

Enhancing junior doctors' working lives

A progress report



Developing people
for health and
healthcare

www.hee.nhs.uk

Foreword

This report is an important milestone in Health Education England's ongoing commitment to improving the quality of education and training for doctors.

We were all aware of reports of low morale across the junior doctor workforce and indeed it was as a result of potentially the first ever strike by these doctors that it became abundantly clear that there was much more to their unhappiness than the actual contract of work itself.

HEE willingly took responsibility for working with employers, the British Medical Association's Junior Doctors' Committee (JDC), other junior doctor groups and the Academy of Medical Royal Colleges amongst others to address these additional concerns that became known as 'non-contractual training issues'.

I believe that with the development of postgraduate medical education and training from the time of the Calman report we, collectively, had lost sight of the human side of working as a doctor in training in the NHS.

Despite the best intentions of all concerned, reports of lack of information about rotations and on call duties prior to starting a new job were common. Different interpretations of the many rules governing training were a source of frustration. The rising costs of developing as a professional mandated by regulation were a major concern. These were just some of the issues raised during talks between the JDC and NHS Employers.

As is clear from this report, there has been good progress made on addressing these challenges, ranging from new legal protection for junior doctors raising patient safety concerns and the impact on their training to an agreement that HEE will develop a policy to enable joint applications from couples by next year's recruitment cycle.

The formation of the 'Improving Doctors' Working Lives' group has created a forum where these and the other issues detailed in the report can be discussed and debated and plans to improve matters agreed.

The committed input of all members of this group has been invaluable, as has the wider support from across the NHS.

Morale among doctors in training is nevertheless still fragile and it will take more than the process improvements already implemented to improve that.

The NHS needs these vital clinicians to feel valued and supported and that they are key components in all aspects of the service.

They should not have to compromise their training in order to deliver the service - we all need to recognise and respect their professional needs as well as their professional skills.

Enhancing junior doctors' working lives: a progress report

The appointment of the Guardians in every trust is to be welcomed as a new role to give doctors a direct contact to discuss problems with rotas, including workload, and I hope this report will increase awareness in all those staff who are in contact with doctors in training so that we can continue with the work we have collaboratively started.

Working together with trust and honesty, delivering what we have promised and ensuring mutual respect across all healthcare staff, along with the individual changes resulting from the interventions agreed in this report, will be the start of re-building morale.

I am grateful to all those who have contributed to this work over the past eighteen months. There is clearly more to do and HEE will work with all concerned to continue to raise the quality of training and the quality of doctors' working lives.

Professor Wendy Reid
Medical Director
National Director of Education and Quality
Health Education England

Contents

	Executive summary	5
1.0	Introduction	15
2.0	HEE's working group on improving junior doctors' working lives	18
3.0	Progress update	20
3.1	Difficulties that arise from late rota notification and fixed leave	20
3.2	Deployment problems with inter deanery transfers and joint applications	20
3.3	Limited options for doctors to train flexibly	21
3.4	Varying equity in study leave provision	33
3.5	Potential improvements needed in induction and mandatory training	35
3.6	The rising costs of the training package for individual trainees	36
3.7	Inequality in time out of training	38
3.8	Lack of support for pre-specialty / post-foundation doctors	39
3.9	The need to move home repeatedly during training	40
3.10	The need for a mechanism for whistleblowing against HEE	41
4.0	The context – HEE's wider work programme	42
5.0	Learning from HEE's listening exercise	45
6.0	What are the next steps?	47
7.0	Conclusions	43
	Glossary of abbreviations and initialisations	
	Membership of the working group on enhancing junior doctors' working lives and other contributors	44

Executive Summary

A progress report, including conclusions made by Health Education England's working group on improving junior doctors' working lives.

1. Health Education England (HEE) is the national body responsible for the postgraduate education and training of doctors and dentists in England.
2. The widespread discussions around a new employment contract for doctors in training programmes revealed a significant number of additional non-contractual training issues and concerns. These were having a negative impact on the working lives of many doctors in training, on top of a number of broader service challenges including the increasing work pressures and rota gaps. These other non-contractual issues had also been noted by HEE through our regular feedback mechanisms and were also highlighted by the General Medical Council (GMC) quality assurance processes. While there remain high reported levels of satisfaction with the medical training experience in the UK, these other issues were significant and important to address.
3. It was important to reach agreement on which of these significant training issues to focus. Equally, there needed to be a commitment to address them. This was decided through:
 - tripartite discussion between the British Medical Association (BMA) Junior Doctors' Committee (JDC), NHS Employers and HEE in a subgroup set up in parallel to the contract negotiations;
 - negotiations conducted under the auspices of the conciliation service ACAS, which led to the agreement between the BMA JDC, NHS Employers and the Secretary of State for Health; and
 - commitments made by the Secretary of State for Health in response to junior doctor feedback.
4. The agreed training issues identified were:
 - difficulties that arise from late rota notification and fixed leave;
 - the mechanisms to deploy junior doctors in certain areas or regions that do not adequately facilitate caring responsibilities or the maintenance of relationships and family life;
 - limited opportunities for doctors to train flexibly, including structural and cultural barriers to less than full time (LTFT) training;
 - varying equity in study leave provision;
 - the need for improvements to induction and mandatory training, including an end to unnecessary repetition;
 - the rising costs of training for individual junior doctors, including the cost of examination fees;
 - inequality in time out of training – the need to help doctors with improved, and more individually tailored, support upon their return to training;
 - the need to support an increasing number of doctors at the post foundation/pre-specialty level who are looking for a more flexible approach to career progression;

Enhancing junior doctors' working lives: a progress report

- the need for trainees to move home repeatedly during training where this lacks educational justification or support from trainees; and
- the need for clearer legally-binding protections for junior doctors if they believe they are subject to detrimental treatment by HEE as a result of whistleblowing.

These specific 10 issues were not intended as a comprehensive list of all the challenges facing medical training, but as significant areas on which to focus our work.

5. Further feedback from doctors in training confirmed that these were in fact significant issues and HEE also undertook a more systematic listening exercise to identify wider non-contractual issues affecting morale, as well as seeking examples of good practice. The learning from the listening exercise is examined in further detail in [Chapter 5](#).
6. This report details progress with the ten significant issues identified for a particular focus (paragraph 4). However, there is a recognition that there are still other significant issues to be addressed in the NHS which affect junior doctors and their training. HEE, the medical royal colleges, the GMC, NHS Employers and the BMA are all committed to continued collaborative work, with regulators such as NHS Improvement (NHSI) and the Care Quality Commission (CQC) to make improvements across the system.
7. In terms of those specific ten issues listed, these have been addressed through a variety of means including:
 - by HEE using existing channels such as the medical and dental recruitment and selection programme (MDRS),
 - through a new working group on improving junior doctors' working lives; and
 - by other working groups.

This is summarised in the table on page 7, which provides an overall assessment of current progress and sets out what has been achieved, the next steps, where appropriate, and who has led the work.

8. To put these issues in context, this report also describes some other relevant initiatives being taken forward by HEE to ensure postgraduate medical training is fit for the future. HEE is committed to ensuring that these other initiatives also involve similar joint working with junior doctor representatives from the BMA, the GMC, medical royal colleges and other stakeholders. [Chapter 4](#) of this report provides further detail on this wider work programme.
9. In addition, there are a number of other national initiatives which are also driving improvements for doctors in training: such as the work being taken forward by the Academy of Medical Royal Colleges and individual medical royal colleges; the GMC Flexibility review; and reform of regulation and postgraduate curricula through the new Standards for Curricula and Assessment and the Generic Professional Capabilities.

10. The working group on improving doctors' working lives discussions also highlighted that the wider issues needed to be addressed by partners across the system, including commissioners, regulators, employers and education providers, if we are going to achieve a significant change in the working lives of doctors in training. The suggested actions are:

- Increase awareness of the ongoing work to improve training, and of the improvements made, amongst doctors in training and their educators, and amongst other relevant stakeholders. This will ensure opportunities to effectively collaborate are identified.
- a regulatory focus on valuing the workforce, including doctors in training, and on promoting shared solutions/ best practice across the NHS by system regulators, professional regulators, and HEE;
- creating a culture change in the NHS and championing flexible working more broadly, including beyond doctors in training;
- prioritising the provision of education support and an increased focus on supporting individuals to train, based on their particular circumstances and career aspirations;
- exploring flexible training models and enhancing education and training beyond the traditional pathway;
- developing an extended multi-professional workforce to address workload and quality issues which supports, rather than competes with, junior doctors' training; and
- improved workforce planning informed by information/research into the motivations and future career intentions of the current junior doctor workforce.

Enhancing junior doctors' working lives: a progress report

Overview of the actions	State of progress	What has been done?	The next steps and deadlines	Who has led the work?	Page
Chapter 3.1 – Difficulties that arise from late rota notification including fixed leave					
<p>HEE has instigated a change in process which will ensure that doctors are informed of their placements with 12 weeks' notice rather than the previous target of 8 weeks, and informed of their rotas with 8 weeks' notice rather than the previous target of 6 weeks, enabling trainees to better plan their lives.</p>	<p>In place</p>	<p>The Code of Practice, agreed between the BMA, NHS Employers and HEE, was updated in November 2016 to reflect these improvements. HEE have also fundamentally changed their internal processes to allow these timeframes to be met, recognising that even the previous shorter notice periods were routinely falling short for too many trainees.</p>	<p>Each local office's compliance with these new timeframes are being monitored and reported to the HEE Board, who have adopted this as a key performance metric. Compliance figures will be published on an ongoing basis.</p> <p>HEE and NHS Employers will consider the benefits of incorporating compliance with the Code of Practice into the Learning and Development Agreement (LDA) between HEE and employers, to also be monitored through the quality framework, being mindful of the impact of 'exceptions'.</p> <p>Collaboration across the MDRS and ARCP review programmes, the medical royal colleges and other stakeholders will take place to reduce the 'exceptions' to delivery on the Code of Practice.</p>	<p>HEE's medical and dental recruitment and selection programme</p>	<p>20</p>

Enhancing junior doctors' working lives: a progress report

Overview of the actions	State of progress	What has been done?	The next steps and deadlines	Who has led the work?	Page
Chapter 3.2 – The mechanisms to deploy junior doctors in certain areas or between regions do not adequately facilitate caring responsibilities or the maintenance of relationships and family life					
HEE has launched changes that will enable better flexibility in recruitment for those applying for 2017 recruitment (from November 2016 onwards).	In place	HEE already offers joint applications as part of the 4 nations system in foundation recruitment.	<p>Ahead of 2018 specialty recruitment, HEE will, jointly with the BMA:</p> <ul style="list-style-type: none"> • Scope the logistical viability of opening linked specialty applications via Oriel in 2018 • Review the number of junior doctors with general parental responsibilities to explore future possible options including pre-allocation. This will be based on the number of potential requests collected as part of 2017 recruitment to inform this consideration. 	HEE's medical and dental recruitment and selection programme	<u>20</u>
		New "Inter-Region" transfers are in place ahead of the Inter-Deanery Transfer (IDT) window in February 2017, removing the previous potentially counterproductive requirement for an ARCP outcome 1 to have been obtained, for trainees moving within England.			
		HEE has ensured pre-allocation for trainees with certain specific caring responsibilities or ill health/disability tying them to a specific location, and has put in place facilitated placement swaps to give trainees another opportunity to train in their preferred region or for those wanting to work together with their partner.			

Enhancing junior doctors' working lives: a progress report

Overview of the actions	State of progress	What has been done?	The next steps and deadlines	Who has led the work?	Page
Chapter 3.3 – Limited options for doctors to train flexibly, including structural and cultural barriers to LTFT training					
HEE's working group on improving junior doctors' working lives has committed to stimulating work to identify and remove the barriers to flexibility in training. Different approaches for increasing opportunities for trainees to train more flexibly are initially being piloted in high pressure specialties to explore their success in reducing "burn out" and attrition, and improving morale which boosts recruitment. However they present an opportunity to improve the working lives of trainees in all specialties.	In progress Pilots approved	HEE is proposing a 12 month pilot that would allow all higher trainees (ST4+) in emergency medicine to apply for LTFT training, without having to meet the Gold Guide criteria.	HEE is planning a pilot for 2017. HEE is working with partners to design a detailed and robust evaluation process, to include consideration of impacts upon trainees working LTFT under existing rules as well as those who do not themselves take advantage of the flexibility opportunity. HEE will commission the RCP to develop and pilot a new flexible training model for trainees who want to pursue portfolio careers, modelled upon the Chief Registrar scheme	HEE's working group on improving junior doctors' working lives	21
		HEE's working group on improving junior doctors' working lives is also considering alternative flexible training models, including the inclusion of "non-clinical" days for junior doctors to develop wider generic professional capabilities. This conceptual model originates from the Royal College of Physicians' Future Hospital Chief Registrar Scheme, which is currently being piloted.			
Chapter 3.4 – Varying equity in study leave provision					
HEE's working group on improving junior doctors' working lives has agreed that a consistent process should be implemented to support junior doctors in accessing the educational support required to meet their curriculum objectives. This is important to	In progress	The working group has developed proposals for greater coordination and control of the study leave budget to ensure that all trainees receive the funding required to progress through their specialty curriculum, across the whole length of their programme. This would replace the current system, where trainees generally receive a notional fixed annual	The intention is to introduce a new approach to managing the study budget in 2017. HEE is discussing the implications of the proposed changes with employers and trainees. Consultation has started with colleges and trainees to establish what exactly the study	HEE's working group on improving junior doctors' working lives, the Department	33

Enhancing junior doctors' working lives: a progress report

Overview of the actions	State of progress	What has been done?	The next steps and deadlines	Who has led the work?	Page
<p>address the inequity whereby trainees can be left out of pocket from meeting basic requirements of their training, disproportionately in certain specialties, and different approaches by employers.</p>		<p>allocation, which does not necessarily cover the required costs of meeting their curriculum requirements.</p> <p>There was also agreement to end the use of study budgets to fund essential training required by employers for service reasons, to preserve this for trainees to use for their own educational development.</p>	<p>budget should cover, and how to ensure that the opportunity to use study funding towards individually determined enhancement activities is still retained.</p>	<p>of Health, Medical royal colleges</p>	
<p>Chapter 3.5 – Improvements needed with induction and mandatory training, including an end to unnecessary repetition</p>					
<p>The May ACAS settlement requires employers to participate in the streamlining of processes for recruitment and induction within a region, to minimise repetition and wasted time for trainees upon each rotation.</p>	<p>In progress Phase one by April 2017</p>	<p>All employers are committed to delivering phase one of streamlining by April 2017, when all trainees will be guaranteed access to a standardised recruitment and induction process.</p> <p>The proposed updated study leave processes will ensure that trainees are not required to use their study budget for employers' mandatory training activities.</p>	<p>NHS Employers and HEE will consider the inclusion of the need to deliver streamlined recruitment and induction processes in the LDA between HEE and employers. This could then be monitored through the quality framework.</p>	<p>NHS Employers</p>	<p><u>35</u></p>

Enhancing junior doctors' working lives: a progress report

Overview of the actions	State of progress	What has been done?	The next steps and deadlines	Who has led the work?	Page
Chapter 3.6 – The rising costs of training for individual junior doctors including the cost of examination fees					
The HEE working group has committed to support medical royal colleges with the development of shared principles regarding transparency and criteria for cost-setting that deliver equity and fairness for trainees, and make clear the true costs of training in each specialty	In progress Principles agreed Costs to be finalised	The working group committed to increasing transparency by working with the royal colleges to collate the costs of training, to share this with junior doctors and to ask the academy to agree to shared principles with regard to exam and course fees.	The best practice principles for exam fees have been agreed by the AoMRC, involving junior doctor representatives. The collated costs of training broken down by specialty have been shared with stakeholders to confirm their accuracy before publication online in the spring 2017. This is being taken forward as part of the AoMRC's trainee doctors' group work regarding pre-specialty trainees noted below.	HEE's working group on improving junior doctors' working lives, AoMRC	<u>36</u>
Chapter 3.7 – Inequality in time out of training – helping doctors with improved and more individually tailored support upon their return to training					
The 18 May ACAS agreement for the junior doctors contract committed HEE to lead the process to develop evidence-based, innovative approaches	In progress	The Department of Health have committed recurrent funding towards the delivery of this project from 2017/18. HEE will manage and allocate funding, develop a strategy and delivery plan, and ensure	Scoping work as described and early implementation where feasible and appropriate.	HEE	<u>38</u>

Enhancing junior doctors' working lives: a progress report

Overview of the actions	State of progress	What has been done?	The next steps and deadlines	Who has led the work?	Page
to training to remove as far as possible the disadvantages to those who take time out of their training.		<p>there is appropriate engagement and input throughout this project, involving the BMA and other stakeholders.</p> <p>HEE's executive have agreed to explore a combined approach to managing the project, by which HEE:</p> <ul style="list-style-type: none"> • internally scopes existing facilities and capacity for improving individually tailored support; • consults widely across the system through a "call for ideas"; and • develops a delivery strategy that clearly determines what can be delivered within the system and what requires a separate procurement exercise. 	An evaluation model will be developed by HEE's Commissioning for Quality programme to assess the effectiveness of different approaches to improving individually tailored support upon return to training and inform plans for 2018/19.		
Chapter 3.8 – Lack of support for the increasing number of doctors at the post foundation/ pre- specialty level who are looking for a more flexible approach to career progression					
HEE's working group on improving junior doctors' working lives invited suggestions from the AoMRC trainee doctors' group on measures to develop a positive identity for "pre-specialty" doctors; to recognise this cohort's skills and experience; and to support them to make	In progress	<p>Expansion of the functionality of the current foundation e-portfolio has been explored to allow doctors to document competencies gained outside of a formal training programme prior to specialty training.</p> <p>The AoMRC trainee doctors' group are developing standardised online guidance on training in each of the medical</p>	<p>Further liaison with the GMC regarding prospective approval guidelines.</p> <p>The AoMRC trainee doctors' group are working with the</p>	HEE Working group	<u>39</u>

Enhancing junior doctors' working lives: a progress report

Overview of the actions	State of progress	What has been done?	The next steps and deadlines	Who has led the work?	Page
informed career choices.		specialties, with the intention of featuring a “cost of training calculator” function.	Royal College of Ophthalmologists to co-design a model webpage for the specialty.		
Chapter 3.9 – The need for trainees to move home repeatedly during training where this lacks educational justification or support from trainees					
Frequent rotations are not necessarily negative, however imperfect planning or rotations across large geographic areas can require trainees to move home unreasonably frequently or travel for unreasonable lengths of time.	In progress	A working group involving HEE, the BMA and other stakeholders has been established to explore the rationale, and perceived benefits and disadvantages in rotations through placements at different sites, from the educator, the employer and the trainee perspective. This will identify principles, for example to limit the distance measured by geography or the frequency of rotation within any given training year.	The group will make recommendations on best practice principles and on actions for improvement.	HEE	<u>40</u>
Chapter 3.10 – The need for clearer legally-binding protections for junior doctors if they are subject to detrimental treatment by HEE as a result of whistleblowing					
HEE has committed to removing any potential barriers to trainees' ability to raise concerns and hold HEE to account through the legal system.	In place	As of 9 August 2016, HEE, after discussion with the BMA and NHS Employers, extended whistleblowing protection for junior doctors at the BMA's request. This provided a new legal route directly against HEE, if required, for trainees who raise concerns and believe that HEE has caused detriment to them as a consequence.		HEE	<u>41</u>

1.0. Introduction

HEE's statutory duties and functions

HEE is the executive non-departmental public body responsible for the education, training and development of the healthcare workforce in England. HEE's purpose is to improve patient outcomes by supplying a workforce in the right numbers, with the right values, skills and experience.

Through its local offices and teams working with Postgraduate Deans, HEE plans, commissions and manages postgraduate medical and dental education (PGMDE) for approximately 50,000¹ doctors in training, supporting these individuals to gain professional competencies and progress towards entry onto the specialist and GP medical registers². HEE's 13 local offices host the regional Postgraduate Deans, who co-ordinate and supervise PGMDE in their local area, ensuring that placements and programmes meet the regulatory standards required by the General Medical Council (GMC).

Issues for doctors in training

The last 18 months has brought the training of UK doctors to the forefront of the minds of the medical profession, the NHS, the UK government and the public.³ A number of issues with the current experience of doctors in training have been highlighted and although the contract dispute played out in England, many of the issues highlighted have a similar impact across the UK.

These issues have been highlighted through a number of different mechanisms.

A. Highlighted issues from 'non-contractual' discussions

In December 2015 and January 2016, HEE's Postgraduate Deans, Professor Sheona MacLeod, Chair of the Postgraduate Deans in England, and Mr David Wilkinson, Deputy Chair, provided independent advice to the BMA Junior Doctors Committee and NHS Employers, in tripartite discussions which took place in parallel to the junior doctor contract negotiations between the Government and the BMA.

The tripartite discussions specifically focussed on issues with junior doctors' experiences of their training processes, in order to identify where improvements were needed which were outside the remit of the contract. The shared Terms of Reference reaffirmed all parties' commitment to providing a high-quality training experience, an exemplary working environment and appropriate work-life balance for junior doctors while any contractual issues were deferred to the main negotiating teams.

During these discussions, the following issues were highlighted:

1. Difficulties that arise from late rota notification and fixed leave

Enhancing junior doctors' working lives: a progress report

2. The mechanisms to deploy junior doctors in certain areas or between regions do not adequately facilitate caring responsibilities or the maintenance of relationships and family life
3. Limited opportunities for doctors to train flexibly, including structural and cultural barriers to LTFT training
4. Varying equity in study leave provision
5. Improvements needed with induction and mandatory training, including an end to unnecessary repetition
6. The rising costs of training for individual junior doctors, including the cost of examination fees

As the organisation responsible for training in England, HEE committed to initiating work to address the majority of the issues raised through a working group established by HEE's Postgraduate Deans. NHS Employers agreed to accelerate their work on reducing the need for doctors to repeat mandatory training in induction as they rotate between trusts.

The issues related to rota notifications and deployment were referred to the 4 nation medical and dental recruitment and selection programme (MDRS) to progress.

B. Highlighted issues from further discussions

As the discussions around the contract progressed, other issues were highlighted, which the May 2016 ACAS agreement, between the BMA and NHS Employers, and the Secretary of State for Health, committed the NHS to addressing. These were:

7. Inequality in time out of training – helping doctors with improved and more individually tailored support upon their return to training
8. The support for the increasing number of doctors at the post foundation/pre- specialty level who were looking for a more flexible approach to career progression
9. The need for trainees to move home repeatedly during training, where this lacks support from trainees or educational justification
10. The need for clearer legally-binding protections for junior doctors if they are subject to detrimental treatment by HEE as a result of whistleblowing

HEE committed to developing, with the medical royal colleges and other qualified experts and providers, improved and more individually tailored support processes upon return to training, which will ensure that individuals who take career breaks can rapidly regain their competencies and confidence, and thus reduce adverse effects on subsequent career progression, especially for women returning from maternity leave.

HEE, with the AoMRC, is exploring how best to support the increasing number of junior doctors who are taking time out of the standard training pathways; in order to gain additional experience, ensure an appropriate work life balance, or just take time to make informed career choices.

C. Highlighted training issues raised through the working group, HEE quality management and other mechanisms

With the national focus on doctors in training, a number of similar issues were highlighted through the many junior doctors' fora, HEE's Postgraduate Deans' quality processes, the royal colleges, the GMC⁴, and through other mechanisms.

To ensure we had heard the views of all our doctors in training, HEE undertook a listening exercise during autumn 2016 to gather together the negative themes that are affecting morale and to understand trainees' experiences of the best training environments. Chapter 5 of this report articulates the learning from this listening exercise.

Two focus groups were held with doctors in training during October 2016.

Subsequently the 13 Postgraduate Deans were asked to corroborate the views through their local trainee networks. Alignment existed between the evidence from our focus groups, existing literature^{5,6,7,8,9} and HEE's Postgraduate Deans.

A summary of the negative themes were distilled as:

- "I am not supported",
- "I do not feel valued"
- "I have no autonomy".

A series of quotes that informed this thematic analysis can be found in the [report on the listening exercise](#).

HEE also heard that around the country some excellent training environments already offer positive role models and developmental work experiences; however there is a wide range in quality. Common features occur in the good working environments. They include: supportive and accessible supervision; protected time for clinical experience, education and personal life; team working; effective, fair and timely rota management; engagement from the employer that made the workforce feel valued; and well-organised support systems.

However the listening exercise highlighted that most doctors in training felt disconnected from their employers and this extended beyond trusts, to the regional and national organisations that impact on their working conditions.



2.0 Addressing the issues – HEE's working group on improving junior doctors' working lives

In addition to taking work forward through existing groups and mechanisms, HEE committed to working in partnership with other key stakeholders to address some of the issues relating to its core responsibility for managing high quality medical education and training. HEE's Postgraduate Deans established a working group to explore the issues and to make recommendations for the future relating to:

- identifying and removing the barriers to access to flexible training (see chapter 3.3);
- addressing inequity in the training covered by the study budget (see chapter 3.4);
- the escalating costs of training (see chapter 3.6); and
- enhancing early careers advice and support for post foundation junior doctors (see chapter 3.8).

The membership of the working group on improving junior doctors' working lives, hereafter referred to as the working group, includes representatives from the following organisations:

- HEE's Postgraduate Deans' network
- The 4 nation medical and dental selection and recruitment (MDRS) Programme
- The BMA Junior Doctors Committee
- NHS Employers
- The General Medical Council
- The Academy of Medical Royal Colleges
 - Executive representative
 - Specialty registrar and Foundation trainee representatives
 - The Royal College of Anaesthetists
 - The Royal College of Emergency Medicine
 - The Faculty of Intensive Care Medicine
 - The Royal College of Pathologists
 - The Royal College of Physicians
 - The Royal College of Psychiatrists

Enhancing junior doctors' working lives: a progress report

- The Joint Committee on Surgical Training

Principles

The working group agreed to share intelligence around current best practice, to work collaboratively to identify and understand issues, and to develop solutions that all parties can sign up to and deliver within their statutory remit. In particular, the ethos of the working group is to move beyond the traditional cultural barriers and perceptions that can prevent positive change for trainees.

The working group agreed and signed up to the following principles:

- i. Junior doctors are a valued and essential part of the healthcare workforce now, and in the future.
- ii. There is a current incompatibility between medicine, service delivery and society. Junior doctors now have different, valid and accepted expectations for working and training. Group members agree to review training from this perspective.
- iii. Change is necessary to improve training.
- iv. Any outputs from the group should empower the junior doctor. They are the future healthcare leaders of the NHS, and as such should be able to shape their own future.
- v. Patients are the primary beneficiaries of the work of the group.

3.0 Progress Update

3.1. Difficulties that arise from late rota notification and fixed leave (addressed through the MDRS programme)

The BMA highlighted that the timely provision of rotational information to junior doctors, which enables them to plan their lives (from booking leave for important personal planned events to arranging their caring responsibilities), was a key issue. To enable Trusts to address this, HEE committed to the earlier provision of trainee information to employers, at 12 weeks before the start of placements, rather than 8 weeks.

This requires much more forward planning by all Training Programme Directors across England. Although this reduces some of the flexibility to match placements to individual doctors' needs, the earlier provision enables employers to match trainees' information to establishment; to develop the work schedules that form part of the conditional offer of employment; and provide trainees with their rota and other details about rotations 8 weeks in advance of deployment. This will enable annual leave and individual rostering to be requested and planned.¹⁰

The Code of Practice, agreed between the BMA, NHS Employers and HEE was updated ahead of 2017 specialty recruitment in November 2016, to reflect the agreed changes. HEE is ensuring this change occurs by monitoring and reporting compliance at Board level. The updated Code of Practice has now been published [online](#).

3.2 The mechanisms to deploy junior doctors in certain areas or between regions do not adequately facilitate caring responsibilities or the maintenance of relationships and family life (addressed through HEE's MDRS programme)

The May 2016 ACAS agreement re-enforced HEE's requirement to: "...lead a review of the processes which allow transfer between regions, joint applications between married couples (or those in a civil partnership), and training placements for those with caring responsibilities within defined travel times."

This has also been identified as being of high importance to junior doctors making career-related decisions.¹¹

This is being taken forward by HEE's medical and dental recruitment (MDRS) programme, and is focussing on:

- pre-allocation of trainees with specific caring responsibilities or ill health/disability tying them to a specific location;
- "facilitated swaps" with others if doctors in training are allocated to a different region to their partner / spouse;
- development of Inter Regional Transfers for trainees in England to create increased flexibility in moving between regions in addition to the current Inter-Deanery Transfer (IDT) process; and

Enhancing junior doctors' working lives: a progress report

- scoping a technical solution in Oriel for linking applications in specialty recruitment.

The pre-allocation of trainees with caring responsibilities or ill health / disability, was implemented in time for the recruitment round opening in November 2016. In addition, the facilitated swaps process will be piloted manually with additional administrative time, in the 2017 recruitment round. HEE has updated its medical recruitment guidance to reflect these changes, which is available [online](#).

A working group, including membership from the BMA, will explore future possibilities which could be developed within Oriel.

The Inter-Regional transfer process for trainees moving within England, improving upon the existing IDT process and removing the previous potentially counterproductive requirement for ARCP outcome 1 to have been obtained, is agreed and in place in time for the next Inter-Deanery Transfer Window, in February 2017. Full details can be accessed via the HEE [website](#).

Regular rotations between placements can cause major disruption to trainees' lives, and so HEE's Postgraduate Deans have reviewed placements to identify and reduce any unnecessary rotation, allowing doctors to rekindle the element of local public service and improve the employer-employee relationship. Subsequent to the review, further discussions with the BMA and other stakeholders will take place in early 2017 to consider the impact, benefits and consequences of further changes on the equity of training provision and the future workforce in more remote and rural areas, before further recommendations are made.

3.3 Limited opportunities for doctors to train flexibly, including structural and cultural barriers to LTFT training (addressed through the working group on improving junior doctors' working lives)

Why is this important to junior doctors now?

Work/life balance has been highlighted as a mounting concern to doctors in training, with the risk of "burnout" affecting recruitment and retention in some specialties, and with morale undermined more generally across other specialties by training rules that are increasingly perceived as rigid and out of step with modern employment practices. Concerns about equity in access to flexible working have also been raised.¹² Currently eligible trainees who request LTFT training are mostly able to have their requests accommodated (though service needs can present barriers to this being optimally arranged as currently structured); however the eligibility rules limit access to this opportunity. The BMA was keen to remove what are seen as "arbitrary barriers" by many trainees, in favour of a more individualised and granular approach to work scheduling.

It is difficult to capture the extent of unmet need, as trainees are being advised that they can only access LTFT if they fit the eligibility criteria. However, with the current spotlight on stress placed on doctors in training, HEE accepts the need to review

Enhancing junior doctors' working lives: a progress report

what could be done to increase flexibility, and to be clear about what improvements can be delivered. This will ensure that trainers and doctors in training can be appropriately informed and have accurate expectations of possible options.

There is a new focus on providing more flexible training, which allows individuals greater options in their careers. In the past, “flexible training” referred to what is currently termed less than full time “LTFT training”. Flexible trainees were always supernumerary, i.e. additional to the fixed number of trainees allocated to a department. This approach allowed flexible trainees to work in an individualised pattern without impacting upon colleagues or service delivery. Whilst this approach could create inequity with full time trainees, as the ‘flexible trainees’ could better secure access to training opportunities and suitable on call commitments, the system provided extra money to follow flexible trainees, and they were widely regarded by programmes and employers as a real bonus.

The system of LTFT which is now in place is much less flexible, and doctors work a percentage of the full time timetable. This developed with the use of ‘slot shares’; each doctor doing 60% of the full time workload to allow for a handover period, and 50% on call. This can work well for trainees and employers although there are challenges in making it work successfully. It is also a loss to the trainee as well as the NHS when they would be able to work more than 50% or 60%, but less than 100%, and so the slot share of two trainees in one slot can underutilise their availability. Changes in rotas cause difficulties as childcare arrangements often require weeks or months of notice.

Previously trainees often waited for job-shares before they could be permitted to work LTFT. As LTFT working requests have been accommodated, there have been challenges in arranging slot shares and so there are now more LTFT doctors in full time slots. Slot sharing also requires programmes to ‘over-recruit’ to training slots. If this is not possible, there is again a resultant gap as the LTFT doctor works in a slot the employer is expecting to be staffed on a full time basis. This may have a negative impact, both on patient care and on training, and many junior doctors feel personally pressurised not to increase the service pressures on their peers, even though this ‘gap’ consequence of them working on a LTFT basis clearly reflects deficiencies with the system rather than any individual responsibility.



Percentage of Trainees working less than full time by location

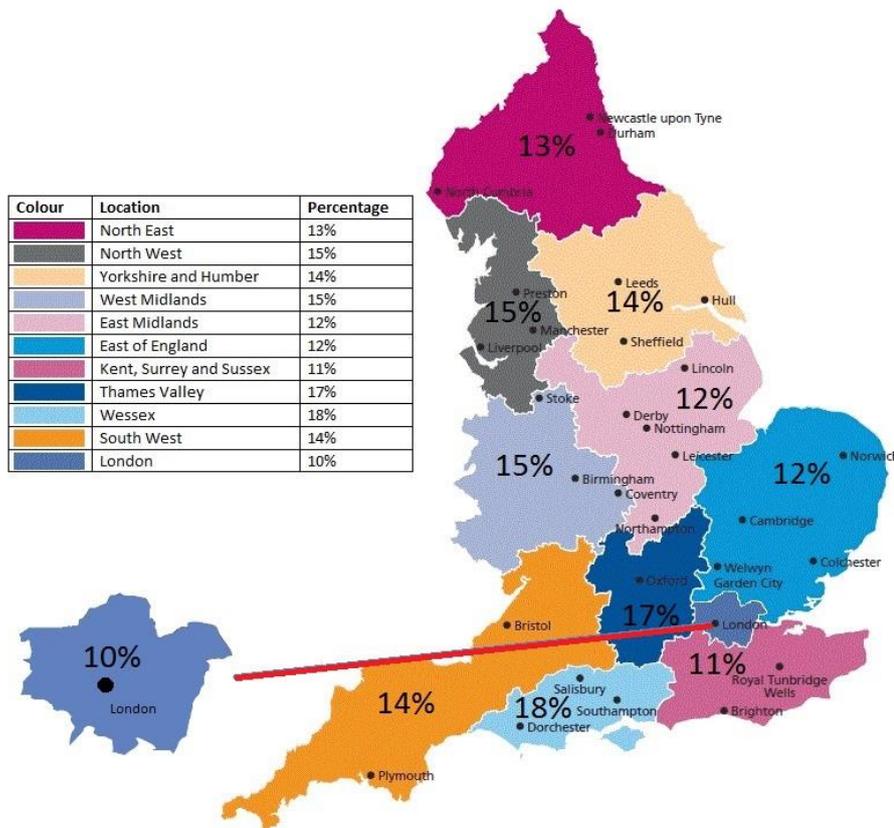


Fig. 1 LTFT training in England by location

Competency-based assessment in principle allows trainees to progress at an enhanced rate and it has been noted in paediatrics that LTFT trainees may not require the same whole-time-equivalent training experience as a full-time trainee. Doctors who spend more time in training perform well in general professional development, which often makes an early Certificate of Completion of Training (CCT) feasible, though this is and should not be an expectation. However, although LTFT trainees may gain their competencies more quickly, many do not choose to progress more quickly through training. Many doctors in training prefer to have had a more thorough base to their training to develop their confidence, or to be able to develop their other interests like teaching or research. LTFT trainees should never feel inappropriately rushed to end training sooner than they would on a pro rata to full time basis. Longer placements are also seen as beneficial for training progress, as trainees spend longer times at one particular hospital and get to know the local team well.

There are more flexible routes to becoming a consultant or GP. The Certificate of Eligibility for GP Registration (CESR) and Certificate of Eligibility for Specialist Registration (CEGPR) routes to the specialist register, confirm equivalence to regulated CCT training. CESR and CEPGR allow flexibility in recognising attainment of relevant specialist qualifications, training and experience, but these routes

Enhancing junior doctors' working lives: a progress report

continue to be undervalued and perceived as lacking the status of a CCT. The CESR route allows individuals to submit evidence of equivalence to CCT requirements by offering evidence of appropriate experience and attainment outwith of approved programmes. However, the process is felt to be cumbersome, and, although the CESR and CEGPR routes allow doctors to be on the GMC specialist or GP register, the CCT is the accepted qualification for automatic recognition of training in other EEA member states. Therefore that those with a CESR have to undergo a recognition process to work in other European states.

Although there would clearly be an impact on service if greater flexibility was the norm, there is also a credible service argument for increasing flexibility and the range of LTFT working arrangements. This model allows for periods of skills consolidation, personal development or recuperation, tailored to an individual, which would encourage trainees to continue to commit to working in high pressure specialties, where retention is an issue. It also enables those trainees whose personal circumstances would otherwise cause them to consider leaving medicine to continue training and working in the health service.

Working group agreement

The working group recognised that traditional perceptions of “normal” career trajectories do not now account for the current needs of individuals in a changing societal context. The group supports increased flexibility in all training, recognising doctors in training have individual rights to “humanity”, including the time for a family and personal life.

The group was also supportive of allowing time for other experiences, in and out of training, and to engage in other pursuits, including other employment, whilst training. It was recognised that a major cultural shift across the profession would be required in order to accomplish this increased flexibility. Working group representatives from the medical royal colleges captured their organisations' views on extending access to more flexible training opportunities. They reported widespread acknowledgement that LTFT training should become more widely available, however, there was also significant anxiety about service barriers, particularly in geographic areas of historic recruitment difficulties, with gaps in training rotas.

The group also agreed it was critical that increasing flexibility opportunities for greater numbers of trainees should complement and reinforce, rather than undermine, the flexibility afforded by existing LTFT arrangements to those who need it for reasons falling within the existing eligibility categories. The group were clear that mainstreaming flexible working within training pathways could be an important factor in challenging negative cultural attitudes to LTFT training within the system and welcomed the GMC work on this.

The GMC's current curriculum reforms and movement towards more outcomes-based training and assessments are intended to address some of the current rigidity in the system, which currently focuses on time served. The General Professional Capability (GPC) framework will also increase flexibility by identifying and requiring common core content across all postgraduate training. The new GMC standards for curricula and assessment systems are moving towards an outcomes based

Enhancing junior doctors' working lives: a progress report

capabilities framework, which could also support flexibility and transferability between specialties.

Learning from current practice - examples from the medical specialties

There are a number of medical specialties for whom doctors in LTFT training form a significant proportion of the training numbers. The chair asked representatives from the medical royal colleges to provide evidence on their approach to flexibility, including the barriers and the enablers experienced in their specialty in allowing more trainees to work flexibly. From this detailed evidence, a summary of which can be reviewed in appendix B, the working group identified a number of key findings.

Specialty (highest LTFT rate)	% LTFT	Specialty (lowest LTFT rate)	% LTFT
Palliative Medicine	25%	Cardio-thoracic surgery	0%
Public Health Medicine	23%	Core Surgical Training	1%
General Practice (practice placement)	21%	Trauma and Orthopaedic Surgery	1%
Genito-urinary Medicine	21%	Intensive Care Medicine	2%
Child and Adolescent Psychiatry	20%	Neurosurgery	2%
Paediatrics	18%	Acute Care Common Stem – Anaesthesia	3%
Obstetrics and Gynaecology	15%	Plastic Surgery	3%
Clinical Oncology	15%	Acute Care Common Stem - Acute Medicine	3%
Medical Microbiology	15%	Core Anaesthetics Training	3%
Core Psychiatry Training	15%	Core Medical Training	3%
		Otolaryngology	3%
		Acute Care Common Stem - Emergency Medicine	3%
		Gastroenterology	3%

Fig. 2 – LTFT training rates, ten highest and lowest by specialties (where total trainees >100)

Key findings 1 – challenges

- Increasing proportion of trainees requesting LTFT**
 Specialties with a higher number of female trainees experience a higher proportion of maternity leave and LTFT training requests. Run-through training (which has limited recruitment points) and attrition exacerbate the negative effects of LTFT. However, it is believed that LTFT training has enabled a significant number of doctors to become consultants, who otherwise would not have continued due to other commitments.
- Changing demand**
 There are increasing requests for less traditional arrangements, e.g. training at 70-80%. There are also requests for increased flexibility in working times;

Enhancing junior doctors' working lives: a progress report

annualised hours; working in 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.

There has also been an increase in LTFT training requests from male trainees who are fulfilling caring roles and from trainees with healthcare requirements, along with an increase in requests from trainees who feel overburdened by full time working, but are not yet sick.

- **Difficulties incorporating LTFT training within a training programme**
Training Programme Directors (TPDs) are having increasing difficulty in organising LTFT programmes in well-balanced training rotations, without disadvantaging trainees who work full time. Challenges, such as deciding which days are non-working; planning LTFT when trainees move between rotations and programmes; ensuring access to Out of Programme (OOP) opportunities; and managing geographical restrictions, have increased the pressures on TPDs. This planning process must be repeated between each year of progression.

The constraints of specialty curricula are often seen as a significant barrier to managing LTFT training, especially in the “craft” specialties, where progression requires the achievement of competencies gained through experience.

Furthermore, as junior doctors develop more varied portfolios, it is particularly challenging for TPDs to create programmes for those training for dual CCT.

- **Disadvantages to trainees**
Training at LTFT as it is currently structured can reduce flexibility and unnecessarily prolong training. Training opportunities may not be equally spread through the week, and may occur on non-working days. Training can be disjointed, with reduced opportunities for sub-specialty exposure, so LTFT doctors are not necessarily able to acquire competencies at a proportional rate to their full time counterparts.

Service pressure to keep two doctors in a slot share can adversely impact on individual opportunities and breadth of experience, or leave trainees feeling compelled to stay in their slot despite having met or exceeded the equivalent curricula requirements. Although it is clear that slot shares are separate posts, trainees are often viewed as a 'pair' and expected to cover each other. If one is off there can be disproportionate pressure on the slot-share to fulfil both duties, and less effort to secure locums to cover the gaps.

With return to work at LTFT following maternity leave, the reduced time for support can make it harder to regain confidence and competence.

- **Changes in structure and potential impact on service**
Some schools have split larger regions into geographically smaller hubs of training to minimise impact on home life and reduce travelling. This can be difficult because of differences in the distribution of ST1 and ST2 posts and if training posts were provided to limit movement, this could result in a restriction on the

Enhancing junior doctors' working lives: a progress report

number of Local Education Providers (LEPs) delivering training. This would likely be at the expense of geographically remote locations.

- **Impact on other trainees**

There are reports of other trainees (usually those working full time) being asked to perform extra duties, which can impact on the quality of their training as well as their own work/life balance.¹³ The high number of mid-grade rota gaps has created increasing service pressures, fostering a feeling that OOP is becoming less accessible.

- **Future workforce planning**

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. A significant increase in part time or job-share consultant posts would require a significant culture change and different planning for the future, but the service must be able to cater for this.

- **Culture change**

All Specialties 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, as well as upon those trainees who need to train LTFT under existing eligibility criteria.

There is still a stigma to applying for LTFT training in some specialties, especially when it creates vacancies. There needs to be a change in culture and attitudes of many of the current consultant workforce to be able to make LTFT training more attractive and widely available.¹⁴



Key findings 2 – enablers and current successes

As indicated in figure 2, a number of specialties have high levels of LTFT training, and well developed support systems for enabling this way of working, delivering a quality training experience for LTFT trainees whilst maintaining service and equity for full time trainees.

- **Curriculum and assessment design**

The GMC's move towards fewer higher-level capabilities described in outcomes-based curricula, embedding the GPC Framework, was highlighted by the working group as a key enabler for more flexible and adaptive training

- **Benefits to recruitment**

Specialties with a high proportion of LTFT trainees report that it has been a valuable means for boosting recruitment and retention, keeping doctors in training and staffing rotas and allowing LTFT trainees to benefit from longer placements and time to consolidate skills. Larger numbers of LTFT trainees can also enable a more even spread of trainees across different hospitals in shortage specialties.

- **Successful Slot shares**

Some schools in obstetrics and gynaecology have introduced greater flexibility in creating programmes, e.g. 3 trainees in 2 slots (80,60,60%), to reduce the number of gaps in full time slots and simultaneously enable LTFT trainees who have capacity to work at greater FTE percentages to do so. These are more successful if trainees collaborate to plan their slot-shares well in advance of commencing in post or can be flexible between themselves to balance work and other commitments and find a slot share partner who will complement their working and childcare or caring arrangements. However the onus should not have to be upon trainees to negotiate arrangements to facilitate this. This also underlines the importance of trainees receiving rota information in good time in advance of their posts, as taken forward by the working group and covered elsewhere in this report.

- **Covering the 'gap'**

In obstetrics and gynaecology, consultants often cover rota gaps created where LTFT trainees are placed in full time slots as higher trainees are the most likely to elect to train LTFT. If this is how the service intends to accommodate LTFT training more widely, planned changes to the service model are needed to stop doctors feeling undervalued by "acting down". It is also recognised that using terminology of 'gaps' being created where trainees work LTFT is generally not conducive to providing a supportive culture towards LTFT training. More careful language should be used in future.

Clinical fellowships with attractive options are employed to stabilise the workforce where LTFT numbers are high.

Similarly, the Medical Training Initiative (MTI) provides flexible, short-term support for rotas from overseas doctors doing up to two year's planned training placements in England.

Enhancing junior doctors' working lives: a progress report

Rota gaps can be evened out between some trusts by placing LTFT trainees in posts that do not have full-time trainees to avoid one having recurring rota gaps and another full with slot shares. However this must already recognise and support the educational needs of individual LTFT trainees.

Some trainees would like the option of formally working at different proportions of full-time training as their commitments change. Although this could be difficult to administer, and to model in terms of workforce impact, it could reduce the impact of gaps as well as make better use of trainees' availability more efficiently for the NHS.

- **Timetabling**

Greater flexibility requires more sophisticated rotation planning, e.g. timetables rotated over a period of weeks to incorporate all the required activities in craft specialties.

Flexibility can also be increased by combining clinical work with non-clinical work for part of the week, for example, leadership, quality improvement, research or teaching developmental opportunities. This alternative approach to flexibility builds time into a programme for developing resilience and maintaining interest. Psychiatry already incorporates this into training.

Further suggested areas for consideration

- Recruitment review for run-through specialties, to explore the possibility of having more recruitment entry points, making it easier to step off and return to training after time out
- Champions to manage the process as effectively as possible. These can be specialty specific, or trust based. The Royal College of Anaesthetists (RCoA) are an exemplar for this approach, with 86% of specialty schools employing a consultant LTFT specialty advisor; 76% having a forum where trainees raise LTFT issues. Formalising guidance for employers regarding the 'flexible training champion' role envisaged by the ACAS agreement could help progress this.
- Improving the process by reducing bureaucracy where possible and reviewing the ARCP process to reduce the burden for LTFT trainees, and opening up slot-share opportunities in subspecialty modules for LTFT trainees
- Providing accurate advice by ensuring that educational and clinical supervisors and TPDs have detailed and up-to-date information about flexibility and that the medical royal colleges have documents providing guidance, such as FAQs on LTFT training. National 'flexible training' days for information sharing and problem solving could also be provided. The RCoA, for instance, provide an "A-Z guide to LTFT Training in Anaesthesia", accessible online
- Change in restrictions to allow LTFT trainees to earn additional money within and beyond medicine, and introduction of less rigid employment arrangements, e.g.

annualised hours. Clarity should be provided that periodic locum working should not be prohibited for LTFT trainees even under current arrangements, because this can be of benefit to them and as well as employers delivering service, provided this is compatible with their eligible need to train on a LTFT basis

- Changes to trainee service provision, such as pooled Out of Hospital commitments
- The development of an alternative workforce, including advanced clinical practitioners and the medical associate professions, to create more integrated teams and relieve some of the service pressures from junior doctors and free up time to train
- Workforce planning information: generate more reliable forecast of the current trainee workforce's intentions with regard to future consultant working patterns.

- **Issues for the Regulator**

The overall regulatory requirements around UK specialty training are established in the Medical Act 1983, incorporating relevant European legislation.

There is a further complexity around part-time working whilst training LTFT. This is requested by some trainees who want to train in a second specialty but maintain their skills in another specialty, for example Occupational Health (OH) and GP. The traditional view has been that trainees should be focussing on their training and should not undertake other paid employment. The GMC are reviewing the position in respect of LTFT training and actively considering whether such requests can be accommodated within the current legal framework.

- **Employer issues**

Working group discussions have highlighted the need for provider support in addressing the challenge of LTFT training. Effective planning of LTFT working patterns into training commissions would enable employers to ensure service provision, whilst making difficult-to-recruit-to specialties more attractive. Employers could work with different proportions of trainees contracted to different levels of LTFT but decisions would need to be made jointly between trainees, HEE, and employers. This would require sufficient notice to enable alternative arrangements to be put in place which could include the development of an alternative workforce to support the junior doctors in training posts.

In addition, a robust evidence base and careful consideration of workforce trends must inform any decisions about changes to working and training patterns. For instance, evidence suggests that those doctors who train LTFT do not necessarily continue to work along this pattern once they have reached CCT. There is a need to explore whether this is because there is a perception that this is the only option for career progression or whether this is due to personal choice. Evidence such as this must then inform local, regional and national workforce planning.

Pilot proposals

1) Emergency medicine

The Royal College of Emergency Medicine has worked alongside HEE to develop a pilot for much greater access to LTFT training, as part of a number of solutions they have initiated to address the specialty's issues with recruitment and retention. The speciality has a shift working pattern, and a flexible approach to consultant working patterns, plus an affiliated advanced practitioner workforce, making an expansion of LTFT training options a feasible initiative.

A 12 month pilot will take place, allowing all emergency medicine higher trainees in England the opportunity to apply for LTFT training, regardless of their eligibility under the current Gold Guide criteria. The purpose of the pilot would be to assess the popularity and impact of a significantly more flexible approach to training and would provide the opportunity to identify the benefits and address obstacles and risks of greater flexibility, using a controlled sample of approximately 478 trainees.¹⁵ It is recognised that the EM trainee population may not be representative of the wider trainee population and so controlling of these factors where possible, and consideration of the generalisability of the pilot, will form a core part of the evaluation. It is also recognised that the attractiveness of LTFT training depends not just upon reduced working hours but also on how it is implemented, for example in terms of notice of rotas, flexibility in the percentage FTE pattern followed, the ability to fix working days including on call commitments to regular days of the week, and the need to find or liaise with a slot share in order to make these arrangements – which the evaluation will also seek to consider.

All trainees accessing less than full time training under the pilot will contribute to the evaluation process and once the pilot application window closed, the working group will have an opportunity to review the number of applicants, analyse the data and to model and evaluate the impact of such a change on a number of levels.

The pilot evaluation will consider the impact on remaining trainees (who continue to work full time) as well as those already training or requesting to train on an LTFT basis for reasons falling within existing Gold Guide eligibility criteria; financial impact (on a broader level); and both the financial and service impact for employers from a workforce perspective.

As part of the pilot evaluation, HEE will carry out a robust analysis of the qualitative and quantitative outcomes based on real data, and make further recommendations about extending this approach to LTFT training to other specialties and trainee grades. The impact upon those LTFT trainees who fall within existing eligibility criteria would be key factor in this consideration, because greater access to flexible working should improve rather than undermine those training LTFT for existing eligibility reasons.

The proposals can be viewed in full at Appendix C.

2) Options for Acute Medical Registrars

The working group has considered proposals for extending the Royal College of Physicians' Future Hospital Chief Registrar scheme as a means of providing alternative flexible training options for trainees. The Chief Registrar pilot is underway with a cohort of 24 higher medical trainees from across England, Wales and Northern Ireland, and seeks to balance training and service requirements, through leadership development opportunities in this area of intense service pressure.

Trainees spend 3 days a week in service/training, with 2 days ring-fenced for a leadership and management focused training opportunity. The current pilot focuses exclusively on trainees doing the acute medical take, with leadership and management as the non-service element of the programme. However, as a model for flexible training it demonstrates how doctors in training could develop a more 'portfolio based' approach to their careers, with a reduction in time spent in traditional training and the opportunity to develop other areas of personal interest. The RCP is now exploring how to adapt the pilot so that the two non-traditional training days could provide education, quality improvement or academic training opportunities.

The College does not foresee that this model need delay doctors' CCT dates, as assessment is competency based, and the skills developed during the 40% of non-service training are also required within the curriculum. This could allow greater flexibility that would encourage doctors to continue in a high pressure specialty, which currently has problems with attrition. Further information on the Chief Registrar scheme on which this will be based can be [accessed online](#).

The working group is keen to explore this as a possible option for specialties, especially where there is high attrition, which would benefit from new approaches to enhancing flexibility. Further attrition data on other medical specialties that could benefit from this approach to flexibility is provided in Appendix D.

The initial pilot commenced in October 2016, with evaluation due in summer 2017. The RCP has encouraged a heterogeneous approach to recruitment and management of the pilot, and will evaluate which models work well. Employers are reportedly enthusiastic, as the proposals present potential cost-savings compared with use of locums. Perceptions from non-participating trainees are also being evaluated. The iterative findings in spring 2017 will inform the criteria for extension of the programme. If the evaluation supports the extension of this approach, impact modelling will be undertaken, and this will be taken alongside provider and junior doctor feedback on acceptability to inform a decision on possible implementation in 2018.

This model is already well established in psychiatry, where all 6 of the higher specialty programmes have 1 day per week for special interest or research, which is ring fenced from other clinical duties. The day is used either for research and or special interest sessions which are agreed and endorsed by the educational supervisor and TPD. Trainees have used their sessions to do research, but they have also been used in a number of diverse ways, for example, to spend time in neurology or radiology, to learn additional psychotherapy modalities, to develop

Enhancing junior doctors' working lives: a progress report

educational interests or subspecialty interests such as asylum seeker mental health or gender dysphoria.

Whilst the extent to which this approach supports trainee retention is uncertain, it demonstrates how the model could be adapted to allow significantly greater flexibility for individual development within a training programme, and be culturally accepted within higher training.

3.3 Varying equity in study leave provision (addressed through the working group on improving junior doctors working lives)

Reported issues

There are system-wide inconsistencies with regard to the provision of study leave. Employers, localities and regional offices can have varying rules and interpretation of laws and guidelines, for example requiring advanced life support training in some departments.

Statutory mandatory training, in particular, presents an issue as this is required by employers in order to comply with employment law, and may need to be repeated to meet employer requirements rather than trainee learning needs. HEE's Quality Framework will monitor and address misuse of study leave, particularly preventing the use of study leave to complete training that does not contribute to a trainee's curriculum requirements or genuine agreed personal development.

These inconsistencies across regions, specialties and employers are accepted to result in inequities, leaving trainees out of pocket from meeting even basic requirements of their training. These are greater in some specialties than others, creating barriers to fair access by trainees.

Further clarity is required as to what constitutes essential, useful, or discretionary training / personal development. The GMC's Generic Professional Capabilities Framework promises to shed some light on this matter, by defining the core professional elements that should be developed within every curriculum, beyond technical ability and specialty-specific knowledge. For instance, leadership is now considered to be an essential general professional capability that should be developed and assessed within the core curriculum.



Definition of study leave

The working group has agreed to the principle of implementing a consistent process to support junior doctors in accessing the educational support required to meet their curriculum objectives.

A proposal has been developed for standardising the mechanism for defining and managing study leave, incorporating the following principles:

- To ensure that all trainees across England have access to the necessary resources to meet their curriculum requirements. This involves equitable access to courses and educational activity deemed necessary by their respective school. This principle is intended to raise the baseline for trainees, and does not imply an end to continuing to use study funding for individually determined enhancement activities as well.
- To realise economies of scale by reviewing courses run both within and across specialty schools to ensure existing study resource goes further (not to make reductions of spend).
- To improve quality, accessibility and value for money.
- To ensure appropriate educational approval is given for courses and educational activity deemed necessary to ensure trainees meet their curriculum requirements. This principle is again intended to raise the baseline for trainees, and does not imply an end to continuing approvals for individually determined enhancement activities.
- To ensure that educational resources, where appropriate, are used to maximise the potential for multi-professional learning, support the wider workforce and to maximise local flexibility, again to ensure existing resource goes further (not to make reductions of spend).

Proposal for standardising the processes to support study leave in England

It is proposed that HEE centralises the study budget nationally, in order to ensure that trainees receive the funding that they require to progress through their specialty curriculum, across the whole length of their programme. This would replace the current system, where trainees are generally granted a notional fixed annual allocation common across specialties within a region or employer, which does not necessarily cover the required costs of meeting their curriculum – which will vary between specialties and across the length of a programme. The intention is to introduce this approach for managing the study budget from August 2017.

The study budget proposals were presented to the Department of Health Tariff and Costing Advisory Group in November 2016. Engagement with employers is now underway to demonstrate the efficiencies and advantages of managing the study budget nationally, for both trusts and trainees. We are also planning discussion with and communications for trainees, to achieve consensus that a standardised approach for managing the national study budget will deliver not only greater equity, but increase flexibility for trainees – as funds will be released according to individual training requirements and opportunities.

Enhancing junior doctors' working lives: a progress report

In order to ensure clarity, equity and value for money so that available resource provides as much training as possible, HEE will be required to collaborate with stakeholders to produce guidance on what should always be included in the study budget and what does not need to be. Widespread consultation is underway to establish a consensus as to what constitutes essential experience for progression, and also what adds value to a trainee's portfolio – because the existing opportunity to use study funding towards individually determined enhancement activities is positive and not intended to be lost. It is accepted that variation will occur by specialty and geography; however, the intention is to remove geographic inconsistencies and unfairness for trainees in the provision of resource and support for meeting curriculum requirements.

3.5 Improvements to induction and mandatory training, including an end to unnecessary repetition

Issues addressed by NHS Employers working with the BMA

The 2016 terms and conditions of service for doctor and dentists in training requires employers to establish regional streamlining processes for recruitment and induction by April 2017, to ensure all trainees within a region are guaranteed access to recruitment and induction processes that limit duplication while maintaining agreed regional standards.

Streamlining is a collaborative programme led by NHS trust HR directors on a regional basis. NHS Employers support streamlining through both regional support and a national network of streamlining programme leads. There are now a range of different approaches to streamlining now underway across England (full regional description can be found in Appendix E) all of which are already established or are planned to be so from April 2017.

For the purposes of recruitment and inductions processes, each programme seeks to reduce duplication of pre-employment checks and mandatory training and induction when employees move from one NHS organisation to another without any break in service through:

- agreeing minimum standards and operational practices to eliminate duplication and inefficiency;
- identifying and sharing best practices through networks of operational managers; and
- benchmarking performance, identifying opportunities and innovations to save money and improve quality

For the doctor or dentist in training moving between trusts within a streamlining region this should mean:

- recognition of a number of pre-employment checks undertaken by the previous employing trust, allowing for a smaller number of checks to be undertaken in line with the regional policy; and

Enhancing junior doctors' working lives: a progress report

- recognition of training programmes undertaken in previous employing trusts, allowing for 'refresher' training required periodically and induction processes unique to locality or employer.

HEE is supporting the process with the development of a high quality standard induction e-learning programme. A number of regions will be adopting this as part of their streamlining programmes from April 2017.

Issues addressed by the working group on improving junior doctor's working lives

There are inconsistencies in what constitutes induction within the same specialty across the UK, and in what trainees are required to do as part of their study leave. A working group subgroup, reporting to the equity in study leave provision workstream, will also review what should be incorporated into mandatory training or induction and therefore funded by trusts as induction, rather than expending trainees' study leave allowance.

The working group recommends that delivery of regional streamlining is included in the LDA between HEE and employers and monitored appropriately through the HEE Quality Framework.

3.6 The rising costs of the training package for individual trainees (addressed through the working group on improving junior doctors' working lives)

In their terms of reference, the working group agreed on a set of value based, key principles:

- Colleges should not make profit from exams; money received should be reinvested in the exam process, or to support trainee education and training.
- Equity and fairness should be ensured across specialties.
- Any impact on patient safety must be considered, with quality assurance and improvements to patient care at the forefront of any decisions regarding training and assessment costs.

Problem reported by trainees

Training to develop the required skills for progression within a curriculum should be provided by the system, and not resourced by individual trainees. However, the BMA and AoMRC trainee committee report escalating costs incurred by trainees through the course of their training programme, including disproportionate costs for LTFT trainees compared with full time colleagues. The working group's study budget proposals, if implemented, would facilitate a significant reduction in costs for trainees by ensuring that all curricula requirements are delivered either through training placements or funded from the study budget, managed by HEE, and this would absorb additional LTFT training costs where there are proportionately greater rather than leaving them for trainees to fund personally as at present.

Enhancing junior doctors' working lives: a progress report

The AoMRC Trainee Doctors' Group has also confirmed through the working group that Foundation Trainees would benefit from greater clarity about the different training routes and the likely cost and time in training, as well as options and cost of training LTFT for individual specialties and sub-specialties in order to plan their future careers.

Establishing an evidence base

In addition to mandatory courses delivered outside of placements, trainees are required to pay trainee administration fees to the medical royal colleges and faculties, membership fees and examination fees.

Instigated by the working group, HEE conducted a survey with the medical royal colleges to establish the unit cost of these fees across the individual specialties and subspecialties, at different points during training, and calculate the total cost incurred across the length of a programme. This investigation also captured data on examination pass rates; minimum as well as average time to reach CCT/CESR; and concessionary rates for LTFT trainees or those earning under a certain threshold, to create a richer dataset that could better reflect an individualised cost and length of training. The full collated costs of training in specialties will be available in the spring of 2017.

Engaging with the medical royal colleges

The initial purpose of this data exercise was to provide clarity for discussions with and amongst the medical royal colleges regarding the setting of costs, and transparency regarding the use of college revenue.

Professor Sheona MacLeod, the working group chair and Professor Sue Bailey, Chair of the AoMRC, met with college examination leads to exchange information and encourage the development of shared principles that all colleges could sign up to. The opportunity to observe and learn from different approaches to cost setting and transparency was welcomed and the key themes produced at the meeting were shared with the AoMRC presidents. The college and faculty presidents agreed a set of principles and obligations for all colleges to be ratified by the AoMRC.

AoMRC agreement on the Costs of Training, March 2017

Specifically, in regards to openness and transparency, the AoMRC has stated that colleges should:

- regularly review and publish a review of their examination costs and the range of improvements and efficiencies achieved e.g. including methods of assessment, decoupling exams, new technology opportunities, consideration of qualification requirements;
- provide a guide to trainees to show the direct and indirect costs underlying development and delivery of high stakes examinations and curricula;
- indicate how any surplus generated is used, and particularly how it supports trainees, or how costs have to be covered from other sources; and

Enhancing junior doctors' working lives: a progress report

- seek to ensure that, aside from any directly sustained extra costs, being Less Than Fulltime Training (LTFT) does not incur additional costs compared with training full time.

With regard to Inter-College Collaboration the Academy states:

- Colleges should, where appropriate, share development and delivery resources, and seek jointly negotiated contracts with external providers, if practical, with the aim of limiting costs.

And with regard to Academic Integrity the Academy agrees:

- Colleges should strive to balance academic and educational best practice, the requirements of the regulators and considerations of geographical and technological access and the number and duration of examinations to minimise direct and indirect costs to trainees.

Further work to provide helpful information for trainees

The AoMRC Trainee Doctors' Group has supported the view that foundation trainees would benefit from greater clarity about the different training routes and the likely cost and time in training, as well as the options and cost of training LTFT, for individual specialties and sub-specialties, in order to plan their future careers.

The verified data (in 3.62) is being used to create an information resource on costs at the core, intermediate and higher specialty stages of a junior doctor's career. This will allow users to see the cost and length of training in different specialties, taking different routes. The AoMRC have agreed to host this facility.

This will enable trainees to make informed decisions and lifestyle choices that fit their chosen career pathways, e.g. the best stage in ones career to train LTFT.

3.7 Inequality in time out of training – helping doctors with improved and more individually tailored support upon their return to training (being taken forward by HEE working with royal colleges)

The ACAS agreement in May 2016 committed HEE to lead a process for developing evidence-based, innovative approaches to training for junior doctors who return to training after time out. The Department of Health has committed to recurrent annual funding for HEE to deliver this programme of work from April 2017.

This is in response to concerns raised by the BMA that the new employment contract would unfairly disadvantage women and have a potentially negative impact on career academics. Also the transition of returning to work and training can place particular pressure upon those with recently acquired caring responsibilities.¹⁶

The purpose of improving individually tailored support will be to mitigate the impact of time taken out of training by supporting doctors to regain their confidence and

Enhancing junior doctors' working lives: a progress report

competencies when they return to training and prevent avoidable delay to their projected CCT date.

HEE will be scoping existing facilities and capacity for accelerated learning opportunities and consulting widely across the system to signpost existing good practice and generate evidence-based, innovative solutions for this. This will involve the BMA and other stakeholders, and inform HEE's strategy and delivery plan, to be finalised in 2017.

3.8 Lack of support for pre-specialty / post foundation doctors (addressed through the working group on improving junior doctors' working lives in partnership with the AoMRC)

The 'pre-specialty doctor' group is made up of around 23,000 medical students, foundation doctors and trust doctors in the UK. It was highlighted that, in order to ensure that individuals continue their careers within the NHS, it is important to consider their needs as a group. A listening exercise was conducted with the Academy Trainee Doctors Group and the Creating Supportive Environments Group to better understand the issues that are important to these doctors, and to consider their needs.

The GMC data shows that the number of F2s applying to specialty training is decreasing.¹⁷ Reasons for this are multiple and include difficulties in deciding on a chosen specialty and the desire for additional time to make an informed decision. These post Foundation doctors need career guidance and support, as well as development of skills for the future

There are a number of other groups of doctors working in trust posts, including international medical graduates (IMGs), those requiring more support to develop specific skills and competencies, and those choosing to take time out of training for different reasons including preventing burnout.

Each of these groups of individuals will have different development needs and require a different type of support. For example, those needing more support to develop competencies require close supervision from trained supervisors, doctors coming from abroad require an introduction to the NHS and may require support with communication skills, and those requiring more time to choose a career path need career planning support.

Issues identified

- Difficulty in getting feedback, especially positive feedback, and recognition for competencies and experience acquired whilst working outside of a formal training programme.
- Concerns that the current system of rotations can limit doctors' opportunities to establish meaningful working relationships, leaving junior doctors in training feeling isolated and disconnected from the values of their employing organisation.
- A need for more in-depth, unbiased career advice for all specialties.
- Concerns about burnout.

Enhancing junior doctors' working lives: a progress report

- A feeling that individuals in this group are not 'useful' to their teams; they know they have more to offer and would like to make a difference to the working environment.

Suggestions from the AoMRC Trainee Doctors' Group for future initiatives

- Clear information on the college's expectations and requirements of doctors in specific specialty training programmes would help ensure doctors are suited to their future careers and help them balance work and other commitments.
- A positive identity for this group of pre-specialty doctors should be fostered, acknowledging that it is important for doctors to make the correct decisions for themselves and for the profession. Organised events, and online fora and networking opportunities could support this.
- Standardised online career guidance information for all specialties.
- Development of e-Portfolio to allow documentation of experience and competencies gained outside of formal training.
- Creating supportive environments guidance and an education faculty to support these groups.

On the basis of these findings, the AoMRC trainee doctors' group are working with HEE and other stakeholders to develop online portfolios to allow doctors to document competencies gained outside of a formal training programme. Expansion of the functionality of the current foundation portfolio has been explored as an option.

At present, European legislation and the domestic legal framework for postgraduate training requires prospective approval of training posts. As such, any competencies gained within a non-approved post could only be recognised towards CESR rather than CCT. However, the GMC's review will look at the scope for greater flexibility around the approval of specialty training and recognition of prior learning. The introduction of outcome-based curricula, the GPC framework, transferable capabilities and critical progression points in the new GMC standards for postgraduate curricula and assessments systems will also be key enablers to greater flexibility in training.

3.9 The need to move home repeatedly during training where this lacks educational justification or support from trainees (addressed through an HEE Postgraduate Dean led working group)

Doctors in training may move between trusts or GP practices many times during postgraduate training. This is usually to ensure that they are given the opportunity to work in a range of different environments, and that the specialty curriculum can be fully covered. This also helps develop a future consultant workforce across the country as doctors in training tend to work after CCT close to where they trained.

Whilst placements have been designed to deliver equity and excellence in training, and ensure that the full curriculum is covered, there has been too little focus on minimising movement where it does not add to educational experience, and is inconvenient for trainees. It is recognised that unnecessary rotation can have an adverse impact on implementation of quality improvement activities and promotion of

Enhancing junior doctors' working lives: a progress report

best practice, both vital areas for supporting the future workforce.¹⁸ Concerns have also been highlighted on the impact for black and minority ethnic (BME) and international medical graduate doctors who may benefit from more time to develop working relationships.¹⁹

A working group involving HEE, the BMA and other stakeholders has been established to explore the rationale and perceived benefits, and the disadvantages, in rotations through placements at different sites, from the perspective of the educator, the employer and the doctor in training. Early work has used focus groups, and initiated stakeholder discussion, and the group will make recommendations on best practice and the actions required for the future. It will identify principles for example possible proposals to limit the distance measured by geography or time that trainees are required to rotate between within any given training year.

3.10 The need for clearer legally-binding protections for junior doctors if they are subject to detrimental treatment by HEE as a result of whistleblowing (addressed through collaborative work between the BMA, HEE and NHS Employers)

As of 9 August 2016, HEE extended whistleblowing protection for junior doctors, after discussion with the BMA and NHS Employers, providing a new legal route directly against HEE, if required, for trainees who raise concerns and believe that HEE has caused detriment to them as a consequence.

We have now voluntarily placed in contracts with local employers a provision that protects juniors against detriment from HEE by providing direct redress for them against HEE through the courts. This does not affect any rights against employers. Guidance is available on [the HEE](#) and [BMA](#) websites.

4.0 The context – HEE's wider work programme

4.1 Postgraduate medical education reform – “improving training, supporting learners”

Wendy Reid, the Director of Education and Quality and Medical Director of HEE, has launched an extensive review of Postgraduate Medical Education and Training. The work on enhancing junior doctors' working lives is one part of this comprehensive programme.

This programme links the collaborative work on 4 nation proposals for initiatives relating to the Shape of Training report recommendations, with work on enhancing junior doctors' working lives and a strategic review of the current training processes supporting progression, linked to appraisal and the ARCP. HEE's new Quality Framework will provide an enabling mechanism to support, inform and assess the achievement of the programme aims.

These are the key inter-dependent strands of the Improving Training, Supporting Learners Programme

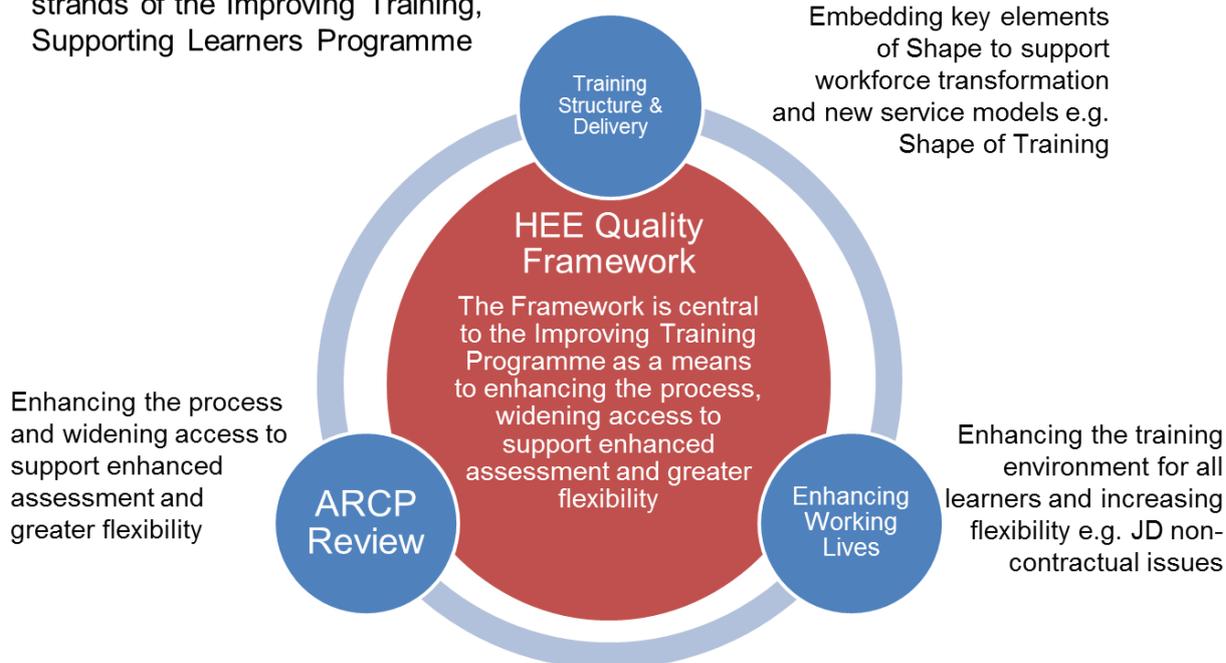


Fig. 3 – “Improving Training, Supporting Learners” Programme structure

A. Training structure and delivery

Working with the royal colleges, HEE has been mandated by the Department of Health to support the development and piloting of proposals to improve training, in line with the principles of the David Greenaway's Shape of Training (SoT) review.²⁰ This includes, for example, work with the RCS on *Improving Surgical Training*.²¹

Enhancing junior doctors' working lives: a progress report

In addition, HEE continues to work in collaboration with the devolved nations through the UK Shape of Training Steering Group, to identify exemplar postgraduate training models and to ensure, where appropriate, that proposed changes are broadly compatible across the UK.

B. ARCP review

HEE has commenced a major review of the Annual Review of Competency Progression (ARCP) in 2017, with participation from stakeholders from across the medical education & training and regulatory landscape.

The aim of the review is to explore opportunities to improve the ARCP process as a means to empower individuals to work towards goals in training. The Review also provides a platform to explore how HEE might unlock opportunities across the wider workforce. The review will be conducted under a number of workstreams. These are:

- 'Appraisal approach' and 'assessment methodology', two strands which have significant overlap and interdependencies. This work will seek to develop a more reflective, developmental approach to appraisal and a clear, consistent, efficient and well-understood approach to assessment whilst meeting GMC regulatory requirements.
- 'Individualised training pathways', which will explore the barriers and opportunities to achieving greater flexibility within training pathways.
- 'Wider workforce', exploring opportunities to consider whether elements of the process could be made available to the wider workforce e.g. advanced roles supporting medical and multi-disciplinary teams.
- 'Resources and feasibility', which will look at the support infrastructure as well as the practical, logistical and financial impact of any proposed changes within the review.

A major aim of the review is to introduce greater flexibility into the processes which support career progression, to reduce unnecessary bureaucracy, and to ensure junior doctors' have sufficient supportive discussions on competencies, and their required personal development.

4.2 HEE's Quality Framework

HEE has launched a new Quality Framework which provides a standardised approach to the review of the learning environment of all healthcare learners consistent with the standards for medical education and training set by the GMC. This provides a mechanism for the ongoing review of the issues highlighted, measuring HEE's response against the key performance domains of assuring high quality patient care; supporting learners; enabling a consistent and comparable view of quality; connecting the national to the local; and facilitating quality improvements. HEE will be considering how to improve the operation of its quality framework in light of the new data available from exception reports and the guardian role created by the new junior doctor employment contract.

Enhancing junior doctors' working lives: a progress report

Further information on HEE's Quality Strategy and Framework can be accessed [online](#).

4.3 HEEs role in workforce transformation

One of the key issues affecting junior doctors is the lack of a sustained and sufficient workforce delivering service at a 'middle grade' level, and the resultant gaps in rotas across the country.

HEE is taking a leading role in workforce transformation that will support delivery of the Five Year Forward View.²² Through this work, we are providing system leadership in the development of workforce solutions that will meet service needs and improve the working lives of healthcare professionals, including junior doctors.

Local Workforce Action Boards, provide the opportunity for HEE and local partners to support Sustainability and Transformation Plans (STPs) by discussing a range of workforce solutions, illustrated in the HEE STAR model in Figure 4. These will help address the key healthcare workforce issues which impact on the junior medical workforce.

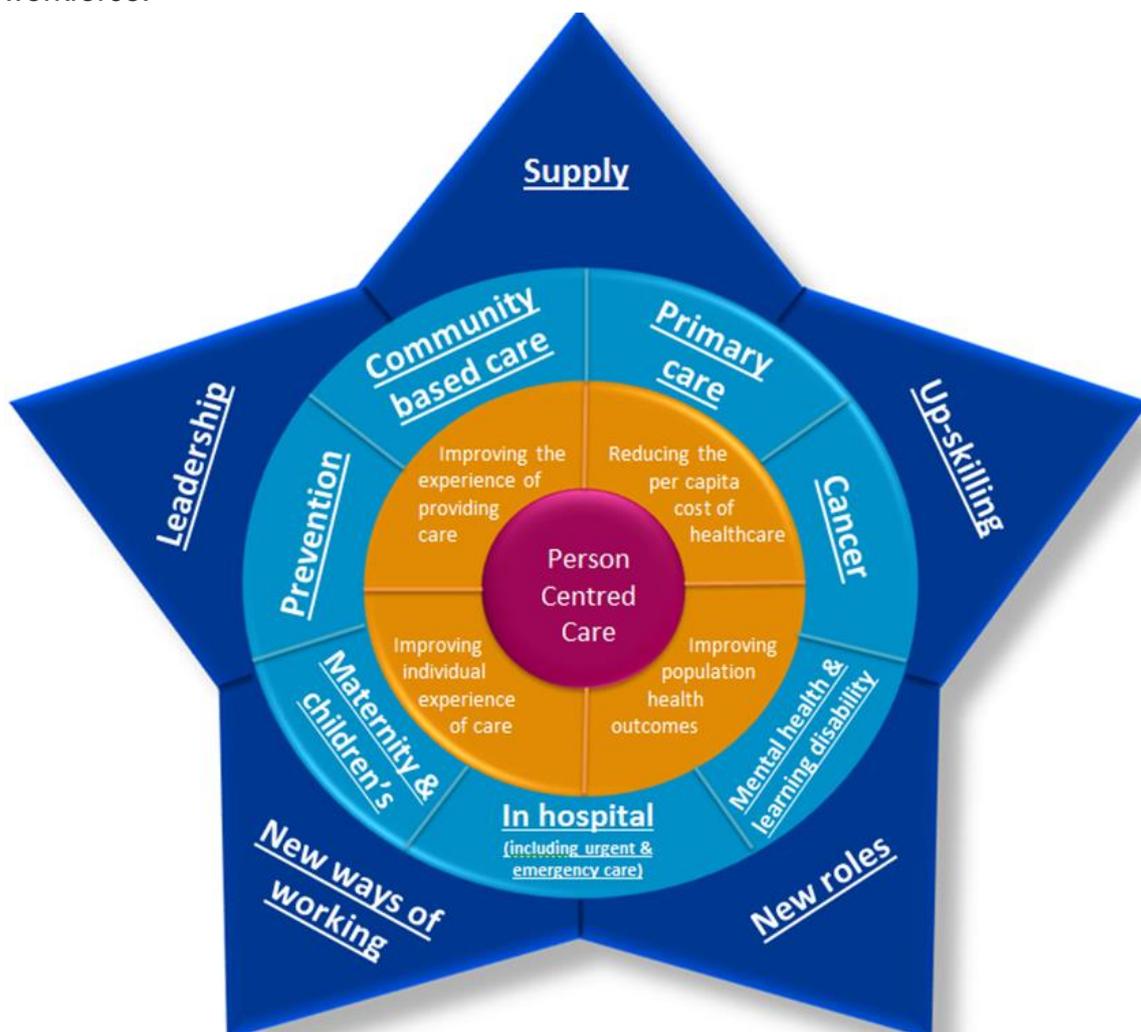


Fig. 4 – HEE's transformation 'star'

5.0 Learning from HEE's listening exercise

HEE's listening exercise provided ideas about junior doctors' expectations of their working lives. Themes emerged about the visions they had for themselves, of their employer and how they expect to be supported by regional/national organisations. The expectations can be summarised as:

- Individual
 - Career
 - Good training environment
 - Positive work relationships
 - Balance of administrative and clinical work
 - Personal life
 - Acceptable work-life balance
 - Access to annual leave
 - Opportunities for less-than-full time working
- Employer
 - Trust
 - Considerate rota coordination
 - Visible CEO and senior management
 - Shared culture of respect
 - Consultant
 - Present
 - Approachable and developmental
 - Available in a crisis
 - Team
 - Well-staffed
 - Integrated team
- Regional/national
 - Regional
 - Presence of HEE's Postgraduate Deans and Directors of Medical Education
 - HEE national
 - Ensuring high quality and supportive training environment
 - Other national bodies (GMC, CQC, NHSI, colleges and faculties)
 - Listen to the junior doctor voice
 - Create accountability
 - Regulate employers.

Several of the expectations highlighted during the listening exercise were also voiced during contract negotiations with the BMA. It is proposed that collaborative work with regulators and relevant arms-length bodies (ALBs), health organisations and the medical royal colleges could lead to a pledge from all organisations to:

- Commit to learning from best practice and case studies identified by HEE/NHSI

Enhancing junior doctors' working lives: a progress report

- Create clear accountability to ensure issues are tackled
- Increase junior doctor engagement at all levels of decision-making
- Encourage clinician presence at board level and in design of systems and processes.

A proposal detailing the current and future work to address morale by collaborating organisations, can be found in [Appendix A the listening exercise report](#).²³ Work is taking place to gather case studies of excellent training environments, including those in which considerable improvements have been made. These real scenarios can act as templates to help trusts and regional/national bodies to address morale issues under their influence.

6.0 What are the next steps?

This report details the progress through the working group on addressing these key issues identified through discussions with the BMA and reiterated in the May 2016 ACAS agreement. However, it is clear both from the discussions in the working group, and from the evidence collected in the listening exercise, that there is much that needs to be done across the system to fully address the fundamental issues that are affecting the quality of junior doctors' training and development, and their morale.

The required actions will necessitate involvement from a number of organisations, and although some are simple, others will be challenging to achieve even with collaboration.

1. Increased awareness of ongoing work to improve training, and of the improvements made, among trainees, as well as relevant stakeholders. This will provide the opportunities to effectively collaborate.

There is a lack of awareness across the junior doctor workforce in the UK that their concerns are being heard and acted upon.

Although there are a number of individual organisational efforts to update trainees on what is being done in response to their voiced concerns, i.e. *"you said, we did"*, this has not had a notable impact on morale.

The commitment and obligation to make junior doctors' working lives better, which is felt by senior leaders across the NHS and was clear in discussions throughout this work, is not apparent to the junior doctor workforce. Much of this will need junior doctors to experience benefits from change in their own environment, but **this could be improved by a more public commitment to addressing concerns, and a clear description of how that will be achieved, for example through the quality mechanisms in HEE and the CQC, NHS Improvement and the GMC.**

2. Regulatory focus on valuing the workforce, including junior doctors, and on promoting shared solutions/ best practice across the NHS, by system regulators, professional regulators, and HEE.

NHS organisations that host doctors in training are subject to a number of regulatory processes.

There would be greater success on improving the issues raised by junior doctors across the NHS, if **each of the regulatory bodies consciously focussed their monitoring processes in every organisation, over the next year, on the domains which impact on healthcare staff and especially junior doctors.** If there was also **collaborative effort to share the results of increased surveillance, and good practice was shared whenever problems were identified,** the impact would be even greater.

Enhancing junior doctors' working lives: a progress report

For example, junior doctors want to be effective leaders and have a desire and ability to contribute to improvement in the NHS, but they do not perceive their working environment as receptive. However, there are numerous examples of trusts successfully engaging with junior doctors to bring about positive change.²⁴

A focus on highlighting and signposting to best practice by CQC, NHS Improvement and NHS England, as well as by HEE, could have a significant impact, and would provide additional support for DMEs and the new Guardians of Safe working as they work to address problems. Examples of good rotating timetables, e-rostering, annualised hours, excellent induction, and effective support to promote workplace satisfaction and mentoring schemes²⁵, would enable others to address issues by seeing what best practice looks like.

3. Creating a culture change and championing flexible working more broadly including beyond doctors in training

The working group discussions, including those by members with colleges' wider educational faculty, highlighted the need for a change of culture in the medical workforce to enable more doctors to consider flexible working. The BMA are supportive of a concerted effort to support this through communications. More will be achieved, if **supported across the board by colleges, employers and HEE, especially with regard to increasing the value placed on CESR or CEGPR routes to the specialty or GP registers.**

A positive focus for information sharing and problem solving, perhaps through flexible training meetings or conferences, might be one way to address this issue. Guidance could also be improved for some specialties to better inform and empower junior doctors to explore flexible training options with their programmes and employers, and to promote a greater acceptance of flexible options.

The ACAS agreement requires the appointment of a flexible working advisor in trusts.²⁶ NHS Employers and the BMA are in active discussion to agree a role description of this advisor, recognising that championing of this role could impact on the perceptions of flexible working. Formalising guidance for employers regarding the 'flexible training champion' role could help progress this. There is also evidence of good practice with some specialty schools' having LTFT consultant specialty advisors and LTFT advisors being identified within trusts.

Some employers would benefit from sharing best practice on how to ensure that trainees who train flexibly or take career breaks are valued as part of a team and the future workforce, and supported through their career transitions, e.g. when returning to work from maternity leave. The AoMRC have published good practice guidance on 'Return to Practice', which can be accessed [online](#). There is also a need to highlight how doctors with chronic illness or disability can be supported, as the culture in the NHS is a concern for this group.²⁷



4. Prioritising the provision of education support, and an increased focus on supporting individuals to train, based on their particular circumstances and career aspirations.

The NHS services are currently under significant pressure and ensuring good patient care and patient safety is everyone's prime concern. However this can mean that the provision of education and training is repeatedly pushed down the list of priorities, in such a way that patient safety and longer term patient care is at risk. For trainees to have high quality feedback on their skills, not only do they need the time for learning, but their **supervisors need the time to teach** and the ability to select the appropriate service opportunities to do so.

The well managed use of the extended surgical team can support doctors and enhance training.²⁸ HEE's new Quality Framework focuses on the educational environment and on the development of the multi-professional teaching team or modern 'firm'. But other **NHS leaders in NHSI, NHSE and CQC all have a role in highlighting the value of education and training and in supporting educational champions**, such as the DMEs in trusts. It should not be acceptable to be meeting improvement targets for services, at the cost of adequate education and training.

The feedback from junior doctors highlighted the huge value they place on interactions with senior medical staff who have an interest in juniors as individuals, and are willing to discuss possible career options, and share insights from their personal career journeys.

Feedback about individual skills helps junior doctors make positive career choices and juniors value any time spent to explain the thinking behind making a diagnosis or management plans, that they were asked to act on.²⁹

Enhancing junior doctors' working lives: a progress report

This personalised teaching is part of what people remember affectionately about the past old 'firm' approach. In planning for the future there is an urgent need to consider how time for this is prioritised, for all staff.

The modern 'firm' is now a multi-professional team, openly recognising that many other staff contributed to the effective working of the medical team in the past, and that an integrated multi-professional approach provides the best outcomes for patients. Organisational leaders need to value the prioritisation of some time, however brief, for personalised feedback and support to junior staff, to ensure the healthcare workforce, including junior doctors, remains committed to working in the highly pressurised environment that exists now in the NHS.

5. Exploring flexible training models and enhancing education and training out of the traditional training pathways

There are **different ways of increasing flexibility in training which need to be explored further**, as they may improve training, promote recruitment, maintain resilience and interest and encourage retention.

Many junior doctors are concerned about possible burn out and having flexibility in splitting training time between high pressure working environments and time for research or teaching, as a possible option, as in Psychiatry training or proposed in the RCP registrar project, might encourage doctors to stay the course in training.

Society has changed, and increasing number of junior doctors wish to train in a specialty while continuing to work in another, as specialty choice does not have to be forever.³⁰ There needs to be consideration of how we can comply with legal requirements and still encourage doctors to make career change decisions if this meets patient need. The current uncertainty around what is allowed needs to be addressed; what additional hours doctors training LTFT in different circumstances can do, and whether the percentage of time worked can be changed, needs to be clarified.

Increasing the options for greater flexibility in medical careers by supporting junior doctors to step on and off the training ladder at suitable points in their personal lives could promote recruitment and retention and enable service provision at middle grade level for some taking 'time out'. This would require a change in the entry points into specialty recruitment, and a review of assessment of training progression and this is one of the areas being explored in HEE's ARCP review.

The GMC outcomes-based curricula will facilitate greater flexibility in training.

An increasing number of junior doctors take time to decide on future careers and choose to work in posts outside traditional training pathways. This, plus any increase in the opportunities to allow trainees to step off traditional training pathways, requires consideration of the support required for those not in training posts for CCT.

The provision of web based resources for this group, such as personal portfolios needs to be explored further. If there is consistency so supervisors are familiar with

Enhancing junior doctors' working lives: a progress report

them and they could link to royal college portfolios, the difficulties in providing evidence of progression in non-training posts would be significantly reduced.

Trusts are developing options to allow junior doctors to try out different specialties in innovative development programmes. However not all of these provide good training and the regulating organisations should be alert to this and highlight both when there are excellent opportunities and when junior doctors are being misled.

6. Developing improved working in a multi-professional workforce to address workload issues and ensure this supports, rather risks competing with, juniors doctors' training

A significant amount of frustration for junior doctors is the result of a failure to adapt the role of junior doctors to the changing requirements of the NHS, and to use the wider expertise that now exists in the workforce. Doctors in training are missing valuable experience and learning opportunities because they are completing tasks based on the way processes worked in the past. They are called to take responsibility for processes such as prescribing, or arranging tests, as a qualified medical professional, but their time and effort is not valued, and they struggle with ineffective systems which require perseverance, rather than professionalism.

There is a continued reliance on doctors in training to provide a service described currently as 'middle grade cover'. Yet there are insufficient numbers of junior doctors to provide this across England, and other professionals can provide much of what is required. For example, in the past, a junior doctor arranged for the patient's prescription and wrote the discharge letter as they knew the detail about the patients care. Doctors are now called to write up discharge prescriptions on patients they do not know, when there are pharmacists with detailed knowledge of medicines and their interactions, and nursing staff with knowledge about the patients' care.

The new contract will increase the focus on the management of rota gaps, highlighted in exception reports, and reported by the Guardians of Safe working. Also HEE's Postgraduate Deans are reviewing training programmes to reduce the movement across significant geographic areas. Increasing cover, and reducing movement, will require **a change in thinking, both about who provides the service traditionally provided by junior medical staff, and also about how both training and service are provided.**

The NHS needs to review patient flow, look at the specific tasks required to support this safely and effectively, and then consider which professional is now best suited to performing the tasks. HEE's STAR model provides a framework for reviewing future workforce need.

7. Improved workforce planning needs to be informed by information / research into the motivations and future career intentions of the current junior doctor workforce

Increasing junior doctor training numbers, without a need for future consultants, may be an insupportable way of addressing the need for middle grade cover, both in terms of expense to the NHS and to individuals who may not get a consultant post.

Much of the current workforce modelling is based on current patterns of working. In order to accurately predict future need, **there needs to be a much greater understanding of the long term career intentions of the current junior doctor workforce, in both traditional training pathways and in alternative trust funded posts.** It seems unlikely that junior doctors who want a more flexible approach to training, will not want this as consultants or GPs, especially as the pressures on the NHS require an increasingly resilient workforce.

The career aspirations of other professionals are also changing and **future workforce planning and modelling needs to be around team based care.**

7.0 Conclusions

The junior doctors' contract dispute has left many consultants, managers, and employers fully aware of the dissatisfaction felt by doctors in training, but unsure of what is being done and what more could be done in a highly pressurised system to address this.

There are some significant issues to address, but this report highlights that there has been progress with a number of the issues raised by junior doctor representatives, and that continued work is planned to address others.

There are also many further small steps that can be taken by all involved;

- HEE, NHSI, the CQC and the GMC, plan to share much more good practice ideas and initiatives from training and the healthcare working environment, to help employers make tangible local improvements.
- Trainees and their representatives, including the BMA, are suggesting simple solutions, and where there is board level interest in listening, improvements are being seen.
- Junior medical staff are engaging with employers to create solutions, using mechanisms such as the trainee forum, and should not be afraid of highlighting concerns.
- Consultants and GPs are working to make junior medical staff feel more valued, and to protect time for teaching, with individualised feedback, and support for junior staff. They need to highlight to their organisations, and to HEE and the regulators, when this is not possible so that solutions can be put in place.

The medical royal colleges, HEE, the GMC, NHS Employers and the BMA are all committed to continuing to work to make improvements, which together, will significantly change the morale of our junior medical workforce and enable them to continue to care effectively for patients in the future.

Glossary of Abbreviations and Initialisations

ACAS	Advisory Conciliation and Arbitration Service
ALB	Arms-Length Body
AoMRC	Academy of Medical Royal Colleges
ARCP	Annual Review of Competency Progression
ARTT	Accelerated Return to Training
BMA	British Medical Association
BME	Black and Minority Ethnic
CCT	Certificate of Completion of Training
CEGPR	Certificate of Eligibility for GP Registration
CESR	Certificate of Eligibility for Specialist Registration
CQC	Care Quality Commission
DME	Director of Medical Education
EEA	European Economic Area
GMC	General Medical Council
GP	General Practice
GPCs	Generic Professional Capabilities
HEE	Health Education England
IDT	Inter-deanery Transfer
IMG	International Medical Graduates
JDC	Junior Doctor Committee (part of the British Medical Association)
KIT	Keeping in Touch
LEP	Local Education Provider
LTFT	Less Than Full Time
MDRS	Medical and Dental Recruitment and Selection programme
MTI	Medical Training Initiative
NHS	National Health Service
OH	Occupational Health
OOP	Out of Programme
OOPE	Out of Programme Experience
PGMDE	Postgraduate Medical and Dental Education
PhD	Doctor of Philosophy
RCoA	Royal College of Anaesthetists
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
SoT	Shape of Training
STP	Sustainability and Transformation Plans
TPD	Training Programme Director
WTE	Whole Time Equivalent

Membership of the HEE Working Group on Improving Junior Doctors' Working Lives

Chair: Professor Sheona MacLeod, Chair of the Postgraduate Deans, HEE
Mr William Allum, Chair of the Joint Committee on Surgical Training
Dr Samira Anane, Flexible Careers Trainee Representative, AoMRC
Professor Dame Sue Bailey, Chair of the AoMRC
Dr Anna Batchelor, Former Faculty Dean, Faculty of Intensive Care Medicine
Dr Ruth Brown, International Committee Chair, Royal College of Emergency Medicine
Dr Wendy Burn, Former Dean, Royal College of Psychiatrists
Professor Ian Curran, Assistant Director for Postgraduate Education, General Medical Council
Professor Jane Dacre, President, Royal College of Physicians (London)
Kate Evans, HEE Dean's Programme Manager, HEE
Jenni Field, Head of Strategic Finance, HEE
Emily Hall, Policy Officer, HEE
Professor Tim Helliwell, Vice-President for Learning, Royal College of Pathologists
Dr Sarah Hallett, Junior Doctors' Committee Education & Training Team, British Medical Association
Julie Honsberger, Yorkshire & Humber Deanery Business Manager, HEE
Jonathan Howes, Specialty Training Manager, HEE
Dr Rachel Lieberman, Registrar, Royal College of Pathologists
Dr Kate Lovett, Dean, Royal College of Psychiatrists
Dr Johann Malawana, Former Chair of the Junior Doctors' Committee, British Medical Association
Dr Ellen McCourt, Former Chair of the Junior Doctor Committee Education & Training Subgroup, British Medical Association
Dr Samantha Mills, National Foundation Doctor Representative, the Foundation Programme Committee, Joint Academy Training Forum, and Academy Trainee Doctors' Group, AoMRC
Ms Sallie Nicholas, Head of the Joint Committee on Surgical Training
Sarah Parsons, Medical Workforce Manager, NHS Employers
Fauzan Palekar, Director of Professional Standards, Royal College of Psychiatrists
Dr Nigel Penfold, Chair of the Training Committee, Royal College of Anaesthetists
Dr Gerrard Phillips, Senior Censor / Education and Training Vice President, Royal College of Physicians (London)
Dr Alison Pittard, Vice Dean, Faculty of Intensive Care Medicine
Dr Melody Redman, Junior Doctors' Committee Representative, British Medical Association
Sam Wakeford, Senior Policy Advisor, British Medical Association
Dr Jeeves Wijesuriya, Chair of the Junior Doctors' Committee, British Medical Association

Mr David Wilkinson, Deputy Chair of the Postgraduate Deans, HEE

Other contributors

Russell Ampofo, Director of Training and Examinations, Royal College of Anaesthetists

Dr Alys Burns, East of England Head of Education and Quality (Secondary and Tertiary Care) and Chair of the National LTFT Training Forum, HEE

Dr Shiv Chande, FMLM Fellow, HEE

Dr Bernice Knight, FMLM Fellow, HEE

Professor Clare McKenzie, Vice-President for Education, Royal College of Obstetricians and Gynaecologists

Dr Julia O'Sullivan, Director of Education and Training, Royal College of Paediatrics and Child Health

Susan Redward, Policy Manager, General Medical Council

Tara Wilmott, former Head of Approvals, General Medical Council

Endnotes

- ¹ 51,631 doctors in training in England at HEE Stocktake, October 2015
- ² There are three recognised routes to the specialty and GP registers: Certificate of Completion of Training (CCT), Certificate of Eligibility for Specialist Registration (CESR), and Certificate of Eligibility for General Practice Registration (CEGPR)
- ³ Walesby, K.E., Lyall, M. J., Mackay, T. W., Wood, B., and Bell, D., "Valuing our trainees: the future of medicine in the UK", *Joint Royal College of Physicians Edinburgh*, (2016), 46, pp.146-9, accessed online at <http://dx.doi.org/10.4997/JRCPE.2016.301>
- ⁴ General Medical Council, *The state of medical education and practice in the UK*, (October 2016); accessed online at http://www.gmc-uk.org/SOMEPEP_2016_Full_Report_Lo_Res.pdf_68139324.pdf
- ⁵ Royal College of Physicians, *Being a Junior Doctor: Experiences from the front line in the NHS* (December 2016); accessed online at <https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor>
- ⁶ General Medical Council, *The State of Medical Education and Practice in the UK* (October 2016)
- ⁷ Royal College of Physicians, *Underfunded, Underdoctored, Overstretched: The NHS in 2016* (September 2016); accessed online at <https://www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016>
- ⁸ Rich A., Viney R., Needleman S., Griffin A., Woolf K., 'You can't be a person and a doctor': the work-life balance of doctors in training – a qualitative study', *BMJ Open*, Volume 6, issue 12 (2016); accessed online at <http://bmjopen.bmj.com/content/6/12/e013897.full>
- ⁹ Wathes, R. and Spurgeon, P., *Junior doctor engagement. Investing in the future* (Faculty of Medical Leadership and Management: March 2016), accessed online at <https://www.fmlm.ac.uk/resources/junior-doctor-engagement-%E2%80%93-investing-in-the-future>
- ¹⁰ This contributes towards delivery of the recommendations of the Royal College of Physicians (London) on rotas, fixed leave and leave management, in their report *Keeping medicine brilliant: Improving working conditions in the acute setting* (December 2016), p. 28. Accessed online at <https://www.rcplondon.ac.uk/guidelines-policy/keeping-medicine-brilliant>
- ¹¹ Cleland, J., Johnstone, P., Watson, V., Krucien, N. and Skåtun, D., "What do UK doctors in training value in a post? A discreet choice experiment", *Medical Education* 50(2), 2016, pp. 189–202
- ¹² British Medical Association, *Ensuring Fairness in Clinical Training and Assessment: Principles and Examples of Good Practice* (June 2016); British Medical Association, *Pre and Post Qualification Training and Development of Doctors: A British Medical Association Vision* (2015); Academy of Medical Royal Colleges, *A Charter for Postgraduate Medical Training: Value of the Doctor in Training* (March 2014)

¹³ See RCP, *Being a junior doctor*

¹⁴ Harries, Rhiannon L., McGoldrick, Ciara, Mohan, Helen, Fitzgerald, J Edward F, Gokani, Vimal J., on behalf of the Association of Surgeons in Training, 'Less Than Full-time Training in surgical specialities: Consensus recommendations for flexible training by the Association of Surgeons in Training', *International Journal of Surgery*, Volume 23, S10-S14 (2015); Harries, Rhiannon L., Gokani, Vimal J., Smitham, Peter J., Fitzgerald, Edward F., on behalf of the councils of the Association of Surgeons in Training and the British Orthopaedic Trainees Association, "Less than full-time training in surgery: a cross-sectional study evaluating the accessibility and experiences of flexible training in the surgical trainee workforce" *BMJ Open*, e010136 (2016); accessed online at <http://bmjopen.bmj.com/content/6/4/e010136>

¹⁵ Number of trainees in ST4-6 Emergency Medicine as per the April 2016 stocktake

¹⁶ RCP, *Keeping Medicine Brilliant*; accessed online at <https://www.rcplondon.ac.uk/guidelines-policy/keeping-medicine-brilliant>; The Academy of Medical Royal Colleges, *Maternity/Paternity Survey Results* (May, 2016); accessed online at http://aomrc.org.uk/wp-content/uploads/2016/06/Maternity_paternity_survey_200416-1.pdf

¹⁷ General Medical Council, *How do doctors progress through key milestones during training?* (2016); accessed online at http://www.gmc-uk.org/How_do_doctors_progress_through_key_milestones_in_training.pdf_67018769.pdf

¹⁸ Royal College of Surgeons (London), *Making the most of trainee doctors' insights* (January 2016); accessed online at <https://www.rcseng.ac.uk/news-and-events/blog/nhs-commitment/>; Academy of Medical Royal Colleges, *Quality Improvement - Training for Better Outcomes* (March 2016); accessed online at <http://www.aomrc.org.uk/publications/reports-guidance/quality-improvement-training-better-outcomes/>

¹⁹ General Medical Council, *Fair Training Pathways for All: Understanding Experiences of Progression* (2016); accessed online at http://www.gmc-uk.org/2016_04_28_FairPathwaysFinalReport.pdf_66939685.pdf

²⁰ Greenaway, David, *The Shape of Training: Securing the future of excellent Patient Care. Final report of the independent review into postgraduate medical education* (October 2013); accessed in full at http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf. For more detail on HEE's work on Shape of Training, visit <https://hee.nhs.uk/our-work/developing-our-workforce/shape-training>

²¹ Further information on the RCS and HEE's work to pilot a new, improved approach to general surgical training, visit <https://www.rcseng.ac.uk/careers-in-surgery/trainees/ist/>

²² NHS, *Five Year Forward View* (October 2014), accessed at <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

²³ Including NHS England, NHS Improvement, General Medical Council, Care Quality Commission, Academy of Medical Royal Colleges and NHS Employers

²⁴ Gilbert, A., Hockey, P., Vaithianathan, R., Curzen, N. and Lees, P., "Perceptions of junior doctors in the NHS about their training", *BMJ Quality and Safety* (2012), Vol. 21, pp. 234-238.

²⁵ Surman, G., Lambert, T.W., Goldacre, M., 'Doctors' enjoyment of their work and satisfaction with time available for leisure: UK time trend questionnaire-based study', *Postgraduate Medical Journal* (2016) Volume 92, Issue 1086, pp.194-200.

²⁶ BMA, NHS Employers, Department of Health: 18 May 2016, *Junior Doctors Contract Agreement* (18th May 2016), accessed online at http://www.acas.org.uk/media/pdf/l/p/ACAS_FINAL_AGREED_NHS_Emp_BMA_DoH_Package_180516.pdf

²⁷ Smith, F., Goldacre, M.J., and Lambert, T.W., 'Working as a doctor when chronically ill or disabled: comments made by doctors responding to UK surveys', *Journal of the Royal Society of Medicine* (2016), Volume 7, Issue 7; accessed online at <http://journals.sagepub.com/doi/full/10.1177/2054270416649282>

²⁸ The Royal College of Surgeons (London), *A Question of Balance: The Extended Surgical Team* (2016), <https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/question-of-balance/>

²⁹ Smith, F., Lambert, T.W. and Goldacre, M.J., 'Factors influencing junior doctors' choices of future specialty: trends over time and demographics based on results from UK national surveys', *Journal of the Royal Society of Medicine*, Volume 108, Issue 10, (Oct. 2015) pp. 396-405

³⁰ Hillman, Sarah, 'Taking a step sideways: switching specialty and revitalising my enthusiasm for medicine', *BMJ Careers* (25 Aug 2016), accessed online at http://careers.bmj.com/careers/advice/Taking_a_step_sideways%3A_switching_specialty_and_revitalising_my_enthusiasm_for_medicine