<td>• Opportunities for less-than-full time working</td>
<td>• Developmental</td>
<td>• Regulate employers</td>
</tr>
<tr>
<td></td>
<td>• Available in a crisis</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Well staffed</td>
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<tr>
<td></td>
<td></td>
<td>• Integrated team</td>
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</table>
**What are HEE doing?**

**HEE listened to the voice of junior doctors during the contract negotiations with the BMA**

A number of projects are underway in response to these requests, which are set out below. Future work includes working alongside NHS Improvement (NHSI) to develop guidance and best practice case studies to share with NHS Providers and other ALB. Furthermore, HEE is strengthening links with Royal Colleges and the Consultant body to help bring about meaningful improvements.

**Support**
- Reviewing the Annual Review of Competency Progression (ARCP)
- Making equitable use of study leave budgets
- Allocating placements considerately for trainees with health issues and caring responsibilities
- Enhancing return-to-training support
- Developing a Quality in Education and Training Framework.

**Autonomy**
- Creating more flexible working patterns (e.g. exploring extension of less-than-full training)
- Designing systems to recognise and accredit experience outside of training
- Facilitating swap process for those with partners and families
- Enhancing transparency in costs to aid decision making (e.g. publishing costs of specialty training for trainee).

**Value**
- Developing the ‘modern firm’ with an initial surgical pilot
- Reviewing length of placements to reduce unnecessary rotation
- Implementing whistleblowing legal protection
- Extending notice for doctors’ placements and rotas
- Developing rota guidelines.

**Supporting learners**

**Improving training**
Existing and suggested work across the NHS

All NHS organisations

- Commit to learning from best practice and case studies identified by HEE and NHSI
- Increase junior doctor engagement at all levels of decision-making
- Appoint an accountable officer responsible for deliverables related to junior doctor morale issues
- Ensure educational representation at board level, and in design of systems and processes.

NHS England

- Facilitate ALBs to work towards sustainable solutions.

NHS Improvement

- Assessment of drivers of low morale in working environment and human resources practices
- Provision of best practice guidance, along with HEE, for NHS Providers and Trusts
- Hosted a roundtable with NHS Providers and other NHS organisations in 2017
- Greater support for Directors of Medical Education
- Appointment of rota guardians in all trusts.

General Medical Council

- Review of flexibility in training with published proposals for making training more flexible
- Embedding doctors in training into design process for National Training Survey
- Development of generic training competencies to support side-ways progression
- Development of credentialing process to offer system agility and individual flexibility
- Ensuring deliverable curriculums
- Changes in GMC Survey to monitor issues related to morale (e.g. pin-pointing rota gaps)
- Review of mandatory training requirements
- Investigate resilience training in undergraduate curriculum.

Care Quality Commission

- Build in issues affecting morale and training into reporting systems frameworks of the ‘Well-Led’ domain
- Raising profile of need for increasing junior doctors representation in inspection process.

Academy of Medical Royal Colleges

- Continue to encourage action on published report ‘A Charter for Postgraduate Medical Training: Value of the Doctor in Training’, endorsed by the BMA, Medical Schools Council, Conference of Postgraduate Medical Deans, GMC, employers and the four UK Chief Medical Officers
- Preliminary work exploring how to build relationships between specialty to specialty, between juniors and seniors, and between clinicians and management
- Managing expectations by publishing a report on Realistic Life of a Junior Doctor.
NHS Providers

- Hosted a roundtable with NHSI chaired by Dame Gill Morgan in 2017
- Engagement with HEE and NHSI on implementation of best practice locally.

British Medical Association

- Working group with HEE and NHS Employers
- Continue promoting voice of junior doctors to relevant organisations

This list has been created from initial collaborative work and is not exhaustive.
Closing Statement

‘It is not for the sake of piling up miscellaneous information or curious facts; but for the sake of saving life and increasing health and comfort’

Florence Nightingale, 1859

The importance of sustained effort in addressing this issue is paramount to our collective over-riding goal to improve patient safety. Florence Nightingale was famed for her work as a statistician relying on good data and evidence to drive forward improvements.

There is unequivocal evidence on low morale and this document presents a strategy on how to improve it. It is now for all organisations to implement and to drive forward improvements. The next step, through collaboration with NHS Improvement, is to recognise and share case studies of excellent training environments for Trusts, to enable them to develop deliverables to improve junior doctors morale.

References

1. General Medical Council. The State of Medical Education and Practice in the UK. Published October 2016.
3. Royal College of Physicians. Being a Junior Doctor: Experiences from the front line in the NHS. Published December 2016.