## APPENDIX B

### Approaches to Flexible Working – Evidence from the individual specialties

### Obstetrics & Gynaecology and Paediatrics

1. Obstetrics & Gynaecology (O&G) attracts a high number of female trainees and, as the training programme is seven years in length, a large number of trainees take maternity leave and then opt to train less than full time (LTFT). The Royal College of Obstetrics & Gynaecology (RCOG), believe that HEE and employers are currently able to accommodate requests for LTFT / flexible training. However, the steady increase in requests, plus the specialty's run-through training programme and decision not to recruit above ST1 entry, makes this challenging. This is exacerbated where the attrition rate is high (e.g. 23% in London). Locums at ST3 and above are difficult to find, as there is no route for them back into the training programme.

2. In Paediatrics, the training programmes are approximately 70% female, and the College has been a strong advocate for making LTFT training easily available as a means to boost recruitment and retention. LTFT has steadily increased and almost 33% of Paediatric trainees are now working LTFT. The range of LTFT working is from 0.5 to 0.8FTE and feedback suggests that this has enabled a lot of doctors to become paediatricians, who otherwise would not have continued because of other commitments.

3. Previously in O&G, doctors would wait for job-share arrangements to enable LTFT training, but the specialty has adapted to manage demand. The College's LTFT policy was initially designed to maximise slot shares, and matching two trainees at 50% or 60% (with 10% 'top up') and proved to be a successful model. However, as LTFT working requests increase,[1] and more gaps occur, it is becoming more challenging to manage slot shares, partly because many LTFT trainees are geographically restricted, and partly because Trusts are struggling to backfill posts.

4. Understandably, Trusts dislike having a 60% trainee in a full time slot, but in Paediatrics, where there are frequent rota gaps, most are happier to have at least half of their gap filled when a full time doctor cannot be provided. Higher numbers of LTFT trainees can also even out gap rates between different hospitals.

5. The increasing demand for LTFT in O&G also now includes some requests to train at 70-80% of a full time rota, as well as a number of male trainees requesting to work LTFT. In Paediatrics there has also been an increase in LTFT training requests from male trainees who are fulfilling caring roles, and from trainees with health needs.

6. In addition, there are requests to create a system with increased flexibility in working times, e.g. term-time only; working from 10am until 3pm to accommodate school hours; exemptions from on-call rotas; and support for trainees who are relatively geographically fixed.

7. The management of LTFT working can be challenging in terms of determining which days are non-working, e.g. as doctors request Friday and/or Monday off and specific requests for days off may not be possible.

8. Doctors no longer expect to train all over the country and are increasingly unhappy with the level of rotation between employers. LTFT Trainees are concerned about whether they can move rotations/programmes to fit family requirements or to access OOP opportunities. However, if trainees have all of their training in one hospital/ city it may

[1] Currently approximately 30% of trainees are either OOP, on maternity leave, or training LTFT

not be possible to create a well-balanced training rotation and could disadvantage trainees without children.

9. Some O&G schools have split larger regions into geographically smaller hubs of training in which trainees remain for the full seven years' training, to minimize impact on home life and reduce travelling. This can be difficult because of differences in the distribution of ST1 and ST2 posts. If training posts were placed at ST1 and ST2 to allow individuals to stay for ST3–7 posts in hubs across the country, the number of Local Education Providers (LEPs) delivering training might be reduced, largely to the expense of geographically remote locations, which could affect service with a lack of availability of a middle grade workforce, and a resultant inability to attract consultants.

10. There are also limitations with sub-specialty exposure for paediatric 'slot sharers' as it is more difficult to place LTFT trainees with differing interests and requirements. Training can be very disjointed and LTFT doctors often put a lot of additional unpaid time into their training. A six month post may give sufficient experience for a FT trainee, but this may not be sufficient for a LTFT trainee with less continuity of exposure.

11. Other trainees (usually full time) have reported that they are asked to perform extra duties, as the numbers of LTFT trainees increase, which may impact on training quality. The high number of mid-grade rota gaps in O&G has created increasing service pressures, and fostered a feeling that OOP is becoming less accessible. The increasing problems with rota gaps and vacancies at middle grades in paediatrics across England, is also having a knock-on effect on the work life balance of all junior doctors including those working full time. Vacancies are resulting in restrictions to OOPE/OOPTs at each level.

12. There are concerns on the ground that there are an insufficient number of trained doctors to safely staff Obstetric units, yet there is also awareness that there is a predicted oversupply. Feedback from junior doctors suggests that it is now unrealistic to think that the reasons for, and expectations of, working flexibly will stop at consultant level. Yet currently most of the LTFT trainees return to full-time after some years. This may be because of the difficulties with consolidating surgical skills and getting enough 'surgical time' to feel confident. This can include both labour ward skills, and theatre time. This is a common concern amongst LTFT trainees as they become more senior, is often cited as a reason for return to full-time working. A significant increase in job-share consultant posts would require a significant culture change.

13. It has been noted in paediatrics that it can also be difficult to support the specific needs of LTFT trainees on their return to work. In Paediatrics, the potential of a greater psychological and emotional impact of returning to working with sick young children is recognised. It is not clear what opportunities there are for reduced or no out-of-hours shifts on return to work, and access to "keeping in touch" days when rotating to a new employer is unclear. Long-term educational supervision is seen as a key enabler.

14. There has also been an increase in trainees who are voicing a desire to train LTFT, not because of caring responsibilities, but because they feel overburdened by full time working. As they are not carers, and have as yet not reached a point of having obvious difficulties with coping or mental health issues, they are not eligible. Currently trainees need to justify LTFT working, and there is not an opportunity to apply for LTFT as a preventative measure. There is a stigma to applying, especially when it creates vacancies. This seen in feedback from a number of specialties, especially those with significant service or training pressures, e.g. higher medical specialties covering the acute take, or higher surgical training.

**15.** Despite all the difficulties cited above the Royal College of Paediatrics and Child Health, and The Royal College of Obstetrics and Gynaecology, and the associated educators in training programmes, have continued to support greater opportunities for working LTFT, and explore ways of enabling this.

### Other specialties

**16.** Some specialties only permit a 50% LTFT training pattern, rather than a range of options. This is easy to manage but does not suit everyone and could unnecessarily prolong training for those wanting a more flexible training pattern.

**17.** In specialties where LTFT is slightly higher than the national average, e.g. Anaesthetics, where it is around 12%, there has been debate about how to increase flexibility. The RCoA, Council, Regional Advisers, TPDs and Heads of Schools support extending LTFT training opportunities in principle, recognising there may be doctors in training who are currently excluded, who could benefit from an option of reduced training hours. However there is concern about funding implications, maintaining the service and an unintended impact on full time trainees. Further detail on the current provision and attitudes towards LTFT training in Anaesthetics can be accessed online.[2]

**18.** Support to increase flexibility in training, including LTFT, is also being explored in specialties where there is a relatively low number of female trainees in the specialty, for example Intensive Care Medicine, where 35 % of training doctors are female, and in Surgical specialties. Here there is a belief that there needs to be a change in culture and attitudes of many of the current consultant workforce to be able to make LTFT training a more attractive and widely available. More outcomes-based curricula and robust assessment models have been highlighted as key enablers for this.

**19.** In 2014, the Royal College of Surgeons released a position statement on LTFT training, recognising that better flexibility could support recruitment and retention in the surgical specialties. The College recognises that LTFT training can be invaluable in permitting a trainee who would otherwise leave the profession to progress to the next stage of her / his career. All the Presidents of the Surgical Colleges have acknowledged that a cultural shift is still required. The ASiT survey of 870 surgical trainees on their experiences of LTFT training, published in the International Journal of Surgery, marks an opportunity to address this recognised need for change.[3]

**20.** The psychiatry training culture is generally accepting of LTFT training, and with recent recruitment levels generally LTFT trainees are in full-time slots rather than slot shares, but this is viewed as also having advantages for managing rotational placements and meeting individual educational needs. In a specialty with recruitment challenges the College believe that opening up LTFT training beyond the current Gold Guide criteria could have a positive impact on retention, and on training culture.

## Current successes in enabling flexibility in junior doctors' working lives

[2] The RCoA published *Less Than Fulltime Training in Anaesthesia & Intensive Care Medicine: An A to Z Guide* on their website in November 2015, accessible at http://www.rcoa.ac.uk/careers-training/training-anaesthesia/special-areas-of-training/ltft-anaesthesia-z-guide

[3] The open access BMJ article, reporting on the outcomes of the survey can be accessed at https://www.asit.org/Content/DynamicMedia/cms-uploaded/files/BMJ%20Open-2016-Harries-.pdf

**21.** When LTFT requests are mainly in higher training years, gaps are on the senior rotas and consultants are often filling these gaps, e.g. in Obstetric units. This addresses the problem but can demoralise consultants, and a review of the configuration of the service workforce is needed so individuals do not feel they are 'acting down'

**22.** Contracted Clinical Fellowships with special interest sessions/ research sessions and teaching posts are employed to cover O&G rota gaps. These attract good candidates and help to stabilise the workforce. Trusts are also using overseas Medical Training Initiative (MTI) doctors to support rotas.

**23.** Flexible training options are much easier to create when departments are fully staffed. LTFT options can even out some gap rates between different hospitals, and flexibility in creating programmes, e.g. three trainees in two slots (80,60,60%), reduces the number of gaps. This requires either an increase in trainees or a reduction in the overall number of training posts if LTFT training increases.

**24.** Effective slot shares require coordination between trainees well in advance of commencement. Rotation planning can be complicated, but this is mitigated when doctors in training can take greater ownership in addressing problems. Slot shares can be provided to LTFT trainees in subspecialty modules with planning. Allowing greater future flexibility would require more sophisticated rotation planning. These solutions require doctors in training to be flexible in finding solutions and to compromise, although many already use some of their time away from training to catch up on experience.

**25.** O&G is a broad craft specialty, so trainees need wide experience to demonstrate their competencies with confidence. This can be challenging for LTFT trainees if all the basic clinical experience does not fit in a 60% timetable; however, timetables can be rotated over a period of weeks to incorporate all of the required activities. This can work well, although it can create delays in the approval of timetables and people are not used to the concept of a two or three week rolling timetable. It is hoped that an expansion of the proposals for a targeted return to training initiative could help address this by allowing doctors to access additional opportunities.

**26.** Most Anaesthetic specialty schools in England have a LTFT consultant specialty advisor, and three quarters have a forum where trainees raise LTFT issues. The consultant LTFT advocate in each School help doctors in training to find local solutions. In Paediatrics, when there is a specific LTFT advisor within the trust, trainees have been better supported in arrangements around maternity leave and in making decisions on the percentage of full time training. The champion of flexible working, which is proposed in the new junior doctor contract in England, is therefore something to promote and encourage.

**27.** In Psychiatry, all six higher specialty programmes have one day allocated per week for special interest/research, which is ring-fenced from other clinical duties. Prior to the Modernising Medical Career reforms, this was two days per week, one for research and one for special interest. Under the current system, the one protected day is used for either research and/or special interest sessions. The sessions are well-received by trainees and an accepted part the culture of higher training in psychiatry.

**28.** Reducing the bureaucracy associated with LTFT is thought to be important by a number of Medical Royal Colleges, with changes to the ARCP process required to reduce the burden for trainees. Ensuring that educational supervisors have good information about flexibility in training would greatly support trainee access, and feedback from HEE's LTFT Forum suggests that this could be improved. Some Colleges have produced

documents or FAQs on LTFT training, e.g. the RCoA “A-Z of LTFT Training”, providing comprehensive guidance for those working LTFT. There are national LTFT fora, and some colleges are considering national flexible training days for information sharing and problem solving.

### Suggestions for further exploration:

**29.** Different flexible options, not just LTFT, e.g. roles that allow trainees to engage in research or teaching as part of a full time week, have been highlighted as an effective approach

**30.** The development of child health workforce including children’s nurses and advanced nurse practitioners is recognised as a major mitigating factor to the need for increased flexibility. HEE’s workforce strategy includes the development of other roles and this could help mitigate the risks involved in increasing flexibility in the future.

**31.** Exploration of the intentions of the current trainee workforce with regard to future consultant working patterns is needed: Do LTFT trainees tend to take up posts as full time consultants because there is a shift to more control of working patterns, and so they can ensure other responsibilities can be managed? Do trainees take up full time posts to maintain their craft skills? Do doctors opt for full time consultant posts as there are currently insufficient flexible options?

**32.** In run through specialties, the possibility of introducing other recruitment entry points may deserve further consideration to allow more flexibility in stepping in and out of training. It is not easy for all doctors to manage dual commitments and many might consider ‘pausing’ training if it was easier to do so.

**33.** Greater ability to change the proportion of LTFT working as circumstances change. This could be challenging, but some doctors would like to have the opportunity of formally working at different proportions of full-time training as their other commitments change, and this could reduce the vacancy factor.

**34.** Changes to service provision need to be considered and some, such as pooled Out of Hospital commitments could benefit LTFT training doctors.

**35.** It was also proposed that restrictions preventing LTFT trainees from earning additional money should be reviewed, as the rules do not apply to full-time trainees. As LTFT doctors in training earn less than their full time counterparts, they have the most to benefit from this change.

**36.** Trainees highlighted that they would also welcome opportunities for less rigid employment arrangements e.g. being able to annualize hours e.g. to support childcare during school holidays.