NHS
Health Education England

# Enhancing Junior Doctors' Working Lives

## A progress report 2018

Developing people for health and healthcare

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# Contents



# Foreword

**Professor Wendy Reid**
Medical Director and Director of Education and Quality, Health Education England

In 2016, we established the Enhancing Junior Doctors' Working Lives programme in response to what doctors in training had told us about feeling undervalued and experiencing low morale. As part of this work, we wanted to look in-depth at the issues that have a negative impact on their quality of life at work and how we might address these.

Last spring, we published our first progress report. This marked the start of a continuous process of focused engagement and improvement, and included measures to make training more flexible and improve doctors working lives.

During this past year, we have continued to work with doctors in training, their representatives and our partners across the NHS to develop, trial and embed further improvements. This document summarises the various aspects of this work, including our Supported Return to Training strategy and investment plan, which outlined how we could deliver better support to those doctors who return to training after approved time out, and our year-long review of the ARCP process and resulting recommendations, which we will be working with partners to implement over the coming year.

We know that for a wide range of reasons, many doctors in training are increasingly seeking more flexibility in their training and career pathway. I am keen to explore ideas that can introduce this further flexibility into the training pathway. For example, we are expanding Less Than Full Time working options, developing flexible portfolio training routes, and exploring how we can adapt Out of Programme arrangements to enable a 'Step-on Step-off' approach. I will also look at how we can help improve the educational supervision that is so essential to a good training experience, following on from our review of the ARCP process. Working in a clinical team that is supportive both professionally and personally is a vital component of high quality healthcare.

I am pleased that we have made such strides in this work over the past year, and would like to thank Sheona MacLeod and David Wilkinson for leading this work. Throughout this process, it has been encouraging to see this programme recognised and supported by the wider system, including doctors in training and the British Medical Association, and for it to form an integral part of Health Education England's recent draft workforce strategy. I look forward to taking these challenges forward, and working with our partners and doctors in training to make them a reality.

**Professor Sheona MacLeod**
Deputy Medical Director for Education Reform,
Chair of Health Education England's Deans

Every day, the NHS provides high quality, safe care for patients because of the dedication and commitment of our healthcare workforce. Doctors at all stages of postgraduate training are a significant and essential part of this workforce. Yet, through our engagement with doctors in training, calls for evidence and ideas, and discussions with those who work and support them, we have heard that they have increasingly felt undervalued by a system which did not appear to recognise their needs as individuals.

As a Postgraduate Dean, I understand the difficulties doctors face and address in their training. Through this piece of work, we aim to embed a culture that welcomes, values and supports doctors, working in multi-professional teams, as they undertake further specialist training. We attract motivated, talented doctors into training in the NHS, and the training they go through should enable them to become confident, versatile, expert clinicians, with the right balance in their lives, to be able to deliver the highest quality care for our patients.

Our work on Enhancing Junior Doctors' Working Lives sits under the Medical Education Reform Programme and was initiated to accelerate a number of improvements specifically on the working lives of doctors training in the NHS. We reported on the programme's progress in March 2017 and, working in collaboration with partner organisations, have continued to take this work forward since. This report summarises the significant progress made over the last year, details some of the many ideas we have heard, and shares doctors' stories of their experiences of the reforms.

However, we realise that there is still much to be done. In the complex environment of the NHS, we need to work across organisational boundaries to find solutions to current issues. We will continue to engage with our partners to take this work forward, including, most importantly, doctors in training themselves. We will report on progress annually and welcome feedback from interested parties.

We are grateful to everyone who has helped and continues to support this work and look forward to working with them over the coming year.

# 1. Introduction

The **Enhancing Junior Doctors' Working Lives** programme was established in March 2016, to address a range of issues that were having a significant negative impact on the quality of life of doctors in training.

These issues had been highlighted initially through discussion with the British Medical Association (BMA) Junior Doctors' Committee and NHS Employers, in parallel to the junior doctors' contract negotiations in 2015 and 2016, then in the Advisory Conciliation and Arbitration Service (ACAS) agreement between the BMA and NHS Employers, and also through Health Education England (HEE)'s own quality management and reporting mechanisms.

HEE established a working group to address these issues, with the BMA Junior Doctors' Committee, NHS Employers, the General Medical Council (GMC), the Academy of Medical Royal Colleges (AoMRC) and other partner organisations. We also undertook a listening exercise to gather information about the issues affecting the morale of postgraduate medical trainees and to hear their opinions about how to improve the learning environment.

Addressing the issues has required cross-system partnership working and a shared commitment to meaningful change.

In **our first progress report**, published in March 2017, we acknowledged that this was just the start of a process of focused improvement to training. During the past year, we have continued to work with doctors in training and system partners to develop, trial and embed further improvements. This report summarises this progress.

Our programme of initiatives to Enhance Junior Doctors' Working Lives fits within a broader programme of reforms intended to modernise our approach to medical education. The Medical Education Reform Programme (MERP) sets out to deliver safe, high quality care, by enhancing the way that we structure and deliver postgraduate medical training. As outlined in Appendix A, the Programme will facilitate the wider cultural change required within the healthcare education system to ensure that we can continue to deliver improvements.

# 2. Progress made since 2017's report

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| **Deployment** | | | | | |
| Difficulties that arise from late rota notification and fixed leave. | Updated the Code of Practice to increase notification of placements from 8 to 12 weeks, and committed to meet this target for 90% of trainee rotations. | Quarterly monitoring and publication of Code of Practice compliance. | HEE | We have achieved 90% compliance with the Code of Practice across England, although some regional variation has been reported and HEE local offices are working with trusts to ensure that information received is accurate and timely. | 17 |
| | | Trainee information received and passed on within the deadline. | HEE, NHS Employers | | |
| | | Further changes made to the Code of Practice, to take account of exceptional circumstances and assess how they impact on the system. | HEE, NHS Employers, BMA | | |
| | | Development of data templates to capture compliance with the Code of Practice more efficiently. | NHS Improvement HEE, NHS Employers | | |

**KEY:** Pink text: activities led by organisations other than HEE.

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| **Flexible training models** | | | | | |
| Limited opportunities for doctors to train flexibly, including structural and cultural barriers to Less Than Full Time (LTFT) training. | Worked with trainees and system partners to develop and, where appropriate, pilot new approaches to flexible training.<br>Worked with system partners to agree a more co-ordinated approach to flexible training across the system. | Piloted an extension of LTFT training in Emergency Medicine, and undertaken an interim evaluation. | HEE, GMC, NHS Employers, Royal College of Emergency Medicine, BMA | 18 trainees in the pilot from August 2017.<br>100% of trainees wish to continue in the pilot.<br>Approval to continue the pilot for a further 12 months from August 2018, and open to a further cohort. | 19 |
| | | Invited the Royal College of Physicians (RCP) to develop plans to design, pilot and evaluate Flexible Portfolio Training. | HEE, RCP | Four complimentary pathways have been developed.<br>Pilot sites to be identified in summer 2018.<br>Trainee recruitment opening in November 2018 for pilot start date in August 2019. | 21 |
| | | The Joint Committee on Surgical Training (JCST) have developed and published a position statement on LTFT training, with considerable trainee input. | JCST | **Position statement** published in September 2017.<br>The statement asserts that all training environments should accommodate LTFT trainees. | 22 |

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| **Flexible training models (continued)** | | | | | |
| Limited opportunities for doctors to train flexibly, including structural and cultural barriers to LTFT training. | Worked with trainees and system partners to develop and, where appropriate, pilot new approaches to flexible training.<br>Worked with system partners to agree a more co-ordinated approach to flexible training across the system. | We have worked with the devolved administrations to incorporate key changes to the 2018 Gold Guide to increase flexibility and achieve a consistent approach. | HEE, the GMC, NHS Education Scotland (NES), the Wales Deanery, the Northern Ireland Medical and Dental Training Association. | The 2018 Guide provides updated guidance on Certificates of Completion of Training (CCT) dates, LTFT training, pauses to training, whistleblowing and Out of Programme Experience.<br>The GMC has clarified the flexibilities which exist for doctors in training who wish to train on a LTFT basis – statement issued in November 2017. | 22 |
| | | The GMC have introduced General Professional Capabilities, or GPCs, which could provide trainees with greater flexibility to transfer competencies and reduce the need to restart training if switching specialty. | GMC | The nine domains are outlined in **the GPC framework**.<br>The GMC has asked colleges and faculties to update their curricula to reflect the new framework by 2020. | |
| | | The AoMRC and GMC are working together to consider how we can support trainees' ability to move between programmes. | AoMRC, GMC | The AoMRC and GMC are identifying and developing shared curricula content between specialties.<br>The GMC's plans for promoting flexibility are outlined in **Adapting for the Future:** a plan for improving the flexibility of postgraduate medical training. | 23 |
| | | Worked to link together the various groups involved in LTFT training across England and the UK to ensure clarity and consistency. | HEE, AoMRC LTFT Training Forum, medical Royal Colleges, NHS Employers, BMA | | 24 |

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| **Recruitment** | | | | | |
| Mechanisms to deploy doctors in training in certain areas or regions do not adequately facilitate caring responsibilities or the maintenance of relationships and family life. | Developed, and are trialling, evaluating and refining new approaches to recruitment and selection. | Implemented and evaluated pre-allocation of placements for trainees with special circumstances. | HEE's Medical and Selection & Recruitment Programme (MDRS), BMA, four nation representatives | 47 applicants pre-allocated to their preferred region at the time that offers were released for the 2017 recruitment round.<br>Pre-allocation to be offered again for 2018 recruitment. | 25 |
| | | Pre-allocation system now being managed centrally to ensure consistency. | HEE MDRS, four nation representatives | | |
| | | Trialled facilitated swaps, allowing applicants who had accepted an offer to swap this with a vacant post in a preferred location. | HEE MDRS, BMA | 10 swaps were conducted in 2017, nine of which were in General Practice. | |
| | | Introduced a system of enhanced preferencing, which will allow applicants, for the first time, to update their preferences throughout the full application process, including after posts have been offered. | HEE MDRS, BMA | The new enhanced preferencing system is open to all trainees in England, including those who have been offered a training post in their first choice of location.<br>This is supported across all four UK nations through the MDRS programme. | |

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| **Costs of training** | | | | | |
| Rising costs of training for individual doctors in training, including the cost of examination fees. | HEE and the Academy of Medical Royal Colleges (AoMRC) have worked to explore the cost of exams and training for doctors in training and develop principles to underpin medical Royal College and specialty faculty cost-setting. | The AoMRC have published agreed principles for the funding and costs of exams across medical Royal Colleges and specialty faculties. A further overview is being planned by doctors in training in the AoMRC. | AoMRC, HEE | | 26 |
| | | The AoMRC have provided the results of an initial overview of the costs of training in different specialties. | AoMRC | | |
| **Study Budget reform** | | | | | |
| Varying equity in study budget provision. | Pooled study budget from the secondary care placement tariff, to implement a system whereby HEE supports all elements of curriculum delivery for trainees on approved secondary care training programmes, and discretionary courses that add value to the individual and support the wider system. | Publication of updated Department of Health and Social Care tariff guidance. | HEE, the Department of Health and Social Care (DHSC) | All trainees in approved secondary care training programmes – both HEE-funded or trust-funded – will have access to study budget under the reforms. | 27 |
| | | Worked with the medical Royal Colleges, Specialty Advisory Committees and trainees to define the mechanisms for approving supported activities. | HEE, BMA, AoMRC, medical Royal Colleges | | |
| | | Commenced implementation of the revised tariff in February 2018, with local offices collecting data from trusts for Heads of Schools and Training Programme Directors to review. | HEE, DHSC, BMA, AoMRC | | |

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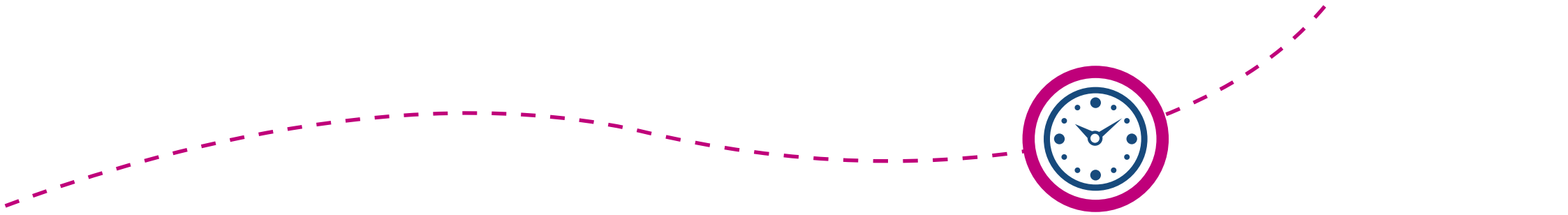
| **Supported Return to Training** | | | | | |
| Inequality for those who take time out of training – the need to support doctors upon their return to training. | Developed innovative and evidenced solutions for supporting doctors in training when they exit, take time out and return to the training programme. | Conducted an evidence-gathering and engagement exercise to ensure that the Return to Training strategy promotes effective approaches and solutions identified by trainees and trainers. | HEE, BMA | Ran a call for ideas from 26 June to 4 August 2017, receiving 116 submissions and 29 organisational responses.<br>Made 10 SuppoRTT commitments, including ring-fencing £6 million to fund resources and activities to support doctors returning to training.<br>Three-year evaluation to commence in 2018. | 29 |
| | | Published our **Supported Return to Training** (or SuppoRTT) strategy and investment **plan** on 30 November 2017. | HEE | | |
| | | Ensured that a co-ordinating function is put in place in each local office. | HEE | | |
| | | Recruitment of fellows, to work with doctors in training, HEE, medical Royal Colleges and employers to shape the approved activities for returners. | HEE | | |
| | | Working with employers to develop packages to support returners. | HEE-provider trusts | | |



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| **Early-careers support** | | | | | |
| The need to support doctors at the post foundation or pre-specialty level looking for a more flexible approach to career progression. | Extended access to the Horus foundation training portfolio. | HEE's in-house portfolio, Horus, was launched in August 2017, providing full access to doctors who have completed foundation training, but are yet to decide on their specialty training route, allowing them to continue to record experience and competencies gained. | HEE | Over 800 doctors who have completed foundation training but are not currently in training are accessing Horus as of March 2018. | 31 |
| **Streamlining** | | | | | |
| The need for improvements to induction and mandatory training, including unnecessary repetition. | NHS Employers' Doctors in Training (DiT) Streamlining programme established with a view to standardise processes between employers, compare performance and share best practice. | Developed six principles for delivering a "perfect rotational process". | NHS Employers | 12 pilot sites and 16 fast followers testing the principles for the rotational process.<br>Pilot extended until the August 2018 rotations to ensure robust testing can take place. | 31 |
| | | Commenced an engagement process with employers to encourage adoption of the new processes. | NHS Employers | | |
| | | Published a toolkit in November 2017 to support full roll-out of the perfect rotational process. | NHS Employers | | |
| | | Liaised with NHS Improvement to build the principles into model hospital reporting mechanisms. | NHS Employers, NHS Improvement | | |

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| **Length of placement** | | | | | |
| Unnecessary repeated home moves during training. | Worked with Heads of Schools, the BMA and the AoMRC to review the principles underpinning lengths of placement, with a view to minimising movement where it does not add educational value. | Agreed a set of principles for good practice for setting the length of training rotations. | HEE, BMA, AoMRC | | 31 |
| | | Conducted an impact assessment for implementing the principles in each local office. | HEE | | |
| **Whistleblowing protection** | | | | | |
| The need for clearer legally-binding protections for doctors if they believe they are subject to detrimental treatment by HEE as a result of whistleblowing. | Provided trainees in England with legal protection if they are subjected to detrimental treatment by HEE as a result of whistleblowing. | Worked with NES, the Wales Deanery and Northern Ireland Medical and Dental Training Association (NIMTA) to update the Gold Guide, to include guidance and signposting to support for trainees who wish to raise a concern without going directly through their employer. | HEE, BMA, NES, the Wales Deanery, NIMTA | | 34 |

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| **Providing individualised support for doctors in training** | | | | | |
| The decline in supportive relationships in the training environment. | Worked with trainees and medical Royal Colleges to explore the attributes of the old Firm model, and consider how to provide the same level of support in modern, working environments. | Developed the concept of the Modern Firm, with the Royal College of Surgeon of England (RCS)'s Improving Surgical Training (IST) pilot, which will commence in August 2018. | HEE, RCS | 23 general surgical trainees expected to commence in IST pilot posts in England from August 2018. | 34 |
| | | Working with the RCP to develop guidance on learning, using effective collaboration in busy workplaces. | RCP | | |
| | | Formally reviewing the Educational Supervisor role and looking at how best we ensure good supervision and good support for doctors in training. | HEE | | |

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| **Review of the Annual Review of Competency Progression process** | | | | | |
| Doctors in training often find the Annual Review of Competency Progression (ARCP) processes inconsistent, stressful, and a tick box exercise without an accompanying formative appraisal. | We have **conducted a 12-month review** of the ARCP process and published our report, Enhancing training and the support for learners, with a set of recommendations which will impact on the working lives of doctors. | Enhancing training and the support for learners report published in February 2018. | HEE, BMA | 680 formal submissions to the call for evidence from individuals and organisations.<br>14 recommendations made, under five themes. | 35 |
| | | Planning for delivering the report's recommendations now underway. | HEE | | |
| | | Plans are being developed to pilot more flexible Out Of Programme (OOP) arrangements in several specialities across the country. | HEE | | |
| | | Working with partner organisations to ensure Educational and Clinical Supervisors receive greater support, information and ongoing training. | HEE | | |
| | | Exploring the how Review's findings can be of benefit other healthcare professions. | HEE | | |

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| **Improving training data** | | | | | |
| The need for a standardised approach to capturing, storing and sharing trainee data, which reduces the administrative burden. | Launched HEE's new online **Trainee Information System (TIS)** as a resource for doctors in training and employers. | Developing data reporting templates to enable automated data collection, so that processes can be done easily and quickly. | HEE | | 36 |
| | | Collaborating closely with the NHS Employers National Streamlining project to provide greater consistency of the TIS / Electronic Staff Record interface. | HEE, NHS Employers | | |
| | | Working to continuously improve our systems and processes. | HEE | | |

# 3. Deployment

We heard that doctors in training want to be given as much notice as possible regarding their next placement, in order to help plan their lives.

We introduced change, following an update to the Code of Practice (COP). We agreed with the British Medical Association (BMA) and employers to provide employers with information 12 weeks before the start of placement, as opposed to the previous eight weeks. This was in response to feedback that notice of deployment to employers was a significant block in ensuring that information could be supplied to doctors in training in a timely manner.

HEE has compiled figures on compliance and most areas have managed to achieve this target and pass on the information 12 weeks in advance, helping employers and doctors in training to plan their rotas whilst taking doctors' commitments into account.

We are aware that some rotas given at 12 weeks are subject to later change for operational reasons. We will be specifically monitoring the areas where this is taking place to identify and resolve any potential issues, and will ensure that the involved trainees are kept fully informed.

We held a lessons learned workshop to examine these issues, attended by NHS Employers and the BMA. The outcome of this was to reduce the number of exception categories and to start collecting data on the number of changes made after 12 weeks, in order to keep these to a minimum.

An initial target of 90% compliance was set for the end of 2017, which was monitored by the HEE Board. A number of different issues, including IT problems, have impacted on HEE's ability to deliver this target.

**"For junior doctors, rotating through multiple workplaces can add to the variety and depth of training, however, it can also have a significant impact on your life outside of medicine. These issues are compounded when rotas or even the place of work are not assigned in a timely fashion before starting a job. Without this information, it can be impossible to organise crucial aspects of daily living such as childcare, or housing. The impact this can have on both individuals and families cannot be overstated.**

**An updated Code of Practice, therefore, is a welcome step for junior doctors. While it does not fix all existing problems straight away, it does mean that the regions and workplaces which struggle to provide this information to junior doctors far enough in advance can be identified, and solutions found. The BMA is working with organisations including NHS Improvement to ensure that the collection of this data at 8 and 6 weeks is robust, to add to the existing monitoring of data at 12 weeks by HEE. This should make the process of moving jobs less stressful, both for junior doctors, and their friends and loved ones."**

**British Medical Association**

**The Code of Practice was refined in 2018 to provide further clarify and reduce the number of exceptions allowable.**

# 4. Flexible training

The need for greater flexibility in training has consistently remained one of the strongest themes in feedback received from doctors in training and has been central to our work this year. We continue to work closely with doctors in training and the medical Royal Colleges to improve the flexibility during a doctor's training in many ways, the advantages of which we explored in our first report last year.

**'Concerns about equity in access to flexible working have also been raised. Currently eligible trainees who request Less Than Full Time 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'.**

**Enhancing Junior Doctors' Working Lives – A Progress Report (2017), p21**

## 4.1 Less Than Full Time Training Emergency Medicine pilot

We heard that some doctors in training would like to train Less Than Full Time (LTFT) for a wide range of reasons that were outside the Gold Guide categories used to prioritise requests. To assess the effect of opening more opportunities for LTFT training to all doctors in training, HEE started a pilot in August 2017 that allowed doctors in training in Emergency Medicine in England to train LTFT without having to meet the narrow categories set out in the Gold Guide. It was thought that a more flexible approach may reduce 'burn out' and attrition, improve morale and aid recruitment to Emergency Medicine, though it is recognised that there is a desire for better access to LTFT training across specialties. This is one of several measures introduced by HEE and the Royal College of Emergency Medicine, aimed at reducing attrition from the specialty.. Fears were expressed that a very high uptake from trainees would negatively impact upon service.

The pilot received 23 applications, with 18 accepting and commencing in post from August, all training 80% of full time.

**The interim evaluation after six months reported a clear message from trainees:**

- That they entered the pilot because they were exhausted by the job.
- They have used the 0.2 WTE time released both to study and undertake other activities outside work.
- They all feel better and that it has increased their chances of remaining in Emergency Medicine.
- Although it has not altered the way they learn, it has facilitated the opportunities to learn and some reported improved clinical behaviours.
- All wished to remain LTFT.

**The interim evaluation of the pilot also highlights:**

- that this initiative seeks improvement to trainees working lives by allowing them time away from their workplace. By its nature, the pilot cannot address the problem of increasing numbers of patients and flow through Emergency Departments which makes the job exhausting.
- any unfilled gaps in the rota as a consequence of the LTFT pilot would mean an additional burden for those working full time. If trainees participating in LTFT training were to continue LTFT throughout their training and new trainees joined LTFT training, then there would be a cumulative effect over time which may worsen any rota gap problem.

When those participating in the pilot were asked whether there was any benefit to patients, some of the responses were:

**"feel more attentive, give patients more time"**

**"more empathetic, more reflective, less tired, less likely to make mistakes"**

**"not so tired or so snappy with patients"**

Given this progress, HEE's Executive has approved a recommendation from the Enhancing Junior Doctors' Working Lives Working Group for the pilot to be extended for doctors already in the pilot for another 12 months, from August 2018 to August 2019 and for the pilot to be expanded to introduce an additional cohort (based on the same principles) from August 2018.

A further evaluation will be carried out after 12 months, which will examine the impact on pilot trainees, other trainees training LTFT or full time, employers and the service. This will help determine whether to recommend the expansion of the pilot to other specialties.

### 4.2 Flexible Portfolio Training

HEE and the Royal College of Physicians (RCP) are developing plans to design, pilot and evaluate Flexible Portfolio Training, which will reduce the pressure of intensive clinical duties by adding in complementary training experience. In the pilot, doctors in training will have protected time to pursue alternative professional development alongside the traditional training in their clinical specialty. For the purposes of the pilot, four complementary training pathways have been proposed:

- Clinical informatics
- Medical education
- Quality improvement
- Research

Based on feedback received, these proposed pathways have been selected as they are attractive and practical for professional development and will support the development of services and address geographical skills gaps. This will be piloted with registrars in acute medical specialties, such as Acute Internal Medicine (AIM)[1], who participate in the acute medical take, with a view to boost recruitment and retention in these high-pressured specialty training areas. We are also scoping the feasibility of extending the pilot to include core medical trainees.

Flexible portfolio careers will be piloted regionally for doctors in training in Acute Medical Specialties such as Acute Internal Medicine (AIM).[1]

Alongside the pilot, HEE and the RCP will work together to engage the wider healthcare and healthcare education system to tackle attitudes which impact negatively on doctors wanting flexible portfolio careers.

HEE and the RCP will be selecting pilot trusts in summer 2018, with a view to identifying doctors in training for the pilot sites during the 2019 recruitment round, commencing in November 2018. Interested doctors in training should look out for updates from the RCP and HEE's Recruitment and Selection team later in 2018 and for the communications which will signpost interested doctors to relevant information.

### 4.3 2018 Gold Guide

In response to feedback, the medical education systems of the four UK nations work together to regularly update the Gold Guide, which sets out the requirements for doctors in training in postgraduate medical education.

The 2018 Gold Guide has changes which increase the options for doctors in training with regard to training flexibly or LTFT training. See Appendix B for more information.

### 4.4 Other medical Royal College initiatives to promote flexibility

#### 4.4.1 Joint Committee on Surgical Training LTFT position statement

In response to a system-wide commitment to promote flexibility, the Joint Committee on Surgical Training (JCST) established a working party to consider how to promote the options for training LTFT in surgery and address the barriers to this. The group had considerable trainee input, publishing a statement and recommendations in September 2017.

The JCST note that all training environments should, in principle, be able to accommodate LTFT doctors in training, as the GMC has previously stated that if a post is approved for training, then it is also approved for a training placement on a LTFT basis.

1 Acute medicine is the part of general (internal) medicine concerned with the immediate and early specialist management of adult patients who present to, or from within, hospitals as urgencies or emergencies. Sourced: Royal College of Physicians. Acute medical care; the right person, in the right setting—first time. Report of a working party. London: RCP, 2007

The JCST recommend that there should be a designated individual in each HEE office or specialty school with responsibility for LTFT and that cross-system collaboration is required to streamline guidance for doctors in training and trainers, simplify processes and enable clear communication.

The statement acknowledges that the biggest challenge will be achieving a cultural shift within the surgical specialties and provides advice on facilitating this change.

**The JCST LTFT policy statement and recommendations can be accessed in full online.**

#### 4.4.2 Psychiatry training

There are other examples of best practice.

The RCPsych (Royal College of Psychiatry) has a long tradition of incorporating a mandatory special interest or research day for all trainees during higher training.

The day is protected from routine clinical work and the timetable negotiated with the educational and clinical supervisors. LTFT trainees also have this time incorporated pro-rata. This approach is summarised in Appendix C.

### 4.5 Flexibility to move between specialty programmes

Some doctors in training, once they have started training, may find that their selected programme is not the one for them and would, therefore, like to pursue other specialty pathways. The Academy of Medical Royal Colleges (AoMRC) and GMC are working together to consider how doctors in training' can move more easily between programmes, in a way that is proportionate to the demand for movement, the impact on doctors in training and the impact on service delivery.

HEE's review, **Enhancing training and the support for learners** encourages recognition of existing competencies through the ARCP process. It recommends greater use of the flexibility contained within the Gold Guide to accelerate training progress when appropriate, once a trainee has entered an approved programme.

HEE is continuing to work with the AoMRC, individual medical Royal Colleges and the GMC to explore further flexible training options.

A working group on flexibility and transferability, which includes both the AoMRC and the GMC, expects to report in the autumn.

### 4.6 Further work

We recognise that there are significant challenges to improving flexibility in training, but believe this is the right way forward for doctors in training and, in turn, patient care and the wider service.

We will assess the impact of the work we have done so far to inform further developments and initiatives.

Cultural change is perhaps the biggest barrier. In an NHS system that is not used to offering flexibility, overcoming this to introduce new training patterns is difficult and will take time. More specialties want to support flexibility, so there is further work to be done to explore how to make this possible, without impacting adversely on patient care.

#### 4.6.1 Co-ordinating flexibility initiatives across the training system

HEE has been working with the other organisations involved to link together the various groups involved in LTFT training across England and the UK in order to ensure clarity on the possibilities in LTFT training and the options for trainees to obtain advice.

Some of these include Champions of Flexible Working, Guardians of Safe Working, Directors of Medical Education and Educational Supervisors, Training Programme Directors, Associate Deans and College Regional Advisors.

We have committed to work with employers, medical Royal Colleges and the BMA to ensure clarity about how the system links together and the remit of those involved. We will ensure there is cross-system alignment and nationally agreed guidelines, with equity in the access to flexible training and the consistent provision of high quality, relevant advice.

# 5. Recruitment

In our first report, we discussed many of the perceived issues with recruitment into postgraduate medical training and have continued to work to address these.

## 5.1 Pre-allocation for doctors in training with special circumstances

In the 2017 recruitment round, HEE introduced a process to enable doctors in training with special circumstances to have placements pre-allocated, allowing them to plan for their personal and work priorities well ahead.

To ensure equity across England, for the 2018 recruitment process commencing in November 2017, the application process has been managed centrally by a single team in HEE, the Medical & Dental Recruitment and Selection (MDRS) team. The MDRS Team manage and deliver improvements in medical recruitment systems for whole of the UK.

In total, there were 81 applicants with special circumstances, across three rounds of recruitment in 2017. Of the applicants who were approved, 47 were pre-allocated to their preferred region at the time that offers were released. Given the success of pre-allocation in 2017, the process is being offered again for 2018 recruitment, with 87 applications already received by December 2017, with another two recruitment rounds still to take place.

To further improve recruitment processes, the uptake and impact of these initiatives is being evaluated by HEE as part of the four nation MDRS programme with input from the BMA Junior Doctors' Committee.

**"Pre-allocation for me has meant I have my family nearby, so I have the support I need to be able to continue working. It also has meant I can get the medical treatment I need, which elsewhere I couldn't get and without which I wouldn't be able to continue working as a doctor."**

## 5.2 Offer exchanges and Enhanced Preferencing

To help doctors in training placed in a different region to their partner or family, HEE operated facilitated swaps for the 2017 recruitment process, allowing applicants who had accepted an offer to swap this with a vacant post in a preferred location.

This process required a two week pause of offers at each stage of recruitment, despite having a relatively low uptake: 10 swaps were conducted in 2017, nine of which were in General Practice. The low numbers were mainly due to the large number of doctors in training wishing to train together in competitive regions such as London, where all posts had already been filled.

HEE has worked alongside the BMA to consider alternative mechanisms that will maximise the opportunities for doctors to train in their preferred location, whilst minimising perceived unfairness for others in the overall recruitment process. It was established that the system of specialty recruitment – which occurs for many specialties, across multiple rounds – was too complex for linked applications to be implemented. Instead, enhanced preferencing and offer exchanges have been introduced for 2018 recruitment, helping doctors in training to work near their families.

Recognising that personal circumstances can change for any number of reasons between the time that applications are submitted and offers being made, this new system will allow applicants, for the first time, to update their preferences throughout the full application process, including after posts have been offered. This will be open to all doctors, including those who have been offered a training post in their first choice location. This has been supported across all four UK nations through the MDRS programme.

# 6. Cost of Training

## 6.1 Cost of training

HEE has continued to work with the AoMRC to improve transparency in the costs of training, to ensure that unnecessary costs are not passed on to doctors in training.

In March 2017, the AoMRC published agreed principles in setting exam costs. Colleges agreed to regularly review examination costs and publish their findings, indicating how costs had been reached and how any surplus income would be used to support doctors in training. The Colleges also agreed to share development and delivery resources and to jointly negotiate contracts, where possible and appropriate, with a view to reducing costs.

Since the publication of the Academy statement, the Colleges and faculties have also worked to establish the baseline costs of training. An initial review was published online by the AoMRC in October 2017. This highlighted the significant challenges in providing accurate information about the training costs for doctors going through training, because of different cross specialty and regional expectations.

However, in order to address the issue of rising costs, the AoMRC will continue to explore how unnecessary expense for doctors in training can be avoided, through greater transparency around costs, with Colleges working together to benchmark costs and share best practice in minimising these.

### 6.2 Study Budget reforms

Doctors in training told us that they feel access to study budgets is inequitable; they said it varies across the country and in many cases they pay for educational activity themselves.

In response, study budget reforms are being introduced to deliver equity of access to educational resources based on individual need and to facilitate improved quality, efficiency, flexibility and transparency. The principles for approving study budget-funded educational activities have been developed through consultation with trainees, their representative bodies, Colleges, Specialty Advisory Committees and Faculties. We are moving away from a notional individual annual study budget allocation that varies, to implement a system whereby HEE supports:

- All trainees on approved secondary care sector training programmes to achieve their curriculum outcomes.
- Discretionary or career enhancing activity and courses that add value to the individual and support the wider system.

A proportion of funding will be pooled from the secondary care placement rate to provide support for all trainees irrespective of post type (tariff- or Trust-funded). HEE local offices started to capture data on study budget funded activities from February 2018. Heads of Schools and Training Programme Directors will monitor and evaluate the range of funded educational activity undertaken to ensure that it is fit for purpose, providing quality and value for money.

**Out of Scope Activities**

- It has been agreed that funding for statutory and mandatory training is an employer responsibility and will not come from the Study Budget.

## Approved Activities

We have agreed with Colleges, Specialty Advisory Committees and Faculties that they will describe expected capabilities and outcomes but not mandate generic or specific courses. High quality locally delivered activity is preferred where possible.

In addition Colleges, Specialty Advisory Committees and Faculties will recommend a range of educational activities or courses that could be grouped around specific themes aligned to the curriculum that will help Schools maximise use of the resource.

Colleges and local education providers may play a role in delivering courses aligned to the curriculum.

It is essential that all educational activity is quality assured.

Through our consultation process we have agreed a set of principles that constitute quality training activity. These principles will be applied across all specialties with the understanding that some specialties will require a greater proportion of the budget than others and that some curriculum stages will require a greater proportion of the budget than others. For every trainee, delivery of curricula objectives based on individual requirements will be the primary consideration. In addition we have agreed that:

- A good educational activity or course is aligned to the curriculum, receives positive feedback from trainees and faculty and offers value for money.
- Heads of Schools could improve efficiency by delivering local training where possible and release resource to reinvest in aspirational activity.
- Data on current activity should be mapped against curricula to ensure that funds are utilised correctly. This will be essential to delivering quality educational activity that meets trainee and local needs.
- Management and leadership skills development should normally be supported.

In addition to supporting all trainees to achieve their curriculum outcomes we have agreed to use these resources to support discretionary or career enhancing activity that is not directly aligned to the curriculum. This can be considered for trainees who have attained their core curriculum competencies and received an ARCP outcome 1 or are on track to do so if they are in their first year. Aspirational activity should align to the trainee personal development plan and would normally align to service needs.

We have agreed to closely monitor use of the resources to ensure value for money and equity and we will be producing a formal annual report for the 2018/19 financial year in June 2019.

# 7. Supported Return to Training

**The 2016 ACAS junior doctors' contract agreement** committed HEE to develop innovative, evidence-based initiatives to "remove as far as possible the disadvantage of those who take time out due to, for example, caring responsibilities".

There are approximately 5,000 doctors taking approved time out of the postgraduate training programme at any given time – roughly 10% of the whole trainee population. HEE conducted an extensive evidence gathering and engagement exercise to inform the development of a Return to Training strategy.

The **Supported Return to Training (or SuppoRTT) strategy and investment plan** was published in November 2017. The document outlines HEE's 10 commitments for supporting returning doctors in training (Figure 1). We have also enabled the development of new simulation training packages to support returners.

A three-year evaluation of the SuppoRTT strategy, will commence in 2018.

| # | HEE SuppoRTT Commitment |
|---|---|
| 1 | HEE will capture data on returners to inform to ensure the SuppoRTT strategy and investment plan continues to provide individualised support for returning doctors in training where and when it is required. |
| 2 | HEE will ring-fence £6m to fund resources and activities to support returning doctors in training, selected in partnership between Educational Supervisor and trainee, using a defined framework. |
| 3 | HEE will coordinate and centralise support for trainee returners to ensure a defined process and framework is followed. |
| 4 | HEE will commission training and resources for Educational Supervisors to help them support returners. |
| 5 | HEE will fund regions to deliver biannual Keeping in Touch (KIT) conferences for doctors in training. |
| 6 | HEE will develop metrics for monitoring delivery of SuppoRTT activities and interventions. |
| 7 | The SuppoRTT programme will collaborate with projects and programmes within HEE and the wider system, to identify and address interdependencies; raise the profile of returners' voices; and realise shared benefits. |
| 8 | HEE will continue to monitor the SuppoRTT programme and implement further recommended changes based on continuing evaluation. |
| 9 | Doctors in training will be involved throughout the design, implementation, monitoring and evaluation, and continuous improvement of the SuppoRTT strategy and delivery. HEE will appoint full time equivalent trainee clinical fellow posts, to conduct further investigation to develop a "menu" of bespoke return to training approaches for doctors in training. |
| 10 | HEE will review these commitments annually to ensure the strategy, investment plan and underpinning processes are delivering the best possible support and outcomes for returning doctors in training. |

**Figure 1 - HEE's SuppoRTT Commitments**

HEE will undertake further work with employers, Directors of Medical Education and Educational Supervisors to embed necessary cultural changes for delivering the SuppoRTT strategy.

**How we are supporting doctors to return to training – some case studies**

Dr A trained to equivalent of ST4 in a medical subspecialty in the UK before leaving medicine to follow her husband overseas. She has not practised medicine for 13 years. She has support from her previous employing trust to undertake a supervised post as a clinical observer with a view to progressing to supported F1/2 role if deemed competent to do so, in order to demonstrate Foundation competencies.

Dr B completed F2 in the UK three years ago with excellent feedback and references. They were due to start a Core Medical Training (CMT) post on completion of F2, but were unable to do so as they developed a serious health problem and have not been fit enough to work since. They wish to return to medicine once their medical condition is stable and controlled. A trust has been identified that is prepared to employ the trainee in a supervised supernumerary post at equivalent of F2 so they have previously achieved Foundation competencies confirmed before re-entering training.

Dr C, a trainee in a surgical specialty, has progressed more slowly than expected and has now developed physical health issues resulting in prolonged periods of sick leave. The intention is to support their return to training when medically fit in a supernumerary post with enhanced supervision and a particular focus on technical skills including additional exposure to simulation to help them to progress in their training.

Dr D is a trainee who completed F1 satisfactorily six years ago before developing health problems. These resulted in long periods off sick and eventually the trainee made the decision to resign from the Foundation programme before completing F2. They did occasional locum shifts in the two years following this, but have subsequently not been able to work for three years. They are now well and keen to return to medicine. The intention is to fund a supernumerary placement as a clinical observer, initially with the intention to progress to an F1 equivalent post with enhanced supervision. Once F1 competencies can be demonstrated, they will hopefully progress to a substantive F2 post to complete Foundation competencies.

# 8. Early career support

HEE's in-house e-portfolio, Horus, went live in August 2017. HEE has made the system fully accessible to non-training doctors who have completed foundation training, but are yet to decide on their specialty training route.

Access to the portfolio allows pre-specialty doctors in training to log experience and competencies gained, which may inform their educational needs assessment should they later join a prospectively approved specialty training programme. This could facilitate accelerated progression within training.

Over 800 doctors not in training have already used the facility and feedback on the benefits of this has been extremely positive.

# 9. Related areas of work

### 9.1.1 Streamlining

As training involves rotating between employers, doctors in training frequently find they are expected to repeat mandatory training and data checking processes.

NHS Employers agreed to address these issues and reduce unnecessary bureaucracy through their initiative, streamlining for Doctors in Training. The Doctors in Training Streamlining programme comprises four workstreams, focused on statutory and mandatory training, recruitment, medical staffing and Occupational Health and HEE is supporting NHS Employers in this work.

For more information see Appendix D.

# 10. Length of placements

HEE agreed to review the frequency of training rotations with a view to minimising unnecessary movement between placements and engaged with stakeholders to explore this issue, including the use of using focus groups to create a set of draft principles, outlined below.

HEE's local offices have conducted an impact assessment for implementing the principles. The assessment listed each programme and rotation and provided a rating as to whether the rotation complied with the principles, or whether alterations would be needed to the rotational programme.

It was recognised that there will be programmes which, for sound educational reasons, cannot be altered. Further work is now being undertaken to reconfigure programmes, where appropriate, and identify the appropriate timescales for changes to occur.

### Length of training rotations – principles for good practice

1. The purpose of rotations in postgraduate medical education is to ensure that doctors in training receive adequate experience in accordance with curriculum standards.

2. Postgraduate medical rotations of all specialties and grades should be regularly reviewed to ensure fitness of purpose with respect to quality of the educational environment in accordance with HEE Quality Framework, satisfactory progression in training and personal and educational needs of doctors in training.

3. While making a commitment to reduce the need for frequent geographical moves, there is a need for flexibility of approach and recognition of local circumstances and training needs.

4. There is no precise definition of "geographical location"; an emerging consensual definition is that a change of geographical location refers to a physical move to a different training site that is not more than 60 minutes commuting time from the previous location. The new location may or may not be within the same employing organisation.

5. A transparent approach with respect to allocation of doctors in training across a region is important; while acknowledging the views of doctors in training regarding where they would wish to be trained, there is a risk that less popular locations which also deliver good training might be disadvantaged.

6. There are occasions when it may be necessary to move doctors in training to alternative geographical locations when issues or concerns regarding educational environments occur.

7. There will be occasions for military doctors in training when the needs of the Defence Medical Service will dictate the need for an additional or alternative placement.

8. The following suggested lengths of training in specific locations are outlined by level of training. These suggestions represent guidelines and are not prescriptive:

- **Core training and early years of run-through training:** the preferred option would be for the majority of placements in core training to be undertaken in the same geographical location. Core training placements should be no less than four months in duration, and would ideally be of six months duration. If, for educational reasons, it is required for core doctors in training to be placed elsewhere, it is recommended that this should take place in a single block at the beginning or end of the training programme.

- **Higher training:** a consensus view is that, wherever possible, higher doctors in training should remain in the same geographical location. This should be for a minimum of 12 months, and longer (i.e. two to three years) where possible. However, it is recognised that not all training locations have the capacity or breadth of experience to meet all curricular needs and rotation to another location is needed. Careful consideration should be given to the timing of such placements to minimise the disruption caused by frequent changes in location within programme i.e. continuous blocks of two-three years in the same location.

- **Less Than Full Time doctors in training** in core and higher training posts should have their placements considered for possible increases to the pro-rata length of their rotations.

9. With respect to geographical location, it is considered that a commute of up to 60 minutes from base is acceptable, depending on local transport arrangements. It is acknowledged that public transport arrangements may differ depending on the geographical area and this should be taken into consideration. In addition, possible significant safety issues with respect to commuting after a shift should be acknowledged.

   It may not be possible in all cases to minimise travel time to under 60 minutes for academic doctors in training when considering the travel required to meet both academic and clinical requirements However consideration should be given to the difficulties that different bases cause and measures taken as appropriate to reduce the impact of travel time.

10. We should collate and share examples of good practice to include the following:

- Doctors in training should be aware at the start of their rotation if they are to be expected to move and the reasons for this.

- There should be mechanisms for doctors in training to indicate their preferred training locations with clear and transparent processes for the allocation of different training locations such that doctors in training know their future training locations a minimum of six months ahead of time. It is noted that some rotational information is available with two to three years notice, which has been highlighted by doctors in training as the ideal.

- There should be pairing of a popular location (such as a teaching hospital) with a less popular District General Hospital, to support delivery of good training within less popular locations.

  Where it is not possible to restrict commuting times between locations to under 60 minutes, Postgraduate Deans should develop clusters of trusts or training locations that will provide the majority of training for a given specialty.

# 11. Whistleblowing

HEE has ensured that all trainees have legal protection to address any detriment that they might suffer from HEE's actions as a result of a whistleblowing report. In September 2016, the BMA agreed legally binding protections with HEE for doctors in training who raise concerns in the workplace. This agreement, negotiated with HEE, NHS Employers and the Department of Health and Social Care, ensures that doctors in training will have legal protection if they are subjected to detrimental treatment by HEE as a result of whistleblowing. The legal protections were applied retrospectively from 3 August 2016.

The HEE Agreement has been agreed so that protection is extended to all postgraduate trainees, whoever their contract of employment may be with, or is intended to be with, when they commence or recommence training.

HEE has worked with NHS Education Scotland (NES), the Wales Deanery and the Northern Ireland Medical and Dental Training Association (NIMTA) to update the **Gold Guide (page 74),** to include guidance and signposting to support for trainees who wish to raise a concern without going directly through their employer.

# 12. Providing individualised support for doctors in training

We have heard there is inequity in the level of support offered to doctors in training, with variation across different specialties and geographies. With the current pressures in the NHS, it is important that doctors have effective supervision and support in place to enable them deal with any working or training issues and concerns, and to be able to discuss their development and career choices.

## 12.1 Improving Surgical Training pilot

The Royal College of Surgeons of England (RCS) is working with Health Education England (HEE) to pilot a new competence-based, run-through surgical training programme in general surgery. The pilot will trial improvements in the quality of training, a better balance between service and training for trainees, and the professionalisation of the role of trainers. It will also look to develop members of the surgical care team to work alongside surgical trainees to improve patient care.

Foundation trainees applying for core-level surgical training via the 2017/2018 national selection process will be able to choose Improving Surgical Training (IST) pilot sites via the existing post preferencing system.

The IST pilot will focus initially on general surgery from 2018, with urology and vascular surgery to be added from August 2019. Pilot trainees will follow the existing core and general surgery curricula, but with increased time allocated to training, reduced on-call rota commitments and better use of the surgical care team.

All IST placements aim to provide an improved working environment and more valuable training opportunities within a multi-disciplinary team. This is the essence of the Modern Firm, a working and training environment that offers mutually supportive relationships whilst recognising profession-specific needs.

### 12.2 Royal College of Physicians' guidance to support learning in modern teams

HEE are working with the RCP to develop guidance on the provision of support for learning, using effective collaboration in busy workplaces. This will complement the **RCP's Improving Teams in Healthcare (2017) resources** and consider profession specific needs and inter-professional opportunities and be framed within the context of the modern multidisciplinary teams.

### 12.3 Medical mentoring e-learning programme

HEE e-Learning for Healthcare (HEE e-LfH) has developed an e-learning programme to enable junior doctors to complete training to be a mentor without needing to travel to a teaching session.

Mentoring plays a significant part in the development of a trainee. Indeed, the Call for Ideas for HEE's SuppoRTT initiative revealed that many trainees greatly value the guidance and support that a mentor can provide.

Evidence shows that, whether the relationship is formal or informal, a good mentor can be instrumental in the development of not only a trainee's skills and knowledge, but also their behaviour, attitude and professional outlook.

The online course helps trainees to develop their mentoring skills, increase their awareness of the roles and responsibilities of a mentor, and highlights how being a mentor may benefit their own personal development.

Further information on accessing this learning resource is available at https://www.e-lfh.org.uk/programmes/medical-mentoring/

### 12.4 Review of the Annual Review of Competence Progression process

HEE has recently completed and published **Enhancing training and the support for learners**, a review of the ARCP process and the wider appraisal, assessment and support to doctors in training in this process.

The review and its recommendations have highlighted a number of areas for improvement which will impact on doctors' working lives.

Working closely with doctors in training, we heard that they often found the processes inconsistent, stressful, and a tick box exercise without an accompanying formative appraisal. In particular, they were keen that flexibility in training was promoted through the system.

The recommendations of this review are in Appendix E.

These link to enhanced training and support for learners and include more flexible Out of Programme (OOP) arrangements to allow trainees to step out of the training pathway for a period of time in a more flexible career development pathway. Plans are being developed to pilot this in several specialities across the country.

The Review recommends a more supportive approach for doctors in training. This should include career advice, support for areas of clinical and personal development and guidance on future development. The need for high quality face-to-face feedback for trainees was identified as essential, in the context of the recommendation that ARCP panels, a key point of face-to-face professional support for many trainees, should be entirely in absentia.

There is a need for recognition of the challenges that LTFT doctors face in their training. The Review highlights the need for greater equity in accessing LTFT training and for enhanced ARCP support and feedback for doctors in training working LTFT.

A major finding in the report was the key role of the Educational and Clinical Supervisors and that they need much greater support, information and ongoing training. HEE is working with other organisations to ensure that this happens. Work is being planned to ensure that all involved are clear about their responsibilities, what they can expect from the process and are appropriately trained. HEE is exploring how what was learned through the review can be of benefit other healthcare professions.

HEE will continue to engage with those involved with the review over the coming year.

## 13. Improving training data

Following the launch of HEE's new online TIS as a resource for doctors in training and employers, our MDRS team is developing data reporting templates to enable automated data collection, so that processes can be done easily and quickly.

HEE is collaborating closely with the NHS Employers' National Streamlining project to provide greater consistency of the TIS / Electronic Staff Record interface.

In carrying this work forward, we recognise that technical failure and human error can cause major disruption, failure to deliver targets, anxiety for individuals and that we therefore need to continue to improve our systems and processes.

# 14. Next steps

This report details the significant progress made to improve the working lives of doctors in training during the past 12 months, building upon the work in the report published in March last year. However, there is still much work to be done, both in HEE and across the NHS.

Enhancing Junior Doctors' Working Lives will continue to be an important focus of HEE's Medical Education Reform Programme over the next year, with some of our plans set out below. In doing this, we will continue to engage widely, most importantly with doctors in training themselves, as they are the inspiration and drivers for this work.

Over the next year, HEE will provide leadership in co-ordinating activities across the system and in identifying and promoting initiatives and innovation for supporting doctors in training.

We will work to embed good practice through our Quality Framework, which is the means by which HEE assesses and improves the quality of the clinical learning environment. We will highlight where education providers have made tangible improvements and by sharing the relevant good practice we will enable trusts to see how to improve their training and training environment when we find there are issues.

Crucially, we will continue to work with system partners to engage with doctors in training and their representative bodies, notably the BMA JDC, to ensure that views and concerns are heard and addressed.

**Among the important themes that we will be examining over the coming year are:**

- the provision of educational and clinical supervision
- empowering doctors in training to ensure they have time for both clinical work and educational opportunities, for example, with work scheduling
- the provision of pastoral support or mentorship
- effective, supportive, multi-disciplinary team working
- what more can be done to tackle bullying and harassment
- guidance on safe reflective practice.

The framework and assessments tools, such as the GMC National Training Surveys and the HEE National Education and Training Survey will be used to evaluate our success in embedding the improvements identified within this report.

| Milestones for the year ahead | |
|---|---|
| **Date** | **Activity** |
| **March 2018** | Implementation plan for the ARCP review recommendations in the **Enhancing training and the support for learners** report. |
| **March 2018** | Commencement of the second year of the LTFT training pilot in Emergency Medicine, with applications opening to a second cohort. |
| **April 2018** | HEE local offices to commence management of local study budgets. |
| **May 2018** | Initial findings report for doctors in training rotation streamlining process following completion of February and April rotations. |
| **Spring 2018** | Advice to HEE Executive Team regarding the possible expansion of LTFT training opportunities to other high-intensity specialties, following the initial pilot in Emergency Medicine. |
| **Summer 2018** | Appointing pilot sites for the Flexible Portfolio careers pilot |
| **Summer 2018** | Regional SuppoRTT Fellows commence work reviewing implementation |
| **Summer 2018** | Final rotation for pilot sites to test the doctors in training rotational process. |
| **September 2018** | Launch the national toolkit to enable all employers to implement the "perfect process" for training rotations. |
| **2018** | Development of study leave modules in HEE's TIS to support management of new processes. |
| **November 2018** | Application window for trainees to apply for flexible portfolio training posts opens |
| **March 2019** | Offers for Flexible Portfolio training placements |

# Glossary of Abbreviations and Initialisations

| | |
|---|---|
| **ACAS** | Advisory Conciliation and Arbitration Service |
| **AIM** | Acute Internal Medicine |
| **AoMRC** | Academy of Medical Royal Colleges |
| **ARCP** | Annual Review of Competency Progression |
| **BMA** | British Medical Association |
| **CCT** | Certificate of Completion of Training |
| **CMT** | Core Medical Training |
| **COP** | Code of Practice |
| **DiT** | Doctors in Training |
| **DHSC** | Department of Health and Social Care |
| **DME** | Director of Medical Education |
| **GMC** | General Medical Council |
| **GP** | General Practice |
| **GPCs** | Generic Professional Capabilities |
| **HEE** | Health Education England |
| **IDT** | Inter-deanery Transfer |
| **IST** | Improving Surgical Training |
| **JCST** | Joint Committee on Surgical Training |
| **KIT** | Keeping in Touch |
| **LTFT** | Less Than Full Time |
| **MERP** | Medical Education Reform Programme |
| **MDRS** | Medical and Dental Recruitment and Selection programme |
| **MTI** | Medical Training Initiative |
| **NES** | NHS Education Scotland |
| **NHS** | National Health Service |
| **NIMTA** | Northern Ireland Medical and Dental Training Association |
| **OOP** | Out of Programme |
| **OOPE** | Out of Programme Experience |
| **PGMDE** | Postgraduate Medical and Dental Education |
| **RCP** | Royal College of Physicians |
| **RCPsych** | Royal College of Psychiatrists |
| **RCS** | Royal College of Surgeons |
| **SuppoRTT** | Supported Return to Training |
| **TIS** | Trainee Information System |

# Appendices



# Appendix A

## The Medical Education Reform Programme

Through the Medical Education Reform Programme (MERP), we aim to achieve:

**For the public** – a highly trained, highly motivated workforce delivering safe, high quality, compassionate patient care.

**For doctors in training** – a more flexible system of training that recognises them as individuals with lives outside work, by enabling medical careers to be more tailored to individual clinicians, reducing some of the current causes of dissatisfaction with the training system and its process and enabling a better work life balance. .

They should be valued as highly trained professionals in a working environment in which they can learn safely and where clinicians are empowered to develop their careers and those facing challenges are provided with the support they need.

**For employers** – a highly motivated, flexible workforce that is willing and able to meet the needs of the service now and in the future and helps to address recruitment and retention issues.

**For the wider workforce** - unlocking opportunities for career development to meet the evolving needs of patients and services.

We want to ensure that doctors in training are supported, valued and provided with the means to become competent and versatile clinicians, integrated into multi-professional teams within changing service models.

Throughout our work so far, the voice of doctors in training has been key.

The programme is supported by a working group of key stakeholders and we are grateful for their important contribution to this work

# Appendix B – The Gold Guide 2018

## The Gold Guide 2018 - seven key changes which increase flexibility and consistency

1. **Layout**
   We have re-sequenced the guidance to reflect the training cycle, increase clarity and reducing duplication. These changes have been undertaken to improve consistency in application.

2. **CCT Date**
   The guidance now makes specific reference to bringing forward a trainee's CCT date, as opposed to previous editions, which concentrated only on extending training.

3. **LTFT Training**
   The Gold Guide now clarifies that LTFT doctors in training can undertake part-time working whilst undertaking LTFT training. The guidance on Category 2 requests has also been expanded.[2]

4. **Pausing Training**
   The guidance introduces the concept of a pause in training as a no fault decision, as opposed to a punitive measure.

5. **Whistleblowing**
   The guidance advises doctors in training to contact HEE, NHS Education Scotland (NES) the Wales Deanery or the Northern Ireland Medical and Dental Training Association (NIMTA) for guidance and signposting to support in the event that they wish to raise a concern without going directly through their employer.

6. **Out of Programme Experience (OOPE)**
   The Guide expands the criteria by which a trainee may apply for an OOPE. The full criteria include enhancing skills in medical leadership, academia, medical education or patient safety, or enhancing clinical skills related to but not part of the curriculum. Such experience may benefit the doctor (e.g. working in a different health environment/country) or may help support the health needs of other countries (e.g. with Médecins Sans Frontières, Voluntary Service Overseas, global health partnerships).

2 A Category 2 request for LTFT Training can be made by doctors in training with unique opportunities for their own personal or professional development, for example training for national or international sporting events, or short-term extraordinary responsibility, for example a national committee; religious commitments – involving training for a particular religious role with requires a specific amount of time commitment; non-medical professional development such as management courses, law courses, fine arts courses or diploma in complementary therapies

## 7. Providing Clarity in relation to specific areas

The Guide provides clearer advice on:

- the management of an outcome 5 (incomplete evidence presented – additional training time may be required);
- consultant application and statutory leave;
- managing an out of programme career break (OOPC)
- maximum extensions to training; and
- how experience in a Local Appointment for Service (LAS) post may contribute to progression of training.

# Appendix C – Psychiatry training

The Royal College of Psychiatrists has incorporated a mandatory special interest or research day for all trainees during higher training for many years.

The day is protected from routine clinical work and the timetable negotiated with the educational and clinical supervisors. LTFT trainees also have this time incorporated pro-rata.

Whilst traditionally it is taken as a day a week, some trainees have preferred to take it in a block of several months, for example, to pursue a specific research project.

The special interest or research project is agreed with the educational supervisor and has incorporated clinical experience in sub specialities of psychiatry (e.g. perinatal, tertiary mood disorder clinics, addictions etc), other medical specialties (e.g. neurology, old age medicine or neuroradiology), education, research or management and leadership.  The outputs are assessed via the ARCP process.

The attraction of including this opportunity in every trainee's timetable is that it is equitable, no special application is required and time for progression of clinical competencies is the same for all trainees. The Royal College of Psychiatrists is particularly proud to have used this to design its flagship sustainability and parliamentary scholar schemes for higher trainees.

# Appendix D – Streamlining work with NHS Employers

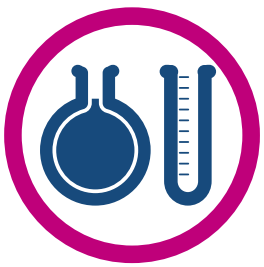
NHS Employers committed to address the problems that doctors faced with repeated checking of the same employee information and repeated induction and training programmes that provided no new information.

A national Streamlining Steering Committee established a Programme Team at the end of 2017 to develop key principles for all employers to follow as best practice, when doctors in training rotate between employers. Organisations were asked to apply to become part of the pilot team responsible for testing and finalising these principles. To date the pilot sites have made excellent progress in reviewing the core principles. To ensure robust testing can take place, the pilot has been extended to capture the August 2018 rotation, prior to the process being fully released nationally.

A comprehensive toolkit will be produced to ensure that nationally, all employers can implement the new recommended processes and achieve a more streamlined approach to doctors rotating during training, which will ultimately eliminate repeated training and reduce unnecessary repeated checks.

The impact of these changes and recommended best practice will be closely monitored by reviewing the results of the GMC National Trainee Survey, as well as capturing more detailed analysis from the doctors in training at our pilot sites.

Going forward, the results will enable us to provide further recommendations. This includes reviewing rotation start dates for higher level doctors in training, to ensure we can deliver information that must be shared with employers in a timely manner to support all of the principles of the "perfect process".



# Appendix E – Recommendations from the **Enhancing Training and The Support for Learners** report

### Delivery of Educational and Clinical Supervision:

**Recommendation 1:** Trainees should have regular high-quality formative feedback, which includes preparation for, and timely feedback after the ARCP, and should include career discussions at appropriate points.

**Recommendation 2:** The ARCP decision should not be a surprise to trainees, and trainees who are not progressing should be identified and supported in a timely way.

**Recommendation 3:** Educational Supervisors should be appropriately supported, trained and given adequate time in their jobs plans to fulfil the role. Clinical Supervisors providing day to day support for those they are training should have regular contact with the Educational Supervisor.

**Recommendation 4:** Educational Supervisor reports should be quality assured to ensure they provide a consistent and high quality summative assessment of progress.

The following recommendations are made with regard to Theme 2 of the review: Consistency of ARCP Panels:

**Recommendation 5:** Formative feedback is crucial to empower trainees. As per the Gold Guide, ARCP decisions should be made in absentia. Therefore, post-ARCP feedback, including recognition of the achievements of those performing well, should be offered to all trainees in a timely and supportive process.

**Recommendation 6:** Training and national guidance should be provided to ARCP panels to aid consistent decision making, with provision of decision-aids that are applicable nationally and are consistent in quality across specialties.

### Professional and personal support for trainees:

**Recommendation 7:** Educational Supervisors, ARCP Panels and trainees should be provided with high quality information about the professional and personal support available to all trainees.

### Standardisation of quality assurance and quality management processes

**Recommendation 8:** HEE should work with the AoMRC and medical Royal Colleges to ensure a standardised approach to improving the quality of ARCP processes, ensuring that good practice is shared across specialties and geographies

The following recommendations are made with regard to Theme 5 of the review: Defining and communicating the ARCP process:

**Recommendation 9:** A shared understanding of the purpose of the ARCP (as described in the Gold Guide), is needed, with clarity on the steps involved including those required for revalidation by the GMC.

**Recommendation 10:** All involved in ARCP processes should understand their responsibilities and trainees should know the competencies they need to achieve at the start of a training year and these should be free from unexpected amendments.

**Recommendation 11:** National training bodies, should coordinate and implement system wide communications to set out the expectations of the system, and empower trainees.

### Promoting flexibility in postgraduate training:

**Recommendation 12:** Out of Programme (OOP) arrangements should be adapted to allow a 'Step-on Step-off' approach that allows a more flexible training pathway.

**Recommendation 13:** Building on our evaluation in GP training, deferred entry should be explored in other specialties in the future.

**Recommendation 14:** All trainees should have equitable principles applied to requests to train less than full time (LTFT).

### Utilising the ARCP model for supporting SAS grade and developing trust grade doctors:

**Recommendation 15:** There should be a more flexible, evolving approach to supporting the professional development for SAS grade and trust grade doctors.

The following recommendation is made with regard to: Competency progression within the wider workforce

**Recommendation 16:** HEE will work with stakeholders to further explore and pilot a structured, consistent and sustainable national clinical competency process in line with the five principles above to support Advanced Clinical Practice development across several specialties.

# Acknowledgements


## Organisations and committees represented on the membership of the Working Group for Enhancing Junior Doctors' Working Lives

The Academy of Medical Royal Colleges
The Academy of Medical Royal Colleges Trainee Doctors Group
The Academy of Medical Royal Colleges LTFT Training Forum
The British Medical Association Junior Doctors' Committee
The Faculty of Intensive Care Medicine
The General Medical Council
The Health Education England Deans
Health Education England Medical and Dental Selection and Recruitment Programme
Health Education England National Policy and Programmes
Health Education England Technology Enhanced Learning Programme
NHS Employers
The Royal College of Emergency Medicine
The Royal College of Physicians of London
The Joint Committee on Surgical Training
The Royal College of Anaesthetists
The Royal College of Pathologists
The Royal College of Psychiatrists
Trainee Representatives

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