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Health Education England

Increased Opportunities for Less Than Full Time Training For Junior Doctors – Pilot Proposal

Introduction

Alongside the focus on the new contract, the junior doctors' dispute also highlighted wider, non-contractual concerns around medical training, particularly the need for greater flexibility and to boost morale. This is core business for HEE, but has provided fresh impetus to explore innovative solutions and develop new approaches to postgraduate training.

HEE is taking forward a range of initiatives to address these concerns. One such initiative, agreed with NHS Employers and the BMA JDC, is to explore providing more opportunities and wider access to less than full time training (LTFT). It is thought that a more flexible approach may:

- reduce 'burn out' and attrition;
- boost morale; and
- aid recruitment.

There is sociological evidence to support this approach to modern training methodology. Generational theory has emerged from hard evidence and ongoing research, and provides a scientifically credible basis for understanding society and groups.[1] Our more senior trainee population are "Generation Xers" and are known to prefer options and flexibility; they dislike close supervision, preferring freedom and an output driven workplace. They strive for balance in their lives, they work to have a life, they don't live to work. Our more junior trainees, the "Millennial Generation", have grown up quickly in an age of unprecedented diversity and exposure to other cultures. They are confident, assertive and have been characterised as "Generation Why". They have strong ethical principles and demand a reason and rationale; the traditional "because I said so" isn't going to cut it with them.

Therefore, it is intended to undertake an initial LTFT pilot from spring 2017 for all Emergency Medicine (EM) higher trainees across England.

Historical data is difficult to analyse, but in broad terms the starting position is that up to 50% of all those who start training in Emergency Medicine permanently leave the specialty prior to completing training. Some take career breaks, training opportunities elsewhere in the UK and overseas, but they are usually retained within the specialty. We already have evidence that more recent changes within the specialty may have reduced this level of attrition, but until we are able to observe a full training cycle, firm conclusions would be premature.

In the 2015 Emergency Medicine Trainee Association (EMTA) survey, 76% (575 respondents) report being at risk or high risk of burnout. In the same survey, trainees called for increased flexibility and in particular increased availability of less than full time training for all trainees.

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[1] Howe, N., & Strauss, W. *Millennials rising: The next great generation* (New York: Vintage, 2000); Evans, K.H., Ozdalga, E. & Ahuja, N. "The Medical Education of Generation Y" *Academic Psychiatry* (2016) 40: 382; Codrington, Graeme and Grant-Marchall, Sue *Mind the Gap!*, (Penguin, 2004); Wolfinger, Emily and MrCrindle, Mark, *The ABC of XYZ* (UNSW Press:2009); Kupperschmidt, B. R. "Multigenerational employees: Strategies for effective management", *The Health Care Manager*, (2000), pp. 65-76.

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It is intended that learning from the pilot be shared with other specialties and across the wider system.

Background

The 'Working Group on Improving Junior Doctors' Working Lives' met in March 2016 to discuss non-contractual matters relating to education and training that had been raised through the discussions in parallel with the junior doctor contract negotiations. Access to LTFT training was discussed, in particular the possibility of allowing **all** junior doctors the ability to work flexibly should they wish to. Although the Gold Guide makes clear that any trainee with a well-founded individual reason should be permitted to train LTFT, junior doctor representatives reported that some trainees do not consider this option in the absence of a caring responsibility.

It was suggested that this would not significantly reduce output as only a few trainees would access this, but it would significantly reduce attrition from the specialties covering the high pressure workload of acute and urgent care. There was a belief that simply knowing that there was the option to rebalance their lives for a period of time, would encourage junior doctors who were concerned about their ability to continue to work in very pressured environments to continue in training, especially as more flexible consultant working is becoming much more common. It would also reduce HEE costs relating to sickness absence and supported return to training, and the negative impact on individuals and their careers.

Whilst there was recognition of the potential benefits for junior doctors in allowing a more flexible approach to LTFT training, and agreement that LTFT working may also improve retention, there was a degree of apprehension as the impact of a more flexible approach is not known.

In April 2016, 87 trainees in England were training less than full time in Emergency Medicine, 7.7% of the total cohort. According to the Gold Guide, the only requirement to be permitted to train less than full time is a well-founded, individual reason. Applicants for less than full time training are prioritised into two categories, but the Less Than Full Time Training Forum feels that everyone who wishes to train LTFT is accommodated. Usually, less than full time trainees have a disability or health issue or a significant caring responsibility, but there are those who have a unique opportunity for personal or professional development or a religious commitment. It is not known whether a cohort of trainees exists that would wish to train LTFT outside of those categories.

In 2014, Health Education England substantially increased its ST1 intake from around 200 to over 300; the majority of this cohort will enter ST4 training in 2017. In addition, 61 Direct Route of Entry (DREEM) trainees were appointed in 2014, the majority will enter higher training in 2017. There will be attrition and trainees taking time out of programme, or slowing progress for other reasons, but it is expected that the number entering ST4 in 2017 will be at least 100 more than ever before.

Even if the proportion of higher trainees training LTFT tripled to 24%, then the trainee whole time equivalent workforce would still be significantly higher than in 2016.

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Proposal

It is proposed to implement a 12 month LTFT pilot from Spring 2017 for all EM higher trainees across England.

- Emergency Medicine is a specialty where we need to build upon recent improvements in recruitment to ensure workforce supply.
- This would be a controlled sample of approximately 478 higher EM trainees in England,[2] in a specialty with a sessional shift working pattern, which will facilitate rota management;
- The Royal College of Emergency Medicine (RCEM) has provided written support for this pilot; the Chair of the Training Standards Committee is a member of the smaller Working Group which developed this proposal.
- The proposal was initiated with the support of the previous RCEM President; the incoming President has confirmed ongoing support.
- NHS Employers, the AoMRC and the BMA Junior Doctors Committee have confirmed their support for the pilot as part of the Improving Working Lives Group and within the smaller Working Group which developed this proposal.[3] The implementation arrangements were discussed at the Medical Workforce Forum on 23 September.
- The GMC have confirmed their support for the pilot as part of the Improving Working Lives Group. They have confirmed that there are no regulatory issues.
- The pilot principles were discussed at the DH Implementation and Engagement Board and were supported by NHS Improvement and NHS Employers.

The purpose of the pilot would be to assess the popularity and impact of a more flexible approach to training. This is an opportunity to identify the benefits and address obstacles and risks of being more flexible, using a controlled sample.

The pilot would permit all higher EM junior doctors in training to apply for less than full time training (at 50%, 60% or 80% of a full time post). It is proposed that the pilot would be an England-only initiative under HEE, and would involve all local offices.

If LTFT trainees wish to increase their training time, or return to full time training, this will be accommodated when agreed by the Training Programme Director given the training capacity available across the programme. This usually aligns with the rotation date, but may not be immediately available.

This proposal would not be applicable to those who are out of programme or undertaking acting up arrangements, but would be permissible to those who are working as an NIHR Academic Clinical Fellow or Clinical Lecturers.

[2] Number of trainees in ST4-6 Emergency Medicine as per the April 2016 stocktake

[3] See Annex A for notes of endorsement from NHS Employers, the AoMRC the BMA JDC. A further note of endorsement is expected from the GMC in early 2017.

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What would this mean for trainees and local HEE offices?

Trainees in higher EM across England would have access to LTFT training from Spring 2017, without needing to demonstrate a case of need. In brief, these individuals could request LTFT training, at a rate of 50%, 60% or 80% (at the trainee's discretion where possible). Robust communications will be put in place to ensure that trainees are aware that pilot places are not guaranteed. Whilst the intention is to approve all applications, the implications for service and educational standards would require consideration in all cases.

Should there be a higher than expected demand, normal application processing times may be exceeded and a waiting list may be required. Availability will be on a first come first served basis. Availability will be reviewed regularly to ensure stability of the workforce and to ensure any patient safety risks are identified and managed; approval of less than full time training will be dependent upon exigencies of the service. Applications for those individuals who demonstrate they meet the Gold Guide criteria would need to be prioritised. Given the total increased trainee population, we would expect employers to support where necessary an increased proportion of trainees training LTFT. Should the proportion of LTFT trainees approach 20% a waiting list may be required. It is quite possible that demand will be low.

What would this mean for employers?

All training providers will be expected to support the pilot objectives, but Training Programme Directors will need to manage trainee placements to ensure a balanced, equitable approach as they do now. In particular, they must ensure that no one location is put under pressure by having large numbers of LTFT trainees.

Ultimately, if the employer is unable to support the proposed LTFT trainee, then they are free to decline the arrangement; an individual's needs and expectations must be considered in the context of educational standards and service capacity.

As noted previously, the occupancy rate for higher Emergency Medicine training in 2017 will be higher than it has ever been. Even if a higher than anticipated proportion of trainees wish to train LTFT, as a direct consequence provider costs will be reduced as the demand for locums and agency charges will be less.

Trainee doctors within the pilot would not be able to choose which days they wish to reduce their hours and working hours/days would be agreed with the employer/host organisation.

Evaluation

The evaluation mechanism would need to be agreed but would require feedback from employers, RCEM, trainees and HEE.

It would be a mandatory requirement for trainees accessing less than full time training under the pilot to contribute to the evaluation process.

Once the pilot application window closed, the Working Group would have an opportunity to review the number of expressions of interest, analyse the data and to model and evaluate the impact of such a change on a number of levels. Consideration will be given to the impact on remaining trainees (who continue to work full time); financial impacts (on a broader level); and both the financial and service impact for employers from a workforce

perspective. Once the analysis and further modelling has occurred, recommendations and planning for the proposed pilot would proceed.

As part of the pilot evaluation, HEE would apply robust analysis of the qualitative and quantitative outcomes based on real data.

Tier 2 Impact

Tier 2 applicants would need to liaise with their HEE local office to ensure that any proposed reduction in working pattern does not compromise their visa requirements.

Equality Impact Assessment

Hill Dickinson solicitors would be requested to undertake an equality impact assessment on the proposal to ensure that any equality issues are identified.

Duration of Pilot

The duration of the pilot would need to be agreed.

Inter-deanery Transfer (IDT)

Higher EM trainees who are approved under the pilot by a local office (who do not meet the Gold Guide criteria) and wish to undertaken an IDT to Scotland, Northern Ireland and Wales would not be eligible to remain less than full time upon transfer (unless they have had a change of circumstances and subsequently meet the Gold Guide criteria – and are approved by the accepting organisation).

Higher EM trainees who are approved under the pilot by one HEE local office may transfer to another HEE local office and access the same less than full time commitment, subject to exigencies of the service.

Initial HEE Cost Modelling

Costs for LTFT trainees are potentially higher where local offices provide a top-up payment to cover employer administrative costs of accommodating a LTFT trainee. In addition, LTFT trainees require at least an annual ARCP and it is likely that curriculum delivery costs will be higher over the duration of the programme. However where training capacity is limited, a higher proportion of slot shares makes less than full time training financially more efficient.

A review is being undertaken to explore a consistent funding arrangements for LTFT training across England.

Conclusions

To support HEE's wider agenda to enhance junior doctors' training, we would like to pilot increasing opportunities for LTFT training. It is thought this could:

- reduce 'burn out' and attrition;
- boost morale; and
- aid recruitment.

Consequently, HEE Exec is invited to:

- comment on the proposals;
- endorse the implementation of the pilot from Spring 2017