Improvements to junior doctor training and employment in Scotland
Views of the Scottish Junior Doctors Committee

The Scottish Junior Doctors Committee represents all doctors in the training grades in hospital and public health medicine practice in Scotland. We value the high quality Scottish medical training available which includes diversity of urban and rural health care settings and access to five leading universities. We are therefore deeply concerned that there are indications that a career in medicine in Scotland is declining in popularity, with low applications and fill rates for some specialty training programmes (notably, Psychiatry, GP, core medicine, core surgery, medicine specialties (HST), Occupational Medicine, Emergency medicine (HST) and Anaesthesia (HST)). This is putting pressure on service delivery and impacting on the junior doctors training in these programmes.

We recognise that the rest of the UK is experiencing similar recruitment problems across some of these specialties and we acknowledge that more work is required to disentangle and further explore the precise factors that are impacting on particular specialties’ and regions’ abilities to attract and retain junior doctors. However, more generally, we know that career decisions are based on a combination of intertwining factors which may well change throughout doctors’ careers. The findings of the BMA’s cohort studies career choices survey show that quality of life appears to have been, and will increasingly be, the biggest influencing factor on cohort doctors’ career decisions. While interest in a particular specialty can initially form career decisions, work/life balance and limited variety/pace within a specialty are the factors that most influenced cohort doctors’ reassessing their desired specialty post graduation.¹ The prospect of improved quality of life is a fundamental factor to doctors choosing to relocate overseas.²

We believe that the highest calibre of junior doctors will only continue to be attracted to work and train in Scotland if the employment and training package being offered is appealing. This paper looks at the areas we believe are important to improving junior doctor training and employment which will help Scotland attract and retain the very best trainees.

Career opportunities
It is vital that there are excellent career prospects for junior doctors in Scotland in order to encourage trainees to commit long-term to working for NHSScotland.

We firmly believe that if junior doctors do not anticipate long term training opportunities in Scotland, they will seek opportunities elsewhere; reducing applications for higher training and consultant posts. This was acknowledged in the Scottish Government’s consultation on Specialty Training intake numbers 2013 and beyond which highlighted that perceived poor career expectations in Emergency Medicine had likely been a reason for the reduced application rate over the last two years.

This is also supported by the findings of the BMA’s 2006 Cohort Study’s fifth report in 2011 which showed that 20 per cent of responses by respondents indicated that cohort doctors would have looked to work overseas if they were not able to secure a ST3 post.³ Evidence from the BMA’s survey on junior doctor’s morale and career intentions survey 2011 showed that responses from respondents who were not in higher specialist training (e.g. F1/F2, CT1/2, out of programme or career break) indicated that junior doctors were most likely to want to move

¹Career choices: Findings from BMA Cohort Studies, BMA, August 2012 (http://bma.org.uk/-/media/files/PDFS/Working%20for%20change/Negotiating%20for%20the%20profession/Workforce/careerchoicescohortstudyreport.pdf)
abroad to continue training if they were unable to find an accredited training post in the future (61 per cent of responses).  

Medical students and junior doctors also indicate that they will look to work overseas in the event of not being able to secure a post on completion of CCT. Evidence from the BMA’s survey on career intentions of the future medical workforce showed that respondents were most likely to indicate that they would leave the UK permanently to work overseas if they could not find a consultant or GP post on qualification in their preferred location and specialty. Respondents undertaking foundation training, respondents working as ST1-ST3, GP registrars and respondents in non-training grades all indicated that they would be most likely to choose to permanently work overseas in the eventuality that they did not secure a CCT post on qualification.  

Data from the GMC appears to show that more doctors are choosing to leave the UK after completing training. The number of doctors who applied for a Certificate of Good Standing, which doctors must usually provide to their new regulator when moving abroad to prove their registration status, fitness to practise and their ‘standing’ or ‘good character’ as a healthcare professional, showed that the number of applications from doctors on the specialist register and on the GP register have increased by 22.8 per cent (1,120 in 2010 compared to 912 in 2008) and 17.8 per cent (656 in 2010 compared to 557 in 2008) respectively.

In order to retain trainees, Scotland must ensure that training numbers are based on accurate workforce planning, with NTNs closely matching the anticipated service need for consultants and GPs. This must be supported by doctors being provided with comprehensive and sound careers advice throughout their training. We have been concerned at repeated suggestions that core training numbers should be increased over attrition rates and workforce planning projections to “improve competition”. We believe that any deliberate attempt to create oversupply is likely to exacerbate, rather than solve, recruitment problems. Targeting resources at attracting candidates to hard to fill posts through making the posts more attractive would be a more effective and efficient use of resources.

**Careers Advice**

It is important that medical students and junior doctors have the knowledge and skills they need to form a career path and manage it effectively.

Providing advice early in the undergraduate course will enable students to optimise all the opportunities given to them during their course, particularly while undertaking clinical placements, as well as beyond university during the foundation programme.

Each of the Scottish medical schools are active in providing careers support. However, feedback we have received from students suggests that provision is variable across the schools, ranging from a planned careers programme provided throughout the five year course and including dedicated careers advisors, to more ad hoc voluntary events organised annually, often by student societies. It is also clear that exposure to particular specialties during clinical placements or talks from members of clinical academic staff, provides information on particular specialties but not necessarily a broad range. Medical students would benefit from access to more structured, comprehensive careers advice, earlier in the medical school curriculum, in order to enable them to better understand the scope of specialties available within the profession.

We are aware that NES publishes a Scottish Medical Careers Handbook, as well as details of the different training programmes available in Scotland on the NES website. The NHS Medical Careers website is also a helpful UK resource. However, this information does not appear to be always reaching medical students across different years. We hope that work as part of the Medical and Dental Recruitment and Selection Project on career planning which is seeking to develop a four country approach to how career information is shared will help to address this. Within Scotland, we believe there may be scope for medical schools to work more closely with

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1 Career intentions of Junior doctors, BMA, October 2011
NES on delivering careers advice from the start of the undergraduate curriculum. NES is in the unique position of being able to provide a national overview which would be very valuable to students and trainees.

We are supportive of foundation trainees being able to access high quality specialty tasters in order to give them insight into specialties they have not previously experienced, helping to develop career exploration. The Collins evaluation of Foundation Training recommended that access to tasters should be maximised and simplified and we would support the use of tasters being further promoted among trainees as a valuable tool in helping to select a career path.

Academic foundation trainees are allocated mentors who provide experience of clinical academic life, clinical academic career paths and are a sounding board for research ideas. Feedback from trainees who have completed the programme is that this has been valuable. Mentoring is likely to help foundation trainees get more from their programmes, as well as support them in building career networks, and we would welcome mentoring and support for trainees being improved and expanded.

In South East Scotland, we understand that the Surgical Training Programme Director has set up the South-East Scotland Surgeons-in-training mentoring project (SESSION). This involves junior doctors and consultants posting profiles on Linked-In and trainees can approach them to be their mentor. We understand the project is still getting underway but we welcome initiatives that will increase trainees’ access to suitable mentors.

**Host health boards**

**If doctors are to be encouraged to commit to working for NHSScotland long term, they must be issued with contracts of employment that reflect the length of their training programme.**

It is completely inappropriate that FHOs and StRs continue to only been issued with employment contracts covering the length of their individual placements which may be for four or six months, even though their rotational programme may be for a number of years and they may be remaining with one Health Board while undertaking several placements. No other group of NHS Scotland staff is treated this way.

It is also cumbersome for medical staffing and it makes transfer of occupational health records difficult and slow, meaning a number of junior doctors have to repeat blood tests. This issue needs to be resolved through “hosting” arrangements that enable juniors to be issued with contracts that reflect the length of their training programme. These were the employment arrangements for SpRs and we understand that secondment arrangements have recently been agreed for trainee placements of three months or less. Host health board arrangements should be extended to cover the full length of all juniors’ programmes.

As the situation with regard to lead employer arrangements is variable elsewhere in the UK, introducing these arrangements in Scotland would serve to promote training in Scotland, helping to attract, as well as retain trainees.

**Access to flexible training**

**There needs to be greater recognition of the shift in work/life balance and increased need for flexible training.**

Access to flexible training is aimed at retaining doctors within the medical workforce who are unable to continue their training on a full-time basis and to promote career development and work/life balance for doctors training within the NHS.

We appreciate that access to flexible training is resource limited and acknowledge that medical staffing teams, liaising with NES, work hard to try and accommodate requests. However, ‘tight’ rotas can limit the degree of flexibility that may be required and we are concerned that there are continuing difficulties accommodating trainees’ requests for flexible training, particularly across specialties that attract a high number of applications. Ultimately, restricting requests will serve to
make training less attractive and may lead to trainees leaving the specialty they are training in. As similar difficulties are being experienced in particular specialties across the UK, Scotland promoting access to flexible training, especially within these specialties, is likely to serve not only to retain but also attract trainees.

**Study leave**

*Good access to study leave, adequate study leave budgets and highly rated local courses will promote Scotland’s training reputation.*

Study leave is an integral part of professional development and junior doctors should be actively encouraged to take their study leave entitlement. This funding should not be used for compulsory formal teaching which is part of the training programme.

While it is helpful that Scotland has a central policy and application form, ensuring consistency, we are concerned that the current study leave policy is restrictive, for example, it limits personal study leave to one week which does not provide flexibility and acknowledge that in some years trainees may have two diets of exams and require more personal study time but in other years may not have any exams and would therefore require less personal study time. We are supportive of the study leave policy being implemented pragmatically.

A difficulty for trainees in Scotland is that many courses are held outwith Scotland and often in the South of England which makes them expensive, in terms of travel and accommodation costs, as well as more time consuming for trainees in Scotland to attend. This is likely to mean that more of the study leave budget in Scotland is spent on subsistence, rather than courses, and more study leave time spent travelling, compared to other parts of the UK, reducing opportunities for trainees to access courses. We would be supportive of NES looking at what courses could be delivered in Scotland in order to promote Scotland as a high quality training centre. Overall study leave budgets will also need to take account of the extent to which budgets are being required to cover subsistence costs and may need to be increased in order to ensure trainees in Scotland are not at a disadvantage.

**High quality training**

*Training quality must be given the utmost importance.*

We recognise the significant work undertaken by NES, its deaneries and NHS Boards to quality assure training programmes. While reports are available on the NES and GMC websites, we would welcome more engagement with trainees in terms of regular reporting on how issues identified as requiring action are being taken forward, as well as promoting areas of strength. This would demonstrate to trainees the significant importance given to the feedback they provide.

While overall satisfaction with training, which is a proxy measure for the quality of training, is fairly high in Scotland and on a par with other UK nations, we would welcome continued improvements. In particular foundation doctor satisfaction should be targeted as it is low compared to core and specialty trainees in Scotland, and compared to the rest of the UK.⁶

It is vital that trainees are working at a level appropriate to their competence, with necessary supervision and support. There must be adequate time in consultant job plans for teaching and supporting trainees.

Trainees’ perceptions of training quality are informed by the experience of their undergraduate clinical placements. It is therefore also vital that medical students’ clinical placements provide high quality teaching in order to help retain medical graduates. We welcome the work NES has undertaken to develop a range of national quality standards applicable to undergraduate teaching within the NHS to evaluate the quality of teaching. Again, we would support further sharing of the action taken to address any problems identified as part of this work to promote this to students.

The unique training Scotland is able to offer, which includes diversity of urban and rural health care settings across all four deaneries and access to five leading universities with excellent research, should be promoted. We believe that trainees will be attracted to Scotland based on a reputation of high quality and unique training.

Programme information
When applying to foundation and specialty training programmes, which can last between two and seven years, it is important that trainees have a clear understanding about the programme(s) they are applying to and are informed about the likely rotations they will be undertaking.

Juniors want to be able to plan their lives and any lack of information about future employment is likely to deter junior doctors from applying to particular programmes. At the same time, more information about the educational value of different placements within rotations will serve to attract trainees.

Over the last few years there has been progress in producing enhanced training programme descriptors, as well as information on living and working in Scotland. A Code of Practice was agreed between SJDC, MSG and NES which lays out the agreed set of information that recruiting organisations and employers should provide to doctors in training at each stage of the recruitment process, the first post and subsequent rotations. It is important that there are continued improvements in the level of information provided to ensure trainees have as much information as possible about their programme and future rotations and at the earliest opportunities, in order to allow them to plan their lives appropriately.

A difficulty has been promoting this information to junior doctors, particularly those who may not be actively considering applying to Scotland. The move to more specialties undertaking UK recruitment is likely to serve to promote training in Scotland to a wider pool of trainees. However, currently, many of the UK recruitment websites do not have clear links to the programme information for Scotland and only provide competition ratios for England deaneries. Presence at career fairs outwith Scotland, where information on programmes available across Scotland is available, may also serve to raise the profile of Scottish medical training and should be considered.

It needs to be borne in mind that the deaneries in Scotland will be unfamiliar to those outwith Scotland and it will be unclear which areas each covers. Where appropriate for particular programmes, it may help understanding to refer to the main centre, for example ‘Glasgow and the West of Scotland’.

The geographical size of deaneries and the increased number of national programmes is likely to have an impact on recruitment and these need to be considered when planning programmes. In some cases, better upfront information will help reassure trainees, particularly those unfamiliar with training in Scotland and especially those with family commitments, that many programmes are accessible from the main centres and do not require relocation. Similarly, many programmes in the North of Scotland only require infrequent rotations between Inverness and Aberdeen which can be less disruptive than many other programmes in parts of the UK which involve frequent rotations between different hospital locations.

Consideration must be given to ensuring programmes are attractive and where movement across Boards and deaneries is required, more information on the educational value of the rotations would help promote programmes.

We value the national travel and relocation expenses policy in place in Scotland. This should be highlighted within programme descriptors to ensure trainees are aware that these expenses can be claimed when undertaking placements outwith the agreed base hospitals set out in the agreement.
In terms of the remote and rural placements, while trainees are often very attracted to these, they can sometimes not be prepared for the reality which can lead to some feeling isolated. Better support should be provided to these trainees to improve their training experience.

As stated above, perceptions of training are informed by the undergraduate experience and consideration needs to be given to the placements medical students undertake. While exposure to remote and rural placements, particularly at an early stage, can encourage doctors to choose to continue their careers in these areas, we are concerned that medical students are increasingly required to undertake placements a significant distance from their medical school for many weeks which can be difficult to reach, particularly without access to a car, as well as costly. We welcome the NES Medical ACT policy on student travel and subsistence for remote and rural placements which allows Boards to agree to contribute up to 5% of total ACT to medical schools to cover travel and subsistence costs. However, there is inconsistency in this being applied across the different medical schools, and Edinburgh students currently do not have access to this funding. It is important that placements are accessible and do not result in financial detriment for students, as this may deter them from applying to these areas in future.

**Induction**

Trainees must be provided with a thorough induction prior to starting a new post.

For FHO1s this should include information on shift-work and rest. We were pleased that a period of paid shadowing and induction was introduced in Scotland for FHO1s starting in August 2012 and that a standardised, national programme and dates are being established across Boards from 2013.

We believe this will help enable trainees to quickly settle into teams when rotating between different departments, hospitals and health boards. As these arrangements are also being taken forward in the other UK nations, there is an opportunity for Scotland to put in place better arrangements to help promote working in Scotland. However, there are risks that, if arrangements in Scotland are worse, it could be damaging for Scotland’s training reputation.

We are very happy to provide further information on the points raised in this paper.

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