

## **Less Than Full Time (LTFT) Training in Surgery: JCST Policy Statement**

### **Introduction: purpose of statement**

Less Than Full Time (LTFT) training has been an option for some time, but the experiences of surgical trainees taking it up have not been universally positive. A recent survey by the Association of Surgeons in Training (ASiT) and British Orthopaedic Trainees Association (BOTA) has identified a number of issues, including variable attitudes amongst trainers, fellow trainees and employers, worrying reports about bullying and harassment and difficulties with access to both elective and emergency training opportunities. As a result, LTFT surgical trainees tend to have low levels of satisfaction with their training.

In addition, discussions between the British Medical Association (BMA) and Health Education England (HEE) during negotiations on the new junior doctors' contract in England have highlighted the need to address both LTFT training and wider flexibility of working in order to improve the working life of trainees. HEE has been working with a range of stakeholders, including the JCST, to take this forward, and at the time of writing is planning to pilot a new approach in Emergency Medicine.

If surgical specialties are to attract and retain applicants from as wide a pool as possible, we need to tackle these problems and dispel any negative perceptions about the experience that we offer. In order to examine the current approach to LTFT training in Surgery and identify where improvements are required, the JCST has set up a short-life working group with representatives from the following bodies:

The Association of Surgeons in Training (ASiT)  
The British Orthopaedic Trainees Association (BOTA)  
The Confederation of Postgraduate Schools of Surgery (CoPSS)  
The Royal College of Physicians and Surgeons of Glasgow (RCPSG)  
The Royal College of Surgeons of Edinburgh (RCSEd)  
The Royal College of Surgeons of England (RCSEng).

The group has:

- considered in detail the findings of the ASiT/BOTA survey and the JCST's own trainee survey
- reviewed currently available advice from a number of sources (College websites, the Academy of Medical Royal Colleges, the *Gold Guide*)
- undertaken a survey of current approaches across UK Schools of Surgery
- received individual LTFT trainees' experiences.

The *Gold Guide* (see appendix) states that *HEE, NES, the Wales Deanery and NIMDTA have a strong commitment to helping all doctors in training to reach their full potential and to supporting those with child-caring or other caring responsibilities, health concerns or individual developmental opportunities to continue training on a less than full-time (LTFT)*

*basis. All doctors in training can apply for LTFT training and every application will be treated positively. Those wishing to apply for LTFT training must show that training on a full-time basis would not be practical for them for well-founded individual reasons.*

We welcome this commitment, but in some respects we would like to go further. This statement aims to highlight what we consider to be best practice, signpost to resources for those considering LTFT training and to break down those attitudinal barriers that may have affected the adoption and incorporation of LTFT in surgical training. Most of all, it reflects our commitment to providing leadership and support in this area and to making surgical training as flexible as possible for our increasingly diverse workforce.

## Challenges

While there are some challenges that will be common to all medical specialties, some may be more specific to, or experienced to a greater extent in, surgical or craft specialties. Some of the main challenges are as follows:

- The time needed to master all the different aspects of training in a craft specialty – elective and emergency surgery, outpatient clinics, ward work, development of special interests and wider professional and leadership skills. This requires careful planning of and adherence to timetables and, if possible, 12-month placements.
- Ensuring that assessments and Annual Reviews of Competence Progression (ARCP) are properly *pro rata*.
- The attitudes of trainers and trainees' own peer group.
- Pressures to fill rota gaps and meet service requirements. In some cases a lack of flexibility, for well-founded reasons, may lead to a perceived impact on full-time trainees and foster the attitudinal problems mentioned above.
- The financial impact of working less than full time and administrative complexity for both trainees and employers.
- Linked to the above, the long drawn out process involved in applying for LTFT training and the number of organisations and stages involved.
- The limitations imposed by the *Gold Guide*, which does not allow LTFT trainees to engage in other paid employment, within the NHS or elsewhere within the healthcare sector, without the permission of the Postgraduate Dean. We recognise, however, that a recent [progress report from Health Education England on \*Enhancing Junior Doctors' Working Lives\*](#) highlights the need to consider changes in this area. It states that 'clarity should be provided that periodic locum working should not be prohibited for LTFT trainees even under current arrangements because this can be of benefit to them and as well as employers delivering service, provided this is compatible with their eligible need to train on a LTFT basis.'

## Evidence

### ASiT/BOTA study

A cross-sectional study by ASiT and BOTA ([here](#)) found that the majority of respondents reported difficulty in organising LTFT training and a lack of easily accessible and useful information about how to do it. Particularly worrying was the finding that a significant proportion of LTFT trainees responding to the survey reported bullying, harassment or undermining behaviour, and many qualitative comments in the study highlight problems with attitudes and lack of senior support.

ASiT and BOTA have made a series of recommendations for action at College, Deanery and hospital level. These cover areas such as leadership, senior support, provision of role models and availability of information, advice and guidance. The organisations who have drawn up this statement are working together to tackle as many of these as we can.

### **JCST trainee survey**

The JCST's own trainee survey in 2015-16 found encouraging evidence of good practice, with 92% of responses indicating, for example, that Training Programme Directors (TPDs) understood and were sympathetic to the needs of LTFT trainees. More worryingly, however, 14% reported problems with a lack of support or understanding from consultant trainers and 31% of responses indicated a perception that LTFT working might have an impact on future career prospects. There were also indications of problems with access to research, audit and multidisciplinary team meetings. 16% reported problems with achieving all competencies and 28% the need to work additional (unpaid) sessions to achieve clinical aims.

**(Note:** trainees complete one survey per placement, so the percentages refer to surveys completed rather than actual trainee numbers. The survey is not fully anonymous, which may affect some responses. Data are from informal analysis, not yet published).

### **CoPSS survey**

The CoPSS carried out an informal survey of its members, to which 10 out of 12 Heads of School (or equivalent) responded. All those responding had LTFT surgical trainees and 90% had at least one designated individual to advise LTFT trainees. Most did not have posts in which they would not place LTFT trainees, although one observed that the lack of LTFT trainees in certain specialties had made it difficult to 'test the water'. Several were aware of concerns about trainer attitudes, although they had taken steps to address these and one suggested that attitudes had shifted in recent years. One was also aware of concerns about attitudes among trainee peer groups.

Some further points to note were as follows:

- There are clearly significant variations among specialties. While LTFT training is **not** just for female trainees, these variations may reflect differences in gender balance.
- There were reports of HR-related difficulties over pay and administration and a lack of understanding and guidance about funding streams.
- There were also difficulties in at least one area with slot sharing.
- There were reports of trainees struggling to progress with technical skills when working 60% rather than 80%.
- There were also reports of trainees not being assessed appropriately pro rata at ARCP and being expected to do more clinical work to compensate for their LTFT status.
- One respondent commented that the better the communication by LTFT trainees with their peers and trainers, the fewer the problems.

## Addressing the challenges: recommendations/commitments

The working group has agreed on the following recommendations. We also set out further thoughts in Appendices 1 and 2 on creating learning agreements and ARCPs for LTFT trainees.

**Recommendation 1:** The JCST and partners commit ourselves to making LTFT training an option for all who need/want it as distinct from those who meet the current *Gold Guide* criteria.

**Recommendation 2:** While LTFT training may have an important role to play in attracting women into surgery and retaining them, it must be clear that it is **not** just for women and any trainee may seek to train LTFT for a variety of reasons.

**Recommendation 3:** As a starting point all training environments should, in principle, be able to accommodate LTFT trainees.

**Recommendation 4:** The application process for LTFT training should be simplified as far as possible, working with the Conference of Postgraduate Medical Deans (COPMeD), CoPSS, NHS Employers and equivalent bodies in the devolved nations.

**Recommendation 5:** Specifically, Training Programme Directors (TPDs) should be empowered to facilitate LTFT training arrangements and the process for LTFT training approval should be streamlined as far as is practicable.

**Recommendation 6:** While we recognise that this is a devolved matter, we would like to see equivalent funding arrangements across the UK.

**Recommendation 7:** Whilst currently LTFT trainees are mainly appointed to full time posts, slot shares should be promoted where possible.

**Recommendation 8:** To maximise learning opportunities, LTFT trainees in surgical specialties should normally have one year placements regardless of the percentage worked.

**Recommendation 9:** In surgery, LTFT should be a minimum of 50% of full time training with flexibility for those in a position to work at higher percentages according to individual needs.

**Recommendation 10:** Each Deanery/School should have a designated individual(s) with responsibility for LTFT trainees. Wherever possible there should be a surgical lead for surgical trainees, and ideally someone with personal experience of training LTFT, although senior faculty from non-surgical specialties may also have valuable experience to contribute.

**Recommendation 11:** CoPSS will work to identify consultants with experience of LTFT training to provide advice and guidance to LTFT trainees.

**Recommendation 12:** Each Specialty Advisory Committee (SAC) should nominate an LTFT lead to act as a champion and to support local processes.

**Recommendation 13:** All those with LTFT trainees should familiarise themselves with the rights and obligations of employees and employers. Assigned Educational Supervisors (AES) and named Clinical Supervisors (CS) should understand the pitfalls and address

issues proactively. The GMC mandates that all AES and CS are trained and this should form a part of that training.

**Recommendation 14:** Principles and practical advice on support for LTFT trainees should be included in relevant courses for trainers, such as Training and Assessment in Practice (TAIP) and local Deanery/School-organised faculty training.

**Recommendation 15:** Trainees should take ownership of their training to identify opportunities and be proactive in discussions with TPDs and AES. They should familiarise themselves with the advice in the *Gold Guide* and the policies of their Deanery/School.

**Recommendation 16:** Trainees and trainers should set clear aims at the start of placements. Trainers and employers must hold to what is in the learning agreement, with reasonable notice of any changes and a recognition that those with caring responsibilities may not be able to change.

**Recommendation 17:** All those involved in assessing LTFT trainees and reviewing their progress should ensure that they do so pro rata, while recognising that training is moving away from a purely time-based approach.

**Recommendation 18:** There should be flexibility within the system to allow LTFT trainees to adapt their percentage commitments as their circumstances require.

**Recommendation 19:** TPDs and AES should have support for LTFT trainees in their job plans, working with Trust/Health Board Clinical Directors as needed.

**Recommendation 20:** Good communication on both sides is essential.

**Recommendation 21:** Evaluation of the approaches described in this position statement will be included within the JCST Annual Specialty Reports including its annual survey.

## Appendices

- Appendix 1: Learning Agreements for LTFT trainees
- Appendix 2: Annual Review of Competence Progression (ARCP – for LTFT trainees)
- Appendix 3: LTFT working patterns table
- Appendix 4: Where to go for information
- Personal experience: case studies (or scattered through text).

## Creating a Learning Agreement for a less than full time (LTFT) trainee

*With thanks to Nikola Henderson*

**Note:** This section sets out what we believe to be best practice. We recognise that contractual arrangements for trainees will now vary across the UK and a separate scheme operates in Ireland.

Learning Agreements are created for all trainees and an LTFT agreement has much in common with any other from a training point of view. There are several key areas where it differs from agreements created for full time trainees, however, and these are discussed here. Broadly they fall into scheduling issues and timescale issues.

### Scheduling

The key to avoiding problems with scheduling conflicts is **early and clear communication** with the involved parties. The Training Programme Director (TPD) should place the trainee in a suitable placement and have a thorough understanding of what the trainee is able to commit to and how that would fit in with the clinical commitments in that placement. S/he should liaise with the local Assigned Educational Supervisor (AES) about the trainee and may also find it helpful to speak to the local Director of Medical Education (DME) and College Tutor.

Before sending the LTFT trainee to a placement, the TPD should have discussed with the trainee whether this is compatible with their out-of-hospital commitments. If due to other commitments they cannot work on a Monday, for example, there is no point attaching them to a consultant who operates exclusively on Mondays.

Before starting the assigned post, the trainee should be in touch with the AES to discuss the working hours.

Therefore, **the first priority is to state clearly the days and hours of work, if and where there is any flexibility with those hours and where there is no flexibility.** This also applies to the out-of-hours commitments; the trainee should have it agreed whether they are able to work out of hours on days on which they do not work electively and how that will work in practice. Previous LTFT trainees may have established precedents that may or may not be helpful.

This information should be communicated before a trainee arrives in a unit; it should also be disseminated to the rota master and secretarial staff as well as the other trainees in the unit who may be involved in allocating weekly activities to trainees. It is unacceptable to schedule an LTFT trainee for commitments on days when they are not at work, and it is inappropriate to expect that trainee to arrange for swaps if they are erroneously being considered to be present.

The relative advantages and disadvantages of certain working arrangements are discussed elsewhere in this document. Trainees who work on set days find that colleagues quickly pick up on their schedule and know which days they are at work and which days they are not. Having varied days can lead to confusion about whether or not you are at work but gives greater flexibility.

Trainees with flexibility in their hours will wish to schedule their week around clinical commitments, and those with no flexibility will have to find commitments that fit the schedule. In a consultant-based post, when a trainee works for one person exclusively, there may be a problem with a conflict between a busy clinical day and a day where they have an out-of-hospital commitment that cannot be changed. The TPD, who has sound knowledge of each trainee and each post, should pre-emptively avoid these sorts of clashes

Inherently, LTFT trainees are easier to fit into units where the trainees are shared amongst consultants and commitments are more flexibly scheduled. It is well recognised that LTFT trainees are frequently involved in direct clinical care for every session they are at work and are not scheduled for any study time, which results in this work being done in unpaid time or being neglected. This session should be protected in the Learning Agreement by the AES, and although the temptation to cram a full week of training into the LTFT sessions is often present on the part of both parties, there should be a clearly designated session for private study and audit.

When an LTFT trainee has as many clinical sessions as their full time peers, they are therefore working many extra hours to do dictation and paperwork and other administrative tasks. It is understandable that a surgeon's enthusiasm for theatre and clinical work often leads to them preferring to operate rather than attend to less obviously enjoyable work, and many LTFT trainees will be more than happy to have as much operating as their full time colleague; the educational supervisor should be aware of this temptation. **The LTFT trainee's timetable should represent a pro rata version of those of their full time colleagues, with the same proportion of clinical and non-clinical sessions. Variations should only be a result of reasonable adjustments required by legislation.**

It is crucial to clarify out-of-hours commitments before starting a post and there are several pitfalls to avoid. In a rota where trainees frequently work 24-hour shifts with a day off the next day, it is unacceptable routinely to place the LTFT trainee in the day before their usual day off. It is also unacceptable to place a trainee routinely on for emergencies on a day they do not usually work. The spread should either be equitable or, if it has been decreed that the trainee cannot work a specific day at all, this should be recognised.

It may sometimes be the case that there are some days on which an LTFT trainee cannot work at all and this should be made clear. Problems can arise with trainee-managed rotas where the person responsible for planning the on-call is unaware of the nature of LTFT working hours. The AES should be the trainee's advocate when necessary in this regard and clearly communicate the hours that are and are not worked.

### **Goal setting and timescales**

Setting goals at the initial meeting is familiar to Assigned Educational Supervisors and trainees, but **all concerned must remember that these goals will be achieved pro rata.** A realistic approach is to plan annual rather than 6 monthly goals, as this time period allows projects to be completed and competencies to be achieved.

There are some specific areas in which LTFT trainees may have to be especially aware of the impact of their reduced weekly hours; for example under current JAG<sup>1</sup> regulations for certification of endoscopic procedures there is a one-month time limit to achieve the necessary number of assessments and both the Assigned Educational Supervisor and trainee will have to be organised and aware of this before starting the certification process.

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<sup>1</sup> Joint Advisory Group on Gastrointestinal endoscopy

Due to the nature of LTFT work, it can sometimes be several months before a procedure is repeated. Where possible, the AES should attempt to cluster operations in a time period to allow the trainee to gain confidence in a specific technique. This works particularly well in a unit-based approach where the trainee can attend every operation of a specific type; e.g. all laparoscopic funduplications over several months. In common with all trainees, the LTFT trainee should have a robust system for reflecting on their progress – the ISCP website is well designed for this, as is a training diary. The need for reflective learning and having a system for recording that learning is even more crucial when training is undertaken LTFT.

## **The long term LTFT**

Some trainees may choose to complete all of their training part-time and should be alert to the need for recertification in courses such as ATLS if this has lapsed before certification. Additionally, there will be long-term LTFT trainees who have taken as many as 13 years or even more in which to train, and they should not be discriminated against for having a similar spread of academic publications and presentations. These are recognised for the award of Certification of Completion of Training (CCT) or equivalents and should not be considered out of date.

There may be gaps in training that need to be addressed; an LTFT trainee who has never worked on the day of the subspecialty multidisciplinary team meeting (MDT), for example, will have deficiencies in their education and will need to find a way to overcome these with their AES TPD. The term 'flexible trainee' has been superseded but the principle remains – long-term LTFT trainees require a degree of flexibility in their commitments over the course of their training in order to meet their educational objectives.

## **Example Learning Agreements**

**Example 1:** LTFT ST8 80% (half-day Thursday and Friday) Colorectal trainee attached to unit.

Monday: theatre all day

Tuesday: morning clinic, afternoon free time

Wednesday: theatre all day

Thursday: morning colonoscopy list, finish at 12:30pm

Friday: morning MDT, finish 12.30pm.

- Complete two Multi-Source Feedbacks at 4 months and 8 months
- 40 Workplace Based Assessments (WBAs) focusing on Procedure Based Assessments (PBAs) at Level 4
- Attend course on advanced polypectomy
- Attend national specialist pelvic floor meeting
- Attend European specialist colorectal meeting
- Complete a 6-month project in chosen area of interest
- Submit project to international meeting aiming for oral presentation
- Teach students one session a month
- Complete an audit for national presentation
- Supervise nurse prescriber.

**Example 2:** LTFT ST5 70% (Wednesday all day and Friday afternoon off) Upper GI trainee attached to consultant.

Monday: morning free time, afternoon endoscopy

Tuesday: endoscopy morning, afternoon clinic

Wednesday: off

Thursday: theatre all day

Friday: MDT morning off afternoon.

- Gain certification in upper GI endoscopy
- Attend course on laparoscopic advanced upper GI surgery
- Complete an audit and present nationally
- Meet curriculum requirements for Workplace Based Assessments (WBAs)

## Annual Review of Competence Progression (ARCP) for LTFT trainees

*With thanks to Ciara McGoldrick*

This section relates specifically to the best practice in order to deliver an effective and representative ARCP for less than full time (LTFT) trainees. The issues raised may be relevant to any trainees falling outside the standard training pathway, however – for example, military trainees, those undertaking research or those with prolonged absence resulting from illness. There are specific tasks for trainees, Assigned Educational Supervisors (AESs) and Training Programme Directors (TPDs).

Our guidance assumes that the trainee has been granted permission to train less than full time by the relevant Deanery/School of Surgery and the Specialty Advisory Committee (SAC) for the relevant surgical specialty is aware of the arrangement. The SAC, via the JCST secretariat, will calculate a new revised certification date on the basis of the proportion of full time that the trainee is working.

### **Trainee: creating a timeline**

The certification (CCT or equivalent) date does not automatically appear in the training history section on the latest version (v10) of the ISCP website, but the JCST secretariat writes to all new trainees with their projected dates as part of the enrolment process and will confirm any changes as they occur. There are plans to show more information on the ISCP website in the future, but nor does it automatically generate the transition points from one StR year to another. The key point to grasp is that a training year for the LTFT trainee will differ in length to a chronological year, and will depend on the percentage of full time granted. For example, for a trainee working at 80% one training year is equal to 15 months' duration.

The ISCP system previously had a 'timeline' feature that would pictorially represent progress through training. At the time of writing this is no longer available in its previous form, but there are plans to restore it. In the meantime, it is still possible to record the information under 'Training History'. **Creating a timeline is the first task of a LTFT trainee and will form the basis of planning for future ARCPs.**

This timeline should show the transition between each training year, up to and including certification. Superimposed on this should be the anticipated dates of ARCPs. It can then be seen that progressively the LTFT trainee falls further and further out of sync with full time trainees in comparison.

Any further periods of leave or sickness should be added and the dates amended as necessary. Ultimately the trainee must have an overview of their training, and it is incumbent on them to keep this information up to date and relevant. Important amendments include dates of when a trainee is intending to undertake exams/fellowships/periods of out of programme experience/training/ research/career breaks (OOPE/T/R/C) and trainees should note the following:

- Applications for these important events are tailored around full time trainees.
- While largely LTFT trainees' ARCPs will work by performing the pro rata ARCP for the current training year, and adding in a final ARCP for the most recent year completed, occasionally this will be insufficient.

- For example, for a trainee who has completed ST6 and intends to sit the FRCS Part 1 in June 2019 during their ST7 year, the application form requires the final ARCP outcome 1 for ST6 to be available in March 2019, but the ARCP for ST6 will not be held until July 2019. The LTFT trainee therefore would be disadvantaged by adhering to this timeline and an individual, or exceptional, ARCP may need to be convened to counteract this. This ARCP may be 'virtual'.

Example of a timeline for a LTFT trainee doing 80% of full time equivalent (ST3 at 100% and ST4 onwards at 80%)



\*some deaneries/LETBs run 'mid-year' reviews to assess trainees' progress half way through the training year/period

\*\*expected certification date

Training Type	ST level	Weighting	Start	End	Full time equivalent in qualifying months	Subtotal in months
Full time	ST3	1.0	5-Aug-2015	3-Aug-2016	12.00 (12.00)	12.00
LTFT	ST4	0.8	4-Aug-2016	3-Nov-2017	12.00 (15.00)	24.00
LTFT	ST5	0.8	4-Nov-2017	3-Feb-2019	12.00 (15.00)	36.00
LTFT	ST6	0.8	4-Feb-2019	5-May-2020	12.00 (15.00)	48.00
LTFT	ST7	0.8	6-May-2020	5-Aug-2021	12.00 (15.00)	60.00
LTFT	ST8	0.8	6-Aug-2021	2-Nov-2022	12.00 (15.00)	72.00

## **Training Programme Director (TPD)**

The trainee's timeline should be presented to the TPD on starting LTFT training and this long-term view and pattern for ARCPs should be recorded on the trainee's global objectives for all future trainers to have access to. We recommend that LTFTs move between training posts on an annual as opposed to a 6-monthly basis, so as to minimise transitions. At each ARCP episode, at least one 'interim'<sup>2</sup> ARCP and on occasion one final ARCP may also need to take place. The trainee should calculate what proportion of each of the years in question has been completed and ensure that this is recorded appropriately on the Learning Agreement.

## **Assigned Educational Supervisor (AES)**

Making reference to the timeline, the AES should be satisfied that the point the trainee has reached on their training timeline is understood and all periods of training are accounted for.

The trainee's proposed working pattern should be compared to the job plan of the training post. Potential clashes of LTFT sessions with important learning opportunities should be discussed in full at the objective setting stage. These may include multidisciplinary team meetings (MDTs), regional teaching and time for research and study.

This should be done in a collaborative manner, with both trainee and AES expected to contribute to solutions to maximise training while providing a stable working pattern. Options include:

- alternating weekly patterns (3/6 monthly changes in a 12 month post)
- agreeing a number of MDTs that is considered acceptable for training
- swapping with another trainee
- taking 'compensatory' leave.

Once an acceptable working pattern has been agreed as suitable to deliver the learning objectives of the post, the AES is required to communicate this effectively to whoever administers the rota.

## **Delivering an ARCP for a LTFT**

The assembled panel should be briefed about the pattern of working and the point in the timeline the trainee has reached. The TPD should have had an opportunity to view the Workplace Based Assessments (WBAs) recorded on the ISCP system and be satisfied that the trainee is meeting the objectives anticipated for a trainee at that level. Any queries or indications to the contrary should be discussed with the LTFT trainee in advance. The TPD may need to provide an 'exceptional' ARCP in order to facilitate applications for FRCS/fellowships so as not to disadvantage the trainee as they fall out of sync. This may take place 'virtually' or via Skype or similar.

It is clear that, while the ISCP system is continually being upgraded, it is not currently equipped to deal with such variations in training pathways. The ISCP system will not recognise proportions of training and grant the accompanying change in grade unless there have been two series of educational meetings (initial, interim, final) with an ARCP in between. For example, for a trainee who returns to training a proportion of the time between transition points, this can have a large impact on the ability of the system to truly reflect the

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<sup>2</sup> We recognise that this may not be official terminology, but are setting out the need for a pro rata approach for LTFT trainees.

stage of training. Since June 2016, eligibility for certification for surgical trainees will be confirmed using the ISCP records and so the emphasis on the ARCP panel to amend and personalise the training record in an accurate way becomes even more crucial.

## LTFT Working Patterns

*with thanks to Nikola Henderson*

Way of working	Advantages	Disadvantages
<b>Consecutive days beginning on a Monday</b>	<p>Same as everyone else on Monday morning</p> <p>Clearer leave arrangements as PH's are taken when they fall.</p>	<p>May not suit unit needs or caring responsibilities</p> <p>Lots of Mondays lost due to public holidays (PHs).</p>
<b>Consecutive days beginning after Monday</b>	<p>May be best for unit activities if Monday is a quieter day</p> <p>No PHs on Mondays.</p>	<p>Always 'catching up' compared to peers</p> <p>May be a long gap from Thursday to Tuesday.</p>
<b>Half days</b>	<p>Works well with school age children, able to pick up after school</p> <p>Works well with more fixed commitments, e.g. clinic or scope lists that are scheduled to end at a particular time.</p>	<p>Can be difficult to get away on time</p> <p>Can make a trainee feel very aware of being part time when they ask to leave</p> <p>You may end up working far more hours unpaid and that don't count for training if leaving is difficult.</p>
<b>Unit where trainees are allocated to individual consultants</b>	<p>All the advantages of one-on-one training</p> <p>May not suit a 60% trainee but may work for 80%/90%.</p>	<p>Consultant or other trainee will regularly have to cover 'your' patients</p> <p>Feel that you 'should' be there.</p>
<b>Unit where trainees are allocated to the team/ward</b>	<p>No need for cross covering amongst trainees on your off days</p> <p>Easy to plan training opportunities</p> <p>Works well where consultants regularly share their views on where a trainee is operatively.</p>	<p>Loss of the one-on-one trainer trainee relationship</p> <p>It may be months between lists with your individual consultants as you are there less</p> <p>In a non-communicative unit it may be harder to progress.</p>
<b>Variable days</b>	<p>Gives you flexibility</p> <p>Gives your unit flexibility.</p>	<p>Requires flexible childcare</p> <p>Not clear which days you work, which leads to confusion from colleagues.</p> <p>Pressure to come in to accommodate colleagues leave arrangements/absence.</p>

**Late starts**

Allows morning caring responsibilities to be undertaken (e.g. nursery/school drop).

Absent for 8am ward rounds

Difficult to catch up with ward goings on

May be impossible in certain units.

## Where to go for information

The principles and guidance underpinning LTFT training are well established. Our focus is on making these work for surgery. We are not setting out all the provisions in full, but below are some useful links.

The [Gold Guide](#) (6<sup>th</sup> edition) provides guidance on the arrangements for all aspects of postgraduate training in the UK. Paragraphs 6.57-6.88 cover the arrangements for LTFT training. As noted earlier, paragraph 6.57 states the following:

*HEE, NES, the Wales Deanery and NIMDTA have a strong commitment to helping all doctors in training to reach their full potential and to supporting those with child-caring or other caring responsibilities, health concerns or individual developmental opportunities to continue training on a less than full-time (LTFT) basis. All doctors in training can apply for LTFT training and every application will be treated positively. Those wishing to apply for LTFT training must show that training on a full-time basis would not be practical for them for well-founded individual reasons.*

The Guide, which is due for revision in 2017, also links to documents from **NHS Employers** on [principles underpinning the new arrangements for flexible training](#) and [equitable pay for flexible medical training](#).

Arrangements for the **Irish Health Service Executive (HSE) National Supernumerary Flexible Training Scheme** are set out in the [HSE Guide to the scheme](#).

The **Royal College of Surgeons of England** provides [information on flexible training and working](#) and advice from its [Flexible Working Advisor](#).

The **Royal College of Surgeons of Edinburgh** provides [information on flexible training and working](#).

The **Royal College of Physicians and Surgeons of Glasgow** provides [information on flexible training and working](#).

The **Royal College of Surgeons in Ireland** provides [information on flexible training](#).

The **Medical Women's Federation** also has a [section on LTFT training](#) on its website.

The **Academy of Medical Royal Colleges (AoMRC)** has a Flexible Careers Committee. It has published the [results of its maternity/paternity survey](#) and [guidance on return to practice](#).

The **JCST** has published guidance on the management of surgical trainees returning to clinical training after extended leave – available [here](#).

The **Conference of Postgraduate Medical Deans (COPMeD)** has a LTFT Forum, which produces a newsletter.

Working LTFT may have an **impact on NHS pension contributions and future entitlements**. Possible sources of information include the [British Medical Association \(BMA\)](#).

## Case Studies

### Rhiannon Richards

My name is Rhiannon Richards, I'm (probably) an ST5 in general surgery in Yorkshire. I live with my partner who is a software developer and we have two children aged 3½ and 11 months.

Since returning to work after my second child I'm working 60% of full time in a full time slot. I am cross-covered by full time colleagues and locums who pick up the extra on call shifts. I have been an LTFT trainee since 2014. I returned to work full time after my first child and found that I just did not see him. I went to 60% LTFT 3 months later and have never looked back!

I have found the key to making it work is flexibility. I am fortunate enough to have a flexible nursery and a partner who works an 8-5. This has enabled me to swap shifts to cover clinical commitments, for example doing an extra or different day when my consultant is on call to ensure continuity and taking this time back when things are not as busy. Being flexible maximises training opportunities and generally helps out the surgical department. Proper handover is also essential for making this work.

My experience has been overwhelmingly positive and my consultants have all been very supportive.

I increased my hours to 80% for 1 year to cover an extra day of endoscopy and theatre and found this worked extremely well. Once my baby is bigger, I plan to go back to 80%. Training less than full time provides a great work-life balance. Training is prolonged but this will give me greater confidence as a consultant. I am fresher for work and believe I am able to give more to my training on the days I am in, whilst being able to watch my children grow up.

### Alex Evans

My name is Alex Evans. I am currently an ST8 in Otolaryngology working in South Yorkshire. I currently work at 50% and have done so for nearly 7 years of my higher surgical training, having completed 2 years whilst working full time.

My wife is coming to the end of her GP registrar training, she also works at 50% and this has enabled us to share the childcare of our three children, now aged 10, 8 and 5. This has been particularly important as our middle son was diagnosed with Type 1 Diabetes when he was 3. With no family locally, our working arrangement has meant that one of us is available to provide the necessary additional care and support that he has required as a result of this.

As the only less than full time trainee currently on my training program, a job share is not possible, so the remaining work of my timetable is covered by a locally appointed Trust registrar, who works full time.

I have found working less than full time to have been very beneficial in many areas. It has given me an opportunity to spend more time with my young family than I would have done otherwise. As I approach CCT, I feel I have benefited from the longer training time in terms of acquiring the knowledge and skills required for consultant practice. I have been able to

rotate through nearly all of the local departments – sometimes more than once. In addition I am of the opinion that the European Working Time Directive has had less of an impact on my training than my full time colleagues. I have not found the decrease in workload intensity to have had any detrimental effect on my surgical training.

The only disadvantage I have encountered is that providing continuity of care to patients can be challenging at times, however this can usually be overcome by careful scheduling of clinic appointments and theatre lists and following up on the outcome of treatment. The other challenge has been organising work timetables and on-call rotas for myself and my wife that successfully fulfil our training needs, local service provision needs and our childcare requirements; however this has definitely provided me with increased organisational and negotiating skills!

The local Health Education Authority (previously Postgraduate Deanery) has always been accommodating and supportive of my Less Than Full Time training needs, as have all my Programme Directors and trainers. Despite being initially apprehensive about how training in a surgical specialty on a part time basis would be perceived by my senior colleagues, I have never experienced any negative or discriminatory treatment and would strongly recommend other surgical trainees to consider it.

### **Ria Rosser**

Hello, my name is Ria Rosser. I work LTFT 60% and have been doing so for 9 months. I chose to work less than full time for a few reasons. My husband is an anaesthetist and started his consultant post 9 months ago. My aim was to support him in his first year as a new consultant and support my son in his first year in school. My children are aged 5 and 18 months.

It was total chaos working full time with just one child so when number two came along, to ensure I actually got to spend some time with either of them, I chose to work LTFT. Initially, I struggled with the lack of continuity and not knowing about my patients for two days of the week. In reality, due to rota scheduling and mandatory time off after on-calls my full time colleagues are also experiencing similar issues. I know that in some placements, LTFT trainees are supernumerary or job share with another colleague, but I am the only SpR on my firm. On the days that I am off the consultants will do the ward round or I have to ask a staff grade to cover any jobs and support the juniors.

I have been very fortunate in that my trainers have been extremely supportive. In terms of training, I have one all-day list, a clinic, and MDT weekly and an endoscopy list every other week – I think this comparable to the training of my full time colleagues. I do intend to work full time again towards the end of my training, but for now LTFT has worked really well for me and my family.

### **Lucy Green**

My name is Lucy Green and I am presently working in the Yorkshire and Humber Deanery as a ST6 60% LTFTT in Vascular Surgery, I have one child and I am a single mum. I originally became a less than full time trainee as my son was diagnosed with right-sided Chonal Atresia. Fortunately this was an isolated abnormality but it did mean that over the past two and half years there have been outpatient appointments, operations, scans and hearing tests, all of which would have put far more strain on me than I could have coped with at the time if I had been full time.

I have variously worked in supernumerary posts and in a full rota slot, but for just 3 days a

week. The fact that my deanery has been flexible enough to allow me to continue my training in nearby hospitals has made the difference in trying to cope with my son's medical issues, the dissolution of an unhealthy relationship and also being able to come out the other side a stronger, more insightful professional.

My own parents live 80 miles away and my son's other grandparents live abroad, so this has made childcare less flexible. The deanery were fantastic in organising the LTFT in a speedy manner and the Vascular training programme director has also been flexible in arranging on-calls and start times to help me best with my childcare solutions. This year especially I have felt very supported and valued as a trainee.

### **Jenna Morgan and Natalie Hirst**

Our names are Jenna and Natalie and we are both LTFT trainees working in the same trust as General Surgery registrars in Yorkshire.

Jenna is ST4, she has one daughter who is 18 months old and is married to an Anaesthetic registrar. Her childcare cover is provided by a childminder close to her home as they have no family living close by.

Natalie is ST5, and she also has one daughter who is 18 months old and is married to a non-medic. Her childcare cover is provided by her parents, who live locally.

Jenna works 50% of full time, both electively and on-call, whilst Natalie works 60% of full time electively and 50% for on-call. As such, it's not a job share, our daytime elective commitments are decided according to our individual training needs. We cover the same on-call slot, however, and have divided our shifts up according to our child care and availability. This flexibility has worked really well for us and for our families.

### **Jackie Steinke**

My name is Jackie, I'm an ST4 in General Surgery in SW London and hoping eventually to be a consultant Colorectal surgeon some day! I have one child (for now!), a nearly 2-year old daughter who is full of energy, and am married to an O&G reg who is coming to the end of his training!

I currently work 80% of full time, but worked for 1 year at 60% when I came back to work after a short 6 months of mat leave initially. Last year two full time equivalent slots on the on-call rota were covered by three LTFT trainees at 60, 60 and 80% (with a few locum covers for conflicting days) – not very well thought out as we were on different specialties and covering a lot of the same days, so there were some teething problems initially which were sorted by the end to everyone's satisfaction. This year the 20% of on-calls I don't do, which were my choice, are covered by locum slots, which works really well.

I've been an LTFT trainee for a year and a half now and found the work-life balance much better at 60%, but as I am still in my early reg years, wanted to get some more training under my belt, particularly as we are keen to expand our family further in the next few years. The key to making it work has been firstly that O&G seems to be much better at letting their trainees leave on time, meaning that I can usually rely on my husband to be home at a reasonable time, and secondly that I am lucky enough to have in-laws round the corner who did all the childcare for the first year and now having a wonderful nanny (who is shared with my sister and brother-in-law who are also both surgeons on the SW Thames rotation!) who is flexible and totally understanding of what we do!

In general I don't feel I've encountered any major barriers being LTFT and actually feel it can be seen as having benefited my training so far, in that I progress in LTFT terms, but have always taken days off on days of little clinical activity so essentially have been getting nearly 100% of a full time equivalent elective experience which has been great although of course on-call exposure has been proportional to the actual training percentage! Another thing that's helped has been having very understanding and accommodating TPDs.

Occasionally I've felt a bit like I've had to explain to trainers how LTFT training works, despite by no means being well-experienced with the ins and outs of it, e.g. explaining to Assigned Educational Supervisors that there is a pro rata requirement for WBAs, etc., and find at ARCPs that the system isn't set up to assess a year in LTFT terms but a calendar year and calculating whether the requirements have been met can take a bit of working out!

Overall I have found it a great way to combine surgical training and raising a family and certainly intend on continuing my training on an LTFT basis, probably varying the percentage as I have done so far, dependent on future circumstances!

### **Catriona Heaver**

I am an ST7 T&O trainee on the Oswestry/Stoke rotation in the West Midlands. I have three children aged 7, 4.5 and 2.5 years. I'm married to a Neonatal Consultant who, after our first child, went 60% LTFT so I could get through a few years of training. Being full time however was difficult and I couldn't achieve the work-life balance I needed.

I've been an 80% LTFT since returning to work after our second child. The balance this has given me has been amazing. When I'm at work, I'm at work and finish whenever the job needs me to. My day off though is mine to do all the usual mum things: school run, see teachers, have school friends over, etc.

I am certain that I am a much happier trainee being LTFT and would be reluctant to change this until the end of my training.

It was certainly a big plus for me that my husband had been LTFT. We learnt that from his experience, being 60% didn't feel adequate to be on top of the job so we settled on 80%. I have always been flexible with what day off I have for each rotation so have missed very little and haven't had to extend or repeat training in subspecialty areas of T&O.

We don't have any family locally and so manage very much on our own. For me though, the key to making it work is knowing you have a bulletproof childcare set-up. Not having to watch the clock or worry about nursery pick-up is priceless, so whether you enlist the help of family, partner, neighbours or employ a nanny (that's what we did) make sure you have cover. Knowing your children will be safe, happy and tucked up in bed if you're late will allow you to give your all.

### **Sarah McCartney**

My name is Sarah McCartney, I'm an ST5 in Trauma and Orthopaedics in the Oxford deanery. I have one child who is 17 months old and am married to an academic GP who works part time in Clinical practice and part time for the university. I work 70%. The hours that I don't work are not covered, clinics are reduced and theatre sessions don't require extra cover because there is a fellow. On-call shifts are covered by internal locums. I do all of the daytime on-call shifts, so the only shifts that are covered are non-resident on-call. In the current job each consultant and their registrar is on call for one week in six. I work the full trauma week so I do five sessions in the other five weeks to balance out to 70%.

This is the first placement that I have worked LTFT. It has been difficult for everyone, but things improved when we changed our childcare and got a nanny. The consultant in charge of registrar placements at my hospital has really tried to be flexible and accommodate my training needs, even though having a part time trainee makes things more complicated for him.

At the moment the most difficult thing for me is having to rearrange childcare every six months when I change jobs, as I need to be there for the sessions when my boss is doing clinic or theatre. Fortunately, our nanny has a flexible second job and our parents have really gone out of their way to help us.

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