

# Junior doctor engagement: views from the frontline

Report from a survey and listening exercise led  
by the London Clinical Senate and the Faculty  
of Medical Leadership and Management

**Dr Myra Malik**  
**Dr Jude Tweedie**  
**Dr Katie Humphreys**  
**Dr Michael Gill**

Associate Medical Director FMLM  
Royal College of Physicians Research Fellow  
London Clinical Senate Senior Project Manager  
Chair London Clinical Senate Council



---

# Table of contents

---

Foreword	3
Introduction	5
Summary of recommendations	6
Background	7
Overview of junior doctor training in London	9
Junior doctor representative groups	10
Methodology	12
Findings from engagement survey (Phase 1)	13
Existence and format of JDRGs	13
Purpose, influence, and effectiveness of JDRGs	13
JDRG membership	15
Findings from the listening exercise (Phase 2)	16
Morale	16
Junior doctor leadership and engagement	17
Junior doctor representation groups	17
Flexibility of training	18
Length of rotations	19
Tensions between training and service provision	20
Learning environment	21
London-specific issues	22
Links with other work	23
Recommendations	25
Organisation level	25
System level	29
London region recommendations	31
Conclusion	32
Appendix 1	34
Appendix 2	40

---

# Foreword

---

Evidence shows the link between an engaged and motivated workforce and the quality of care for our patients and fellow citizens. Junior doctors are a significant part of our current and future healthcare workforce. They will be clinical leaders in the years to come. Their experiences now will influence their choices about what they do and where they choose to work. There are over 13,000 junior doctors in London. We want them all to have the best possible experience and to create organisational cultures which enable and empower them to deliver the type of high quality care that they aspire to.

Junior doctors have told us that this is not always the case currently. This report presents findings and recommendations from a project set up to improve the experience of junior doctors, particularly in feeling a genuine part of the organisations in which they train and provide clinical care.

I completed my junior doctor training just as the then Chief Medical Officer, Professor Sir Liam Donaldson, published the report *Unfinished Business*, described a number of problems experienced by some doctors in the junior training grades, and particularly at SHO level.

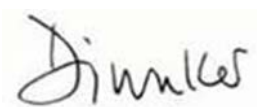
This report identifies many important issues which impact on junior doctors' experience, some are unique to London, some will resonate across the country and many echo those in other reports. What makes this report stand out is the approach taken to hear directly from junior doctors – views from the front line. It makes ten recommendations about actions that will make a positive difference, including several that will strengthen engagement at an organisational level through the development of Junior Doctors Representative Groups. Some may take time; however some can be taken forward relatively quickly and will bring benefits in the short term.

I am grateful to the London Clinical Senate and the Faculty of Medical Leadership and Management for leading this work and to the medical directors and other senior staff across London who gave their support. I would also like to acknowledge Health Education England's support for this work and its recommendations. Most of all I would like to thank all of the junior doctors who participated in the listening exercise for sharing their views and experiences and telling us what training and working in London's NHS is really like. Their insight was invaluable to showing what makes a difference to them and therefore to the patients they look after.

At a time when recruitment to the medical profession seems to be more challenging, with training placements in some areas proving more difficult to fill and with signs that disillusionment and frustration persist, we cannot afford to be complacent in responding to the issues identified.

I encourage everyone who has a role to play in supporting junior doctors to read and act on this report. It is also important to recognise that many of the issues identified by junior doctors in the listening exercise are experienced by other staff groups and many of the recommendations equally apply.

I would like to thank Dr Andy Mitchell my predecessor who initiated the first meeting which generated the momentum for this work, Dr Jane Collins (former Senate Council Chair) for her support and all members of the project team who were instrumental in its delivery.



Dr Vin Diwaker  
Regional Medical Director NHS England (London Region)  
London Clinical Senate Forum Co-Chair

## Acknowledgements

The authors of this report would like to thank Peter Lees, Kirsten Armit, Sue Dutch, and Cheuk Wong for their valuable contributions to the production of this report.

---

# Executive summary

---

This report summarises a collaborative study on junior doctor engagement by a joint working group from the London Clinical Senate and Faculty of Medical Leadership and Management (FMLM). The study set out to identify the major issues impacting on junior doctor engagement within trusts and establish recommendations for trusts and clinical leadership to focus efforts.

This work includes both quantitative and qualitative data collected from those working on the front line of healthcare. In the first phase, a pan London survey was sent out to all medical directors across the region exploring the current arrangements each trust has in place. In the second phase, the working group met with junior doctor representation groups (JDRGs) within trusts to further explore issues and identify areas of good practice. The findings were analysed by the joint working group and are presented in this report.

Survey engagement was excellent with an 82% response rate from the 33 London trusts. Encouragingly, 93% of those surveyed had a dedicated group for engaging with junior doctors. The majority of these had been set-up in their current format in the previous three years. At their best, JRDGs were perceived to have a positive influence on improvement science, organisational strategy, education, pastoral care, research and audit. Nearly one third did not have senior medical leadership representation and nearly half did not include a representative from the executive team or senior management. In addition, one-fifth of JDRGs were felt to not have a contractual role.

The listening events identified key issues around 'speaking-up' about concerns, the negative impact of frequent rotations, the challenges in learning from significant events and the tensions between service provision and training. JDRGs were seen as an important mechanism for meaningful engagement. In exemplar trusts junior doctors were able to describe "a strong sense of belonging".

While there is much to be done, there were clear examples of admirable practice which have shaped the recommendations in this report. The 10 recommendations are actions to improve the engagement of junior doctors with their trusts and thus the quality of their working lives. The recommendations require collaboration and coordination from all stakeholders involved.

# Summary of recommendations

**Recommendation 1:** All trusts with junior doctors should review current status, structure and effectiveness of JDRGs. FMLM to produce a toolkit describing the actions required to run an effective JDRG.

**Recommendation 2:** JDRGs should have a junior doctor representative from each department. These representatives should be provided with adequate support and time to fulfil their role.

**Recommendation 3:** Arrangements should be made for junior doctors sitting on JDRGs to network and participate in education and training that will help them develop the skills needed for these roles. The London Clinical Senate, FMLM and HEE should help facilitate this.

**Recommendation 4:** Junior doctors should work in partnership with medical leaders and managers to co-design solutions to challenges with junior doctor engagement. This should start with the induction process.

**Recommendation 5:** Trusts should provide all clinical staff with a safe and private space to meet with colleagues and provide respite, ideally 24 hours a day.

**Recommendation 6:** Junior doctors should be provided with on-site space to rest when they are doing a night-shift and arrangements should be made for their safe travel home during anti-social hours.

**Recommendation 7:** Investigations should be undertaken to assess whether the length of junior doctor rotations in each trust and department should be increased.

**Recommendation 8:** HEE should consider ways that training programmes can be made more flexible. Also, the F1 and F2 programme should be reviewed to identify what has led to an increase in the number of junior doctors undertaking an 'F3' year before entering core or specialty training.

**Recommendation 9:** HEE should develop an HR mandatory training passport for junior doctors, to reduce the repetition and administrative burden of frequently changing placements.

**Recommendation 10:** Ways of reducing the financial burden for junior doctors and other NHS staff living in London should be investigated.

# Background

In June 2016, NHS England London region in collaboration with FMLM held a listening event, *An open discussion with trainees: their present role in the NHS and as the healthcare leaders of tomorrow*. This took place at a time of palpable disquiet among junior doctors across the country and the first strikes involving doctors in 40 years. More than 35 junior doctors from all grades attended the event along with several senior clinicians and medical directors from across London.

The most striking feedback from junior doctors was that many felt limited affiliation with the organisation in which they worked, with several describing feeling like “migrant workers” in their trusts.<sup>1</sup> They did not feel included or engaged with the organisations in which they worked. This is concerning considering medical engagement is recognised as necessary for positive patient and organisational outcomes<sup>2</sup>.

Wider research suggests the experiences described by the junior doctors attending the listening event are shared by junior doctors throughout the UK. The Royal College of Physicians found that only three in ten junior doctors feel valued by the chief executive of their hospital or trust<sup>3</sup>, while Gilbert (2012) found that less than two in ten feel valued by hospital managers<sup>4</sup>.

Junior doctor engagement matters because these doctors are the future consultant workforce: they are the future departmental leads, clinical directors and medical directors.

Engaged employees have belief and pride in their organisation; commitment to improve outcomes; understanding of the wider organisation context beyond their own job role; respect for colleagues; and a willingness to go the extra mile<sup>5</sup>. An engaged and inspired workforce will be critical to meeting the future challenges and demands of the NHS<sup>6</sup>. The drive for engagement, however, is not just about the future but also the unique position junior doctors hold in being agents for change in their organisations, galvanising the quality, safety and patient experience agendas for today<sup>7</sup>.

<sup>1</sup> Malik M (2016) Listening to be heard – junior doctors putting forward the case for change. FMLM Blog. Available from: <https://www.fmlm.ac.uk/news-opinion/blog/listening-to-be-heard-junior-doctors-putting-forward-the-case-for-change> (Accessed 18/06/18).

<sup>2</sup> Spurgeon, Clark and Wathes (2015) Medical engagement and improving quality of care. *Future Healthcare Journal*; 2(3):199-202.

<sup>3</sup> The Royal College of Physicians (2016) Being a junior doctor – Experiences from the front line of the NHS [Online] Available from: <https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor> (accessed 14/12/17).

<sup>4</sup> Gilbert, Hockey, Vaithianathan, Curzen and Lees (2012) Perceptions of junior doctors in the NHS about their training: results of a regional questionnaire. *BMJ Quality and Safety*; 21:234-238.

<sup>5</sup> Spurgeon, Clark and Ham (2011) Medical leadership: from the dark side to centre stage. Radcliffe Publishing, London.

<sup>6</sup> Gilbert, Hockey, Vaithianathan, Curzen and Lees (2012) Perceptions of junior doctors in the NHS about their training: results of a regional questionnaire. *BMJ Quality and Safety*; 21:234-238.

<sup>7</sup> Keogh (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report

FMLM asserts that: “the NHS cannot afford to let its junior workforce become disengaged. Where poor leadership exists, and engagement is not seen as a priority, there is a risk that good doctors will become mediocre. Junior doctors need to be inspired and engaged so they go on to become engaged consultants, capable of and willing to meet the challenges and demands of the modern NHS. It is a two way street, and junior doctors need to play a role in supporting their trust’s engagement strategies”<sup>8</sup>.

The listening event on June 2016 also highlighted potential solutions for engagement that were being explored by the junior doctors and their trusts. One such solution that was identified was the use and development of junior doctor representative groups (JDRGs). JDRGs that engaged the trust leadership and have active participation from their junior doctors can improve medical engagement and therefore job satisfaction, patient outcomes and organisational achievements. JDRGs were recognised as an important vehicle for engagement and were therefore identified as a focus of this project and a vehicle to explore wider issues within organisations.

To better understand the current issues underpinning junior doctor engagement with their trusts and to see JDRGs in action, the London Clinical Senate and FMLM initiated a joint project to explore in depth the issues underpinning poor junior doctor engagement and present potential solutions. The aim was to contribute to the significant work on junior doctor engagement and add a fresh perspective as these issues are explored at the local level, within employing organisations across different specialities and across the different grades of the junior doctor workforce in London.

The project team sought to assess the state of junior doctors’ working lives in London and create a set of recommendations to improve organisational engagement.

An understanding of what is meant by junior doctors, their training requirements and the details around JDRGs is needed in order to fully understand the context of this report. These are explained in greater detail in the following sections. A conscious decision has been taken to use the term ‘junior doctors’. The report authors understand the negative connotations associated with this title, however no other term encompasses all those who are in training programmes, as well as in non-training roles, clinical fellows and locum roles.

---

<sup>8</sup> Wathes and Spurgeon (2016) Junior doctor engagement – Investing in the future. FMLM, London. Available from: <https://www.fmlm.ac.uk/resources/junior-doctor-engagement-%E2%80%93-investing-in-the-future> (Accessed 05/06/18)



# Overview of junior doctor training in London

All 33 NHS trusts and foundation trusts in London employ junior doctors. These host around 10,500 formal training posts, from foundation trainees to those completing core and higher specialty training. These posts are filled by approximately 13,500 trainees, with a number working less than full time. In addition, there are junior doctors who are not on training programmes, including locums, staff-grade doctors and clinical fellows.

Post-graduate training pathways for junior doctors are overseen by Health Education England (HEE).

The General Medical Council (GMC) sets the standards and requirements for the delivery of all stages of medical education and training. Their document 'Promoting excellence: standards for medical education and training'<sup>9</sup> outlines 10 standards in five themes that they expect all organisations responsible for education and training to meet. Patient safety is at the heart of all the standards.

---

<sup>9</sup> General Medical Council (2015) Promoting excellence: standards for medical education and training [Online] Available from: [https://www.gmc-uk.org/Promoting\\_excellence\\_standards\\_for\\_medical\\_education\\_and\\_training\\_0715.pdf](https://www.gmc-uk.org/Promoting_excellence_standards_for_medical_education_and_training_0715.pdf) 61939165.pdf (accessed 24/01/18).

# Junior doctor representative groups

Junior doctor representative groups (JDRGs) have existed in some form in most trusts for many years, but the constitution and activities of these groups varies widely from one trust to another. The 2016 terms and conditions of service for doctors and dentists in training in England includes a requirement for the guardian of safe working hours and the director of medical education in each employing organisation to establish a junior doctor forum (JDF) which should meet at least quarterly<sup>10</sup>. Guidance from NHS Employers suggests that in addition to supporting and scrutinising the work of the guardian, trusts may wish to widen the scope of the JDF to include<sup>11</sup>:

- Providing a forum for ideas and suggestions to be discussed and put forward for consideration by the appropriate committee
- Providing a forum for the employer to engage with junior doctors in developing and improving its services, working conditions, education and training.

The terms and conditions of service require that the JDF has the following members<sup>12</sup>:

- guardian of safe working hours (chairperson)
- director of medical education or a nominated deputy
- local negotiating committee (LNC) chairperson (or another senior member of the LNC, should there be a conflict of interest)
- junior doctor LNC representatives
- sufficient additional junior representatives that the employer feels are necessary to ensure that there is adequate representation for various sub groups within the junior doctor population covered by the forum


The following members are also recommended for inclusion:

- head of medical HR or nominated deputy
- one or more executive directors
- secretariat from HR or medical education

<sup>10</sup> NHS Employers (2016) Junior doctors forum – guidance for employers [Online] Available from: [http://www.nhsemployers.org/~media/Employers/Documents/Need%20to%20know/Junior%20doctor%20forum-%20guidance\\_November%202016.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Need%20to%20know/Junior%20doctor%20forum-%20guidance_November%202016.pdf) (accessed 13/12/17).

<sup>11</sup> NHS Employers (2016) Junior doctors forum – guidance for employers [Online] Available from: [http://www.nhsemployers.org/~media/Employers/Documents/Need%20to%20know/Junior%20doctor%20forum-%20guidance\\_November%202016.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Need%20to%20know/Junior%20doctor%20forum-%20guidance_November%202016.pdf) (accessed 13/12/17).

<sup>12</sup> NHS Employers (2016) Junior doctors forum – guidance for employers [Online] Available from: [http://www.nhsemployers.org/~media/Employers/Documents/Need%20to%20know/Junior%20doctor%20forum-%20guidance\\_November%202016.pdf](http://www.nhsemployers.org/~media/Employers/Documents/Need%20to%20know/Junior%20doctor%20forum-%20guidance_November%202016.pdf) (accessed 13/12/17).



Guidance from the British Medical Association (BMA) states that if a trust already has a pre-existing junior doctor group or forum, the new forum required as part of the terms and conditions is not necessarily intended to replace it if the existing group already fulfils the responsibilities of the new forum. Furthermore, if the pre-existing group has a different role, there is no need to replace or merge the two groups, both groups can co-exist<sup>13</sup>.

At the time of completion of this study, all trusts in England should have a JDF. Some of these may be long-standing and fulfil the requirements of the terms and conditions along with a wider role in improving and developing the working lives of junior doctors. Other JDFs may have been set-up as a result of the terms and conditions and have a more limited role restricted to fulfilling the contractual requirements. In order to be comprehensive, this report refers to all groups as junior doctor representative groups (JDRG).

---

<sup>13</sup> British Medical Association (2017) Junior doctor forums [Online] Available from: <https://www.bma.org.uk/advice/employment/contracts/junior-doctor-contract/junior-doctors-forums> (accessed 13/12/17).

---

# Methodology

---

The evidence presented in this report was gathered in two phases:

1. A pan-London survey completed by medical directors exploring the current arrangements for JDRG
2. A listening exercise held in a sample number of London trusts, aimed at exploring the survey findings. This included exploring the issues impacting on the working lives of junior doctors, and formulating solutions by identifying areas of good practice for junior doctor engagement.

The London Clinical Senate and FMLM surveyed medical directors in all London trusts between 20 January and 10 February 2017. The survey sought to explore the current arrangements for JDRG in each trust including participation, support, effectiveness and influence. The full list of survey questions can be found in Appendix 1. The survey was piloted with the medical director at one trust to test the format and questions asked; it was then refined in light of feedback. The final survey was sent electronically to the medical directors of London's trusts along with an explanatory letter. Follow-up emails were sent to encourage responses. Survey results were exported from the online survey software and analysed. An aggregated report summarising responses was sent to each respondent, along with a breakdown of the trust's collective response.

An option for trusts to participate in the follow-on listening exercises was included in the survey. The majority of respondents accepted. Visits were subsequently made to six JDRGs, encompassing a mixture of single and multi-site, acute and mental health trusts with a geographical spread. The visits were undertaken by members of the project team, comprising representatives from FMLM and the London clinical senate. The overall project team consisted of: the deputy chair of the London Clinical Senate; the chief operating officer of FMLM; the chair of the FMLM TSG; the FMLM TSG representative for London; the clinical senate programme lead; and the clinical senate senior project manager. At least two clinicians attended each visit. Liaison took place with respective JDRG chairs in advance and time allocated on each JDRG agenda was 20 to 30 minutes, although in most cases discussions continued for longer. An appreciative enquiry model was used, with open unstructured discussion and some prompts to gather the opinion of junior doctors present about engagement with each trust and on wider issues that they felt affected their working experiences. Discussions were documented anonymously, shared with respective JDRG chairs, and analysed to explore key themes.

---

# Findings from engagement survey (Phase 1)

---

Of the 33 trusts invited, 27 (82%) participated in the survey. Surveys were completed by medical directors' support staff, but some were completed with the assistance of HR directors and junior doctors themselves. The full responses to the survey are shown Appendix 1 and a summary of the key findings is given below.

## Existence and format of JDRGs

Of the 27 respondents, 25 (93%) said that they already had a dedicated group for engaging with their junior doctors. Most of the JDRGs (64% of those that had responded) had been set up in their current format within the previous three years. This included new groups as well as those that had changed or evolved from groups that had been established over decades.

Of trusts that had multiple sites, just over half had site-specific arrangements for their JDRGs; examples of these arrangements included holding cross-site meetings via a VCR link.

Many trusts met on a monthly basis (44%), while 24% met on a bi-monthly basis and 28% met on an ad-hoc basis as they were newly established. Around 19 trusts (76%) provided administrative support for their JDRG and 20 JDRGs (80%) had written Terms of Reference.

Of the two trusts without a JDRG (7% of those who responded), one said that advice on how to set-up a successful group would be useful, while the other did not want support.

# Purpose, influence and effectiveness of JDRGs

Participants were able to select multiple options in response to these questions. The most common purposes of the JDRG were:

- to develop improvement ideas and help support the organisation's strategic goals
- to inform the trust board
- to provide pastoral care
- for contractual purposes alongside other roles
- to carry out an educational role.

No respondent replied that the group was for contractual purposes alone. Around 20% of participants indicated that the JDRG within their organisation had no contractual role.

When asked what areas of the trust the JDRG had influence on, no medical directors answered 'no influence'. In fact, 96% of respondents felt their JDRG had influence on education and training and 68% said it had an influence on improving clinical care. Trust policies and procedures were felt to be influenced by the JDRGs in just over half of trusts (52%), organisational strategy in 40% of trusts and improvement science, research and audit in 28% of trusts. Approximately 24% of the respondents said the groups had no specific objectives set but was used as an opportunity to raise issues and concerns.

Over half of respondents (56%) said the JDRG had links with other groups within the trust or with JDRGs in other trusts. Among the groups linked with the JDRGs were: the trust partnership committee, the hospital management team, the medical education board, the contract steering group and the National Medical Workforce Forum. Respondents said the JDRGs had formal links with the local negotiating committee in 76% of trusts, and with the consultant committee in 28% of trusts.

When asked about the effectiveness of their JDRG the survey highlighted the variability in the presence and effectiveness of the JDRG within trusts. Most of the 83% of trusts who responded to the question said the group was effective.

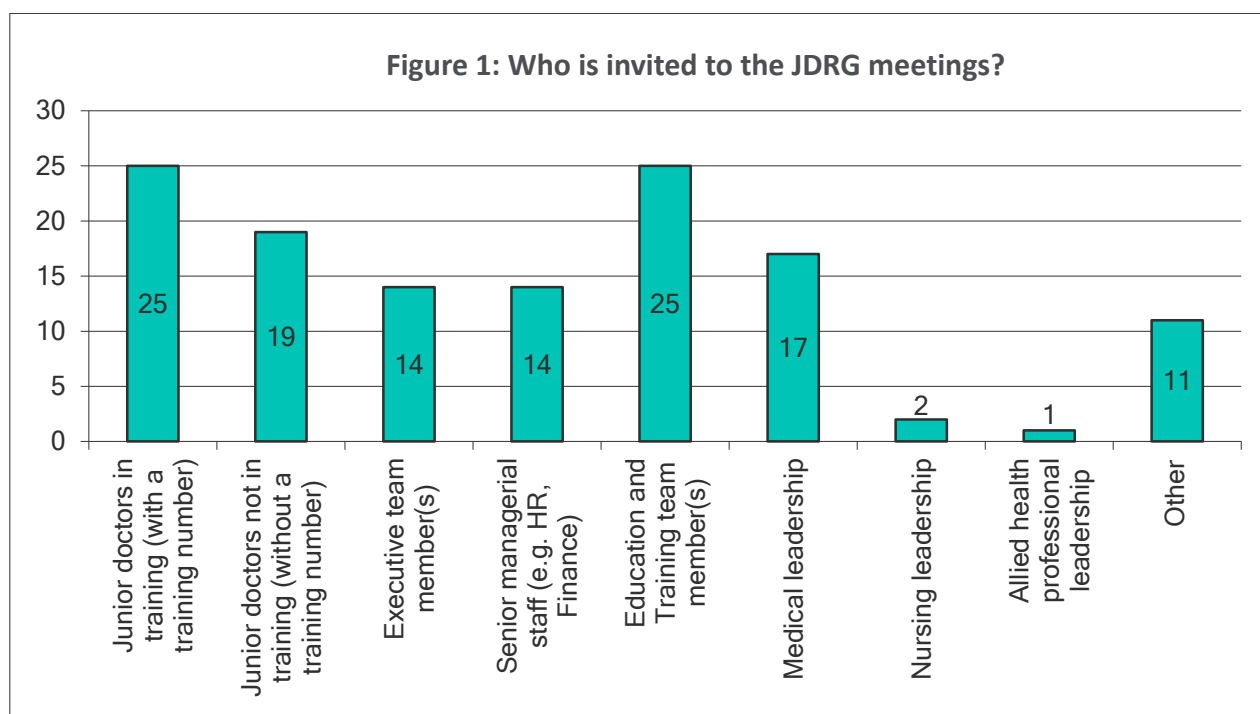
Comments included: "It has been effective in providing a forum where junior doctors can feel heard, it was helpful around the time of the strikes. We are working on having more junior doctors on committees eg patient safety and outcome committee so that they can help shape how we do things".

Suggestions on how the Senate and FMLM might help in engaging with junior doctors across London included organising network events for JDRG lead representatives to attend and establishing a London junior doctor forum.

Comments included: “It would be useful if the London Clinical Senate or FMLM could facilitate a one-day conference with junior doctors and employers to develop new ways of engagement that addresses the issues raised by junior doctors”. Another said: “It would be helpful if the London Clinical Senate or FMLM could work with HEE to develop training programmes that enabled trainees to have two to three-year placements that would support improved engagement with their trust”. Also, “Encouraging junior doctors to deliver management roles early on in their career will support them to identify with their employing organisation better”.

## JDRG membership

Junior doctors in training (with a training number) and education and training team members were invited to JDRGs in all trusts participating in the survey. Junior doctors not in training (without a training number) were not included in the JDRG in nearly a quarter of the trusts surveyed (24%). Nearly a third of JDRGs did not contain a medical leadership representative (32%) and nearly half (44%) did not include a member of the executive team or senior management. The survey revealed a lack of representation from allied health professional leadership and nursing leadership, who were invited in just one or two of the trusts respectively. Figure 1 reveals the full picture with regards invitation to JDRG meetings.



---

# Findings from the listening exercise (Phase 2)

---

Overall, medical directors were supportive of the listening exercise with 80% indicating that they would facilitate a clinical senate and FMLM team listening exercise within their organisation. Four respondents did not answer this question and three medical directors declined a visit. The reasons given included ensuring agreement of the chair of the JDRG and the recent establishment of the JDRG.

During the listening exercise, junior doctors were encouraged to discuss their experiences of the JDRG and wider issues of engagement and morale using the appreciative inquiry model. Notes were taken at each of the listening exercises and collated. The project team agreed the notes before undertaking any analysis; the key themes identified were: morale, junior doctor leadership and engagement, flexibility of training, length of rotations, the tension between training and service provision, learning environment, and London-specific issues. An overview of these themes is given below and further discussion about the issues raised is given in Appendix 2.

## Morale

Morale of junior doctors was a wider issue at the time the listening exercises took place (April to September 2017). Where morale was an issue, contributing factors were:

- the junior doctors' dispute and contract negotiations
- junior doctors not feeling valued by trusts
- junior doctors feeling like itinerant migrant workers
- inconsistent teams and a lack of meaningful colleague relationships
- lacking facilities for rest, food and drink.

Some comments made by junior doctors at the JDRGs visited included:

- "There is a clock in, clock out mentality now. There is no good will for a system that chews people up and spits them out."
- "If you have temporary employees you are never going to get buy-in; people feel disenfranchised."
- "You are on-call with people you never see again."



# Junior doctor leadership and engagement

The challenges facing junior doctors are complex and multi-factorial. However, exemplar trusts were uncovered through this work where junior doctors described a “strong sense of belonging”, where they felt “respected, engaged and listened to.”

When asked what worked well, junior doctors described adequate rest facilities, a centralised doctors’ mess with provision of food and beverages out-of-hours and safe transport after anti-social shifts. Spaces where staff could convene, such as small rooms with kitchen appliances, added to the sense of wellbeing. At an organisational level, positive engagement was seen as a lack of hierarchy, approachable clinical leaders open to quality improvement ideas, strong links between hospital services and specialties, and strong support from medical education departments. Genuine engagement with trust management teams was viewed positively, resulting in junior doctors feeling that management teams wanted to “help, listen and make improvements.” A further comment included: “making junior doctors feel they belong to the whole organisation rather than individual departments/specialties is key in driving excellence within the organisation.”

Concerns regarding junior doctors ‘speaking up’ about trust issues were expressed at a number of the JDRGs. Some junior doctors had a perception that they might “anger the trust or management team if they speak out or flag up issues.” Others stated that the employment arrangement for junior doctors led to difficulties in voicing opinions. “The fact that junior doctors are not Trust employees sometimes becomes a barrier for their voice to be heard.” One solution was to have more co-designed projects between managerial staff and junior doctors.

## Junior doctor representative groups

The six JDRGs visited by the project group varied in form, structure and attendance as well as perceived effectiveness and influence. When JDRGs were perceived to be effective, junior staff reported that they “feel listened to by management”. The most successful JDRG appeared to be those in which the junior doctors chaired or lead the group with support from hospital management, human resources, medical education and others as required. Participating in these groups enabled junior doctors to understand the challenges facing all parts of the organisation. Comments from the JDRG included:

“Lots of issues raised but there aren’t always easy solutions.”

“The outcome might not be what you wanted but it feels like at least you have been listened to.”

“It is useful from a junior point of view to see what the issues are higher up; sometimes you are able to placate a few arguments.”

Protected time to attend the JDRG and support junior doctors taking on these leadership roles was viewed as crucial to their success, as was ‘buy-in’ from hospital management and the medical education department. Other salient features of good JDRGs appear to be those that were not preoccupied with contractual issues alone, instead creating and promoting improvement opportunities. The JDRG was used as a vehicle to bring potential solutions to trusts rather than problems alone. We observed good administrative support with minutes being taken, agendas circulated before the meeting, and actions logged and addressed during the meeting.

Further comments relevant to the function of JDRGs:

- “Most people want to be valued, part of a team and do the job they really enjoy doing.”
- “We have a lot of solutions here we just need to find ways to connect eg this is how we did it, and this is the person you need to influence.”
- “It needs to come back to the essence of what it was all about – patient care.”
- “People want to listen and people want to help.”
- “Not like other organisations feels like a small family.”
- “They do want feedback and they want to help.”
- “If I could do one thing UK-wide it would be to bring back the mess.”

## Flexibility of training

At several JDRGs, junior doctors raised concerns about utilising training opportunities outside the conventional training experience such as out-of-programme experiences, fellowships or research opportunities. It was felt that these opportunities were not always encouraged by senior clinicians and that current training does not support such arrangements. It was also felt that the training system does not support trainees who are unsure which specialty to go into, as there are not enough opportunities to try-out different specialties and decisions regarding speciality have to be made early in their career.

Participants highlighted the increasing number of junior doctors who, after completing foundation training, are choosing to work as ‘F3 Clinical Fellows’ rather than commencing core or specialty training. This included working in a variety of locum or staff grade roles for the year, often in a mixture of specialties, to understand

what they would like to pursue later in their careers<sup>14</sup>. One trainee summarised that, as an 'F3', she is encouraged to attend training while allowing herself to work out her interest and improve her clinical competency. Consequently, she feels she is "getting the best of both worlds" while not being tied to a specific specialty or area.

## Length of rotations

The short length and frequency of rotations was raised repeatedly at the JDRGs as an issue affecting junior doctors' working lives. This impacts significantly on the quality of education and learning on professional development, peer support, and continuity with patients. Feedback and subsequent learning from significant events are all reduced due to a lack of time available. Junior doctors describe this as a "major challenge" in making sustainable improvements in their organisations or building the momentum needed for meaningful change.

In some cases, rotations as short as three or four months have a detrimental effect on many aspects of the junior doctor experience, including:

- The constant battle of unfamiliarity with each new environment which negatively affects training, the care provided to patients and their own morale.
- Difficulties seeking support from colleagues as they do not work with the same people long enough to develop meaningful relationships through which they feel comfortable seeking guidance.
- Lack of continuity within a specific hospital or department means it is difficult for junior doctors to contribute to making sustainable improvements or maintain the momentum for change.
- Junior doctors receive little notice of their next placements and new rotas, making it difficult to plan and organise their living arrangements, personal and family events.
- Frequently changing placements puts considerable administrative strain on both junior doctors and hospitals. With every new rotation junior doctors need to provide proof of address, complete occupational health checks, update their payroll details, and complete mandatory training. Some junior doctors reported difficulties in claiming travel expenses as their 'base hospital' was recorded as their initial placement and not updated when they started a new rotation.

---

<sup>14</sup> General Medical Council (2017) Training pathways: analysis of the transition from the foundation programme to the next stage of training [Online] Available from: [https://www.gmc-uk.org/Training\\_pathways\\_1\\_FINAL2.pdf\\_72695703.pdf](https://www.gmc-uk.org/Training_pathways_1_FINAL2.pdf_72695703.pdf) (accessed 23/02/2018).

Comments made at the JDRGs in relation to the length of placements include:

- “The discontinuity is having a large impact, worse than the contract”
- “As a core trainee I have been in three trusts in a year – you end up getting quite lost.”
- “You are on call with people you never see again.”
- “The shorter rotations don’t give time to build relationships.”
- “The system puts the first hospital you worked in as the ‘base’ and this isn’t updated. This creates problems in claiming expenses.”
- “If people are not investing in me why should I invest in the organisation?”

## Tensions between training and service provision

The unique challenges of post graduate medical education are well recognised<sup>15</sup> particularly the tension between training and service provision. Both are required to develop a clinician fully capable of managing independent practice in the modern NHS.

Junior doctors felt that, at departmental level, their training is not given as high a priority as their service provision. They commented that clinics were routinely overbooked and understaffed with their roles becoming more like ‘firefighting’ exacerbated by rota gaps. Junior doctors also commented on the excessive administrative burden they encounter. Admission packs and discharge letters consume a significant amount of junior doctors’ time, and they felt this was negatively impacting on time spent with patients, learning opportunities and general work satisfaction. One junior doctor felt that that as much as two-thirds of their work comprised activities that were not recognised as part of their training. Also, there were concerns that junior doctors were not involved in the decision making and patient assessment, but bore responsibility to enact decisions in which they had not been engaged.

The issue of junior doctors being unable to take study leave due to rota issues was also raised. Junior doctors recognised the impact of working pressures on senior staff and other members of the multi-disciplinary team; they noted that seniors often wanted to teach but did not have the capacity to do so.

The pressures of service delivery also impacted on the professional as well as the clinical development of junior doctors. Across the groups, trainees described difficulties in attending training days, conferences and meetings.

---

<sup>15</sup> Ludmerer K (2012) *Education and Service: Definitions are the Easy Part*. Journal of Graduate Medical Education. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3546593/> (accessed 05/06/18)

They described these as not only important for educational reasons but also as a strong source of motivation and inspiration for the day job. Junior doctors described feeling unable to contribute meaningfully to service or quality improvement due to being “exhausted and overstretched” in the day-to-day work.

Concerns regarding exception reporting were a common theme across the sites visited. There was inter-trust and intra-trust variation in how exception reports were dealt with by senior staff. Junior doctors noted that the attitudes of individual departments played a key role in how the issues highlighted by the reports were addressed. Junior doctors described feeling as though they were “putting their seniors/consultants on the spot” or “rocking the boat”. Those doctors involved in the JDRGs felt the trust needed to recognise the role of the Guardian of Safe Working and provide support so they could fulfil their role. Junior doctors felt the exception reporting could be a useful mechanism for identifying areas where there are recurrent issues, especially when these are related to patient safety.

Comments made at the JDRGs that relate to the pressures of service provision and rota gaps include:

- “There have been difficulties with the on-call rotas. Workload seems to be the predominant problem. We are trying to adapt the workload but trainees find it difficult. There is only one SHO on call so there is not much accommodation.”
- “The on-call issue is actually getting worse. I think we all agree having another SHO on call but we understand the financial constraints.”
- “In psychiatry, the trainees cover everything medical which frustrates a lot of people. Trainees end up doing ECG/bloods etc.”
- “Workloads on call are too high and the situation is stressful.”
- “Find it very hard to find time or capacity to do more.”

## Learning environment

It was clear from the JDRGs that junior doctors valued high quality education and training. But, a lack of recognition and support from senior doctors, especially when it was thought seniors were less willing to invest time due to the frequent, short rotations, can lead to self-doubt amongst juniors about their progress and abilities. Where regular training and teaching sessions were provided, they were much appreciated by junior doctors who generally wanted more time for practical learning.

Junior doctors are unique by occupying roles with responsibilities and requirements, yet are still viewed to be 'in-training'. This makes the postgraduate learning environment challenging when combining the educational and organisational priorities.

A learning environment also must include peer-to-peer learning and opportunities for discussion and reflection. The loss of safe spaces to take part in these activities is having a significant negative impact. As one junior doctor put it, "there is nowhere private to eat – you end up sitting beside the patient who you have just given terrible news too. It is not a comfortable experience for anyone." In one trust, junior doctors commented on the importance of their mess in providing them with a place to feel comfortable, build relationships with peers and rest when able.

Further comments made by the junior doctors at JDRGs included:

- "I travel to get higher quality training and education."
- "I have been told: You should be able to train yourself as you have a curriculum."
- "Providing training isn't given as high a priority as service provision."
- "I can't tell you how I am doing – feedback is needed."

## London-specific issues

Some of the issues discussed at the JDRGs are London-specific. These include:

- Junior doctors find the cost of living in London too high. Consequently, some junior doctors live in outer London and face long commutes (which are also expensive).
- There was a feeling that some trusts have become complacent since they have a good reputation, so junior doctors are keen to undertake their training there. As a result, these trusts are not making sufficient efforts to provide a good training and working experience as there is a surfeit of junior doctors wanting to train there, so they do not have to actively attract them.

Some comments made at the JDRGs specifically relating to London issues, include:

- "I stay in Air BnB or similar for my on-calls. I pay for this myself. I asked the trust if they could provide accommodation and they quoted £80-£100 per night for hospital accommodation. The cost of the accommodation outweighs the money I make on call."
- "The trust's policy on how quick non-resident on-calls need to get to the hospital during an emergency is unclear."

# Links with other work

Many of the issues affecting the working lives of junior doctors that were identified during the listening exercise have also been identified in other work on this topic.

Some of the main links with other work include:

- a lack of autonomy in training was also identified by HEE as one of the three main issues affecting junior doctor morale<sup>16</sup>. Anaesthetist trainees have also reported frequently changing rotations as one of the main reasons leading to low morale<sup>17</sup>.
- a lack of flexibility of training was also identified by HEE as one of their 10 key training issues, which they specify as: “limited opportunities for doctors to train flexibly, including structural and cultural barriers to less than full time training’ and another of their issues is ‘inequality in time out of training – the need to help doctors with improved, and more individually tailored, support upon their return to training”<sup>18</sup>. Additionally, the Royal College of Psychiatrists found that psychiatry trainees value flexibility and autonomy in their training<sup>19</sup>.
- HEE also acknowledges the increasing number of junior doctors taking ‘F3’ years as a concern: one of their 10 key training issues is “the need to support an increasing number of doctors at the post foundation/pre-specialty level who are looking for a more flexible approach to career progression”<sup>20</sup>.
- frequently changing rotations has been recognised as an issue in national reports, since HEE highlights difficulties that arise from late rota notification and fixed leave as one of the 10 key training issues to address<sup>21</sup>. Others include adequately facilitating caring responsibilities or the maintenance of relationships and family life<sup>22</sup> and addressing the need for trainees to move home repeatedly during training where this lacks educational justification or support from trainees<sup>23</sup>. The Royal College of Psychiatrists identified that having ergonomic rotas co-designed with trainees that are issued in a timely fashion (minimum 12 weeks’ notice) and accommodate pre-existing leave arrangements would improve the working lives of psychiatry trainees<sup>24</sup>.

<sup>16</sup> Health Education England (2016) Junior doctor morale: Understanding best practice working environments [Online] Available from: [https://hee.nhs.uk/sites/default/files/documents/Junior%20Doctors%27%20Morale%20-%20Understanding%20Best%20Practice%20Working%20Environments\\_0.pdf](https://hee.nhs.uk/sites/default/files/documents/Junior%20Doctors%27%20Morale%20-%20Understanding%20Best%20Practice%20Working%20Environments_0.pdf) (accessed 04/01/18).

<sup>17</sup> Royal College of Anaesthetists (2017) Morale and welfare survey [Online] Available from: <https://www.rcoa.ac.uk/sites/default/files/Newsletter17-Feb2017.pdf> (accessed 19/01/18).

<sup>18</sup> Health Education England (2017) Enhancing junior doctors’ working lives – A progress report [Online] Available from: <https://hee.nhs.uk/sites/default/files/documents/Enhancing%20Junior%20Doctors%20Working%20Lives%20-%20A%20Progress%20Report.pdf> (accessed 03/01/18).

<sup>19</sup> Till A, Milward K, Tovey M, Bailey A, Evans C, Howson S, Thom V (2017) *Supported and valued? A trainee-led review into morale and training within psychiatry*. Psychiatric Trainees’ Committee, Royal College of Psychiatrists, UK.

<sup>20</sup> Health Education England (2017) Enhancing junior doctors’ working lives – A progress report [Online] Available from: <https://hee.nhs.uk/sites/default/files/documents/Enhancing%20Junior%20Doctors%20Working%20Lives%20-%20A%20Progress%20Report.pdf> (accessed 03/01/18).

<sup>21</sup> *Ibid*

<sup>22</sup> *Ibid*

<sup>23</sup> *Ibid*

<sup>24</sup> Till A, Milward K, Tovey M, Bailey A, Evans C, Howson S, Thom V (2017) *Supported and valued? A trainee-led review into morale and training within psychiatry*. Psychiatric Trainees’ Committee, Royal College of Psychiatrists, UK.

- the need for improvements to induction and mandatory training, including an end to unnecessary repetition has also been highlighted as a key issue by HEE<sup>25</sup>.
- relating to concerns about service provision and the quality of education, the Royal College of Physicians has also found that the wellbeing of junior doctors is suffering, with four out of five reporting that they sometimes or often experience excessive stress as a result of their job. They also found that many junior doctors reported that workforce pressures limit the time available for their training<sup>26</sup>. Varying equity in study leave provision was also identified by HEE as one of their 10 key training issues<sup>27</sup>.
- relating to excessive workloads, the Royal College of Physicians also reported similar concerns from junior doctors, with six out of 10 junior doctors reporting that patient safety is being put at serious risk due to poor availability of out-of-hospital services and a shortage of available hospital beds and half of junior doctors reporting that patient safety is seriously compromised by gaps in their rotas<sup>28</sup>. Moreover, the Royal College of Anaesthetists confirmed previously identified understaffing issues among anaesthetist trainees in their survey which found that the average trainee across the UK fills a rota gap six times per month<sup>29</sup>.

<sup>25</sup> Health Education England (2017) Enhancing junior doctors' working lives – A progress report [Online] Available from: [https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report\\_0.pdf](https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report_0.pdf) (accessed 03/01/18).

<sup>26</sup> The Royal College of Physicians (2016) Being a junior doctor – Experiences from the front line of the NHS [Online] Available from: <https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor> (accessed 14/12/17).

<sup>27</sup> Health Education England (2017) Enhancing junior doctors' working lives – A progress report [Online] Available from: [https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report\\_0.pdf](https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report_0.pdf) (accessed 03/01/18).

<sup>28</sup> The Royal College of Physicians (2016) Being a junior doctor – Experiences from the front line of the NHS [Online] Available from: <https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor> (accessed 14/12/17).

<sup>29</sup> Royal College of Anaesthetists (2017) Morale and welfare survey [Online] Available from: <https://www.rcoa.ac.uk/sites/default/files/Newsletter17-Feb2017.pdf> (accessed 19/01/18).



# Recommendations

If action is taken to address the issues identified through the survey and listening exercise, the engagement of junior doctors with their trusts and the quality of their working lives could be greatly improved. Many of the solutions are multimodal in approach and require coordination and collaboration from all stakeholders involved. However, many of the recommended solutions would be relatively simple to implement. The potential solutions have been divided into categories according to who would have the largest influence on the change occurring.

## Organisation level

### Junior doctor representative groups (integrating and involving junior doctors)

Effective JDRGs go a long way towards improving the relationship between junior doctors and the trust they work at. They provide a space for junior doctors to raise any concerns that they have and for solutions to be debated. Although they may have limited influence on factors outside of the trust and so may not be able to influence wider issues that are negatively affecting junior doctors, they can mitigate the effects and combat the feelings of distance and disengagement within the trust.


The key factors to aid a successful JDRG are:

- wide junior doctor membership (both in terms of specialty and grade)
- senior management support and presence
- regular meetings, with feedback on actions from previous meetings<sup>30</sup>

Ideally, there should be a named representative for each training programme, who can engage individuals who may not be able to attend in person and feedback any key messages. Additionally, one of the desired commitments that the Royal College of Psychiatrists outlines is that all trainees should have access to an enhanced junior doctor forum with senior management that expands beyond contractual issues and feeds into continual improvement of training, working life and patient care<sup>31</sup>.

<sup>30</sup> The Faculty of Medical Leadership and Management (2016) Junior doctor engagement, investing in the future [Online] Available from: <https://www.fmlm.ac.uk/resources/junior-doctor-engagement-%E2%80%93-investing-in-the-future> (accessed 22/01/18).

<sup>31</sup> Till A, Milward K, Tovey M, Bailey A, Evans C, Howson S, Thom V (2017) *Supported and valued? A trainee-led review into morale and training within psychiatry*. Psychiatric Trainees' Committee, Royal College of Psychiatrists, UK.



**Recommendation 1: All trusts with junior doctors should review current status, structure and effectiveness of JDRGs. FMLM to produce a toolkit describing the actions required to run an effective JDRG.**

The survey showed the variation in form and function of the JDRGs across London. Every trust should assess the efficacy of their JDRG. Each department of a trust should create a trainee representative position. The junior doctor in this role should gather the thoughts of all other junior doctors working in that department and feed these into the trust's JDRG. Additionally, they should disseminate decisions of the JDRG back to the trainees. The role should create a direct link between all junior doctors and the JDRG and provide them with a method for voicing their concerns to the trust management.

**Recommendation 2: JDRGs should have a junior doctor representative from each department. These representatives should be provided with adequate support and time to fulfil their role.**

It is important for each department to be represented at the JDRG to truly reflect the views of junior doctors throughout the organisation. The junior doctor representatives on the JDRGs currently receive limited support and training. Dedicated time and support should be provided to the junior doctors who sit on the JDRG to allow them to effectively fulfil this role.

---

**Recommendation 3: Arrangements should be made for junior doctors sitting on JDRGs to network and participate in education and training that will help them develop the skills needed for these roles. The London Clinical Senate, FMLM and HEE should help facilitate this.**

Some junior doctors suggested that they would benefit from a learning set and networking event regionally for them to learn leadership skills such as chairing a meeting and to share their experiences and be able to share good practice from the JDRGs at each of their trusts. Such a network should also link with HEE to share common concerns and solutions identified that HEE would have the power to influence.

**Recommendation 4: Junior doctors should work in partnership with medical leaders and managers to co-design solutions to challenges with junior doctor engagement. This should start with the induction process.**

For organisations to succeed, all staff must feel valued. Junior doctor engagement presents a unique set of problems among healthcare workers due to employment arrangements, frequent rotations and the sometimes dichotomous experience of training and service provision. As such, engaging this group of staff will require thoughtful innovation. This starts from the moment of arrival at the new organisation and induction is a key part of this process. FMLM produced a report in 2016: ‘Junior doctor engagement, investing in the future’ based on findings from visiting five trusts that had set-up initiatives targeted at junior doctors<sup>32</sup> and their recommendations to enhance junior doctor engagement in trusts also included ‘to give all junior doctors an informative and inspiring induction.’

---

Wathes and Spurgeon (2016) Junior doctor engagement – Investing in the future. FMLM, London. Available from: <https://www.fmlm.ac.uk/resources/junior-doctor-engagement-%E2%80%93-investing-in-the-future> (Accessed 05/06/18)

## Working environment

### **Recommendation 5: Trusts should provide all clinical staff with a safe and private space to meet with colleagues and provide respite, ideally 24 hours-a-day**

The recommendation to bring back the mess was suggested at several JDRGs. These should be multi-disciplinary, not restricted to doctors, and should provide a space for junior doctors to relax and meet with colleagues in an informal setting, allowing the formation of better team relationships and relationships with senior staff. Moreover, the mess should provide junior doctors (and all staff) with somewhere to get food and drink, ideally 24 hours-a-day. Again, this was one of FMLM's recommendations in their report: 'Junior doctor engagement, investing in the future'<sup>33</sup>.

### **Recommendation 6: Junior doctors should be provided with on-site space to rest when they are doing a night-shift and arrangements should be made for their safe travel home during anti-social hours.**

Furthermore, to help junior doctors feel valued and to improve the experience that they have working in trusts, they should be provided with on-site accommodation or space to rest when they are doing a night shift. Arrangements should also be made for their safe travel home during anti-social hours.

---

<sup>33</sup> The Faculty of Medical Leadership and Management (2016) Junior doctor engagement, investing in the future [Online] Available from: <https://www.fmlm.ac.uk/resources/junior-doctor-engagement-%E2%80%93-investing-in-the-future> (accessed 22/01/18).

# System level

## Rotations

**Recommendation 7: Investigations should be undertaken to assess whether the length of junior doctor rotations in each trust and department should be increased.**

Many of the dissatisfactions that were identified at the JDRGs stemmed from junior doctors having rotations that are too short in duration. With the result that they stay with a department for only a short period and therefore struggle to build meaningful relationships with their colleagues and learn about each specialty in adequate depth. While there is benefit in frequently rotating to gain experience of many specialties, this breadth of experience needs to be balanced with depth of learning at each placement. Further research into the impact of various rotation lengths would be useful to assess if what is lost by having longer rotations (such as less variety of specialisms experienced) is outweighed by what is gained in terms of being able to feel a greater part of the team at each placement.

## Flexibility

**Recommendation 8: HEE should consider ways that training programmes can be made more flexible. Also, the F1 and F2 programme should be reviewed to identify what has led to an increase in the numbers of junior doctors undertaking an 'F3' year before entering core or specialty training.**

Several JDRGs that were visited highlighted the issue that junior doctors were unhappy about a lack of flexibility in training programmes. HEE should consider ways that training programmes can be made more flexible, such as for those wishing to take time out to explore research opportunities. The increasing number of F2 junior doctors who are deciding to defer core or speciality training should also prompt HEE to question what the foundation programme is lacking that is causing those who finish it to want more time and/or experience before choosing a specialty, then changes should be made to address this.

## Administrative burden

**Recommendation 9: HEE should develop an HR mandatory training passport for junior doctors, to reduce the repetition and administrative burden of frequently changing placements.**

The idea of an HR mandatory training passport was suggested by multiple JDRGs as a way to tackle the administrative burden on both junior doctors and trusts of frequently changing placements. HEE should keep a central record of junior doctors' HR checks (such as disclosure and barring service clearance, and immunisation and occupational health clearance) along with records of mandatory training that have been undertaken, so this can be simply checked by each new trust that a junior doctor is placed with and avoid the repetition of all checks and training with each new trust. This is also reflected in the FMLM report, 'Junior doctor engagement, investing in the future'<sup>34</sup> as a recommendations for efficient human resources processes.

---

<sup>34</sup> The Faculty of Medical Leadership and Management (2016) Junior doctor engagement, investing in the future [Online] Available from: <https://www.fmlm.ac.uk/resources/junior-doctor-engagement-%E2%80%93-investing-in-the-future> (accessed 22/01/18).

# London region recommendations

## **Recommendation 10: Ways of reducing the financial burden for junior doctors and other NHS staff living in London should be investigated.**

The cost of accommodation in London is an issue that was raised at multiple JDRGs, as many cannot afford to live close to their place of work, so face long, expensive commutes. This is relevant to all NHS staff in London, not just medical staff. Trusts should support their junior doctors to find local affordable accommodation where possible and provide space for staff to rest if needed following a night shift, before they embark on long journeys home. Potential avenues to explore could include opportunities arising from the recent London Health and Social Care Devolution agreement.

# Conclusion

The overwhelming feeling from attending the JDRGs was that those with strong junior doctor leadership had a sense of empowerment and autonomy in their working lives. The key is to support and nurture these groups with continued leadership development for junior doctors so they are beneficial for all concerned, including the patients.

The premise of this collaborative work was to identify areas of good and poor practice in relation to the engagement of junior doctors with the trusts at which they work. JDRGs were used as a medium by which to look into this engagement. The listening exercise, along with several JDRGs, identified many other issues impacting negatively on the working lives of junior doctors and solutions to these issues were identified.

Many of the recommendations that have been suggested in this report concur with findings from other bodies, such as the Royal College of Psychiatrists<sup>35</sup> and HEE<sup>36</sup>.

The value of this work lies in the fact that the views of junior doctors and the level of engagement they have with their trusts was assessed by visiting and observing JDRGs first-hand. This was not done in a specialty or career grade-specific way, but looked at all junior doctors in a trust (including those in and not in training programmes). Additionally, a range of trusts were visited: single and multi-site; and acute and mental health trusts, with a geographical spread across London. It was found that each of the trusts visited had similar issues and therefore recommendations should apply to and benefit all of these trusts.


The limitations for this work are two-fold: the first is that the recommendations are the result of reflections of those on the JDRG we attended, so cannot be said to encompass all views and perspectives. The second limitation is that it focused on junior doctors who are based in hospital trusts and has not included junior doctors on placements in GP practices. Work to look at the experiences of junior doctors in GP placements is required to ensure the experience of this group is also heard.

Overall, this work identified the great opportunity that JDRGs present for enhancing engagement with a trust's junior doctors.

<sup>35</sup> Till A, Milward K, Tovey M, Bailey A, Evans C, Howson S, Thom V (2017) *Supported and valued? A trainee-led review into morale and training within psychiatry*. Psychiatric Trainees' Committee, Royal College of Psychiatrists, UK.

<sup>36</sup> Health Education England (2017) *Enhancing junior doctors' working lives – A progress report* [Online] Available from: <https://hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%20working%20lives%20-%20a%20progress%20report.pdf> (accessed 03/01/18).





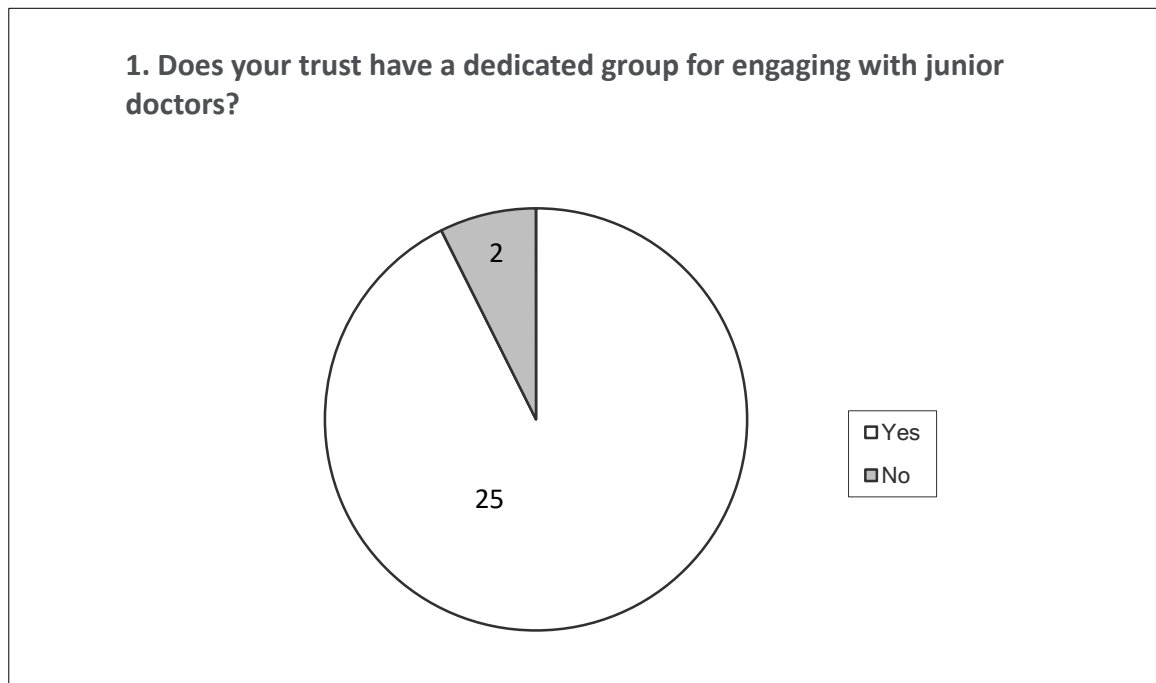
We suggest all trusts should aim to develop their JDRG beyond the requirements of the junior doctor forums outlined in the 2016 terms and conditions of service for doctors in training (England). Well-developed JDRGs can help to build positive relationships between trust management and junior doctors and can be used to identify and rectify local areas of concern for junior doctors.

Although JDRGs are less able to influence wider issues such as the length of rotations, if good relationships are built via the JDRG and junior doctors feel valued and part of the trust, they can contribute to mitigating the shortcomings of the system and minimise any detrimental impact. It is important to remember that an effective JDRG that leads to greater well-being of junior doctors, who feel more invested in the trust, will lead to higher quality of care being provided and a better experience for patients.

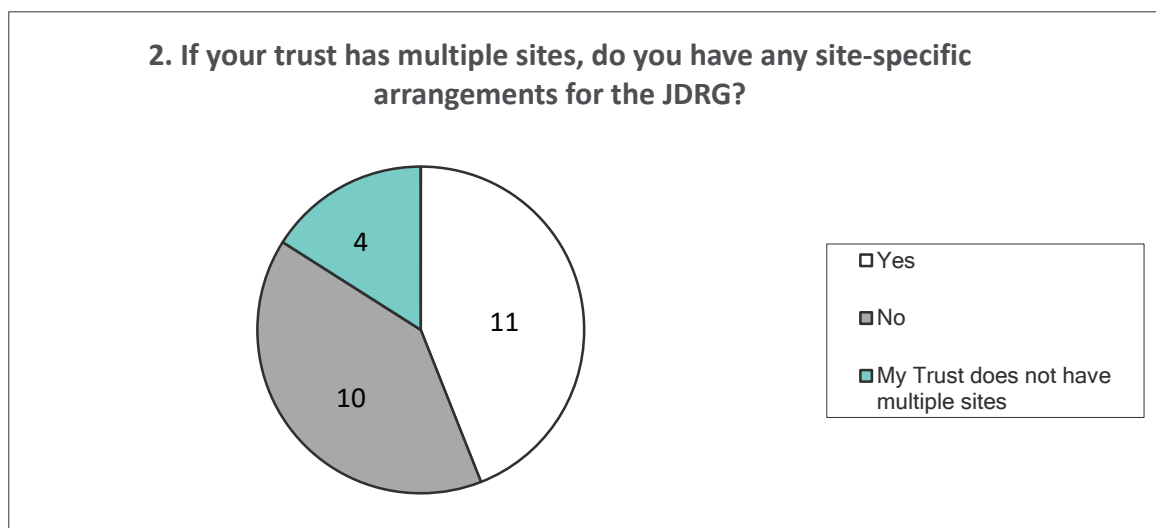
Furthermore, while several of the recommendations in this report would take a long time to implement, such as changing the length of rotations, enhancing JDRGs would be relatively quick to achieve and so the benefits could start to be seen in a comparatively short timescale. Many of the issues affecting junior doctors' working lives are also likely to be experienced by other staff groups within trusts; for example, issues related to a lack of rest, food, and drink facilities. It is likely that this work with junior doctors may act as a catalyst for meeting the needs of other NHS staff. Further work to explore the current issues experienced by these groups of employees would be beneficial.

# Appendix 1

## Responses to survey of trust medical directors about engagement of junior doctors



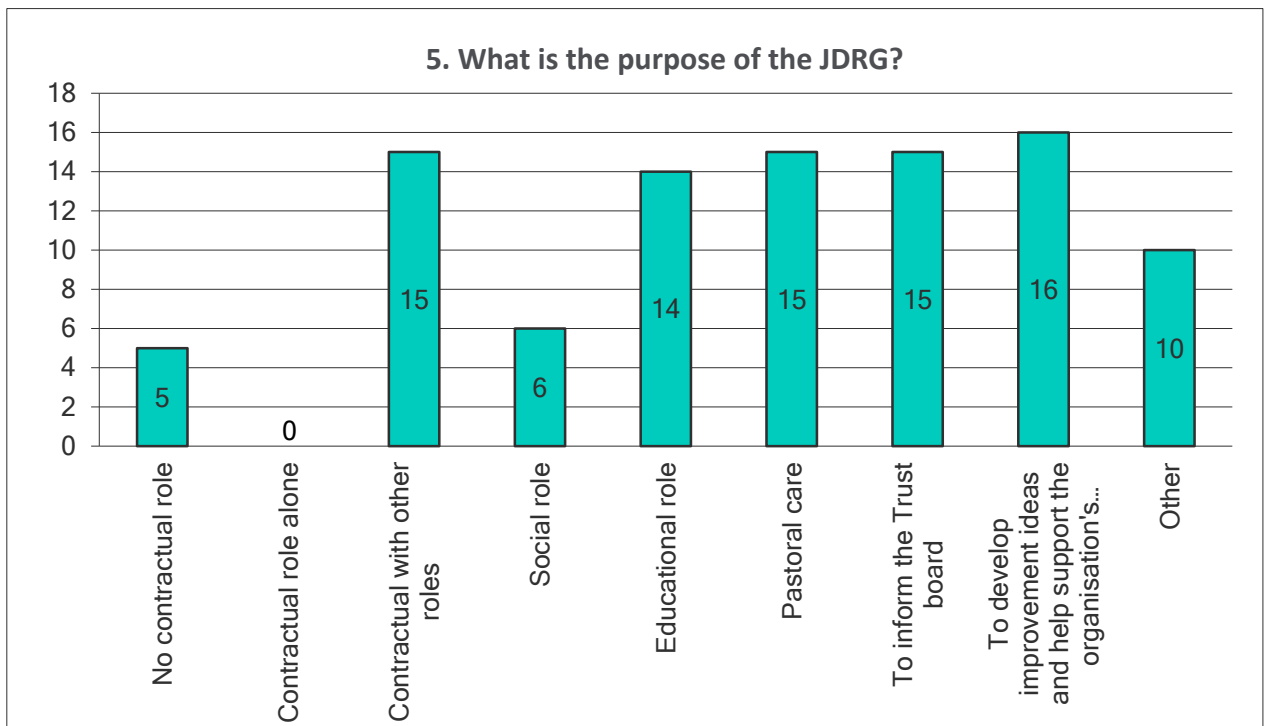
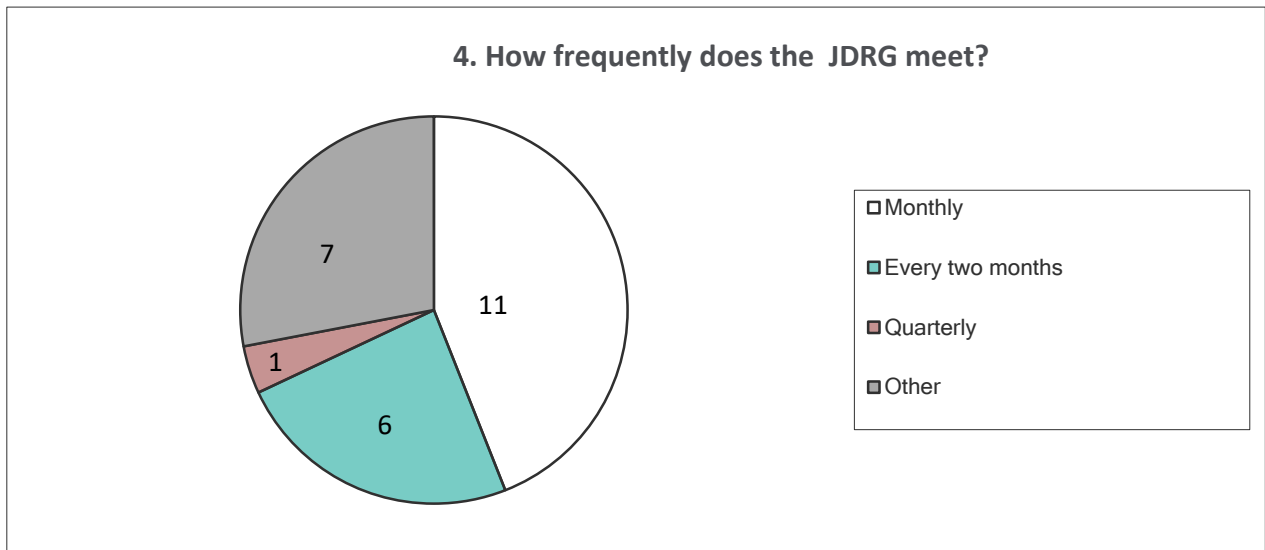
25 out of the 27 trusts which responded to the survey have at least one dedicated group for engaging with junior doctors.



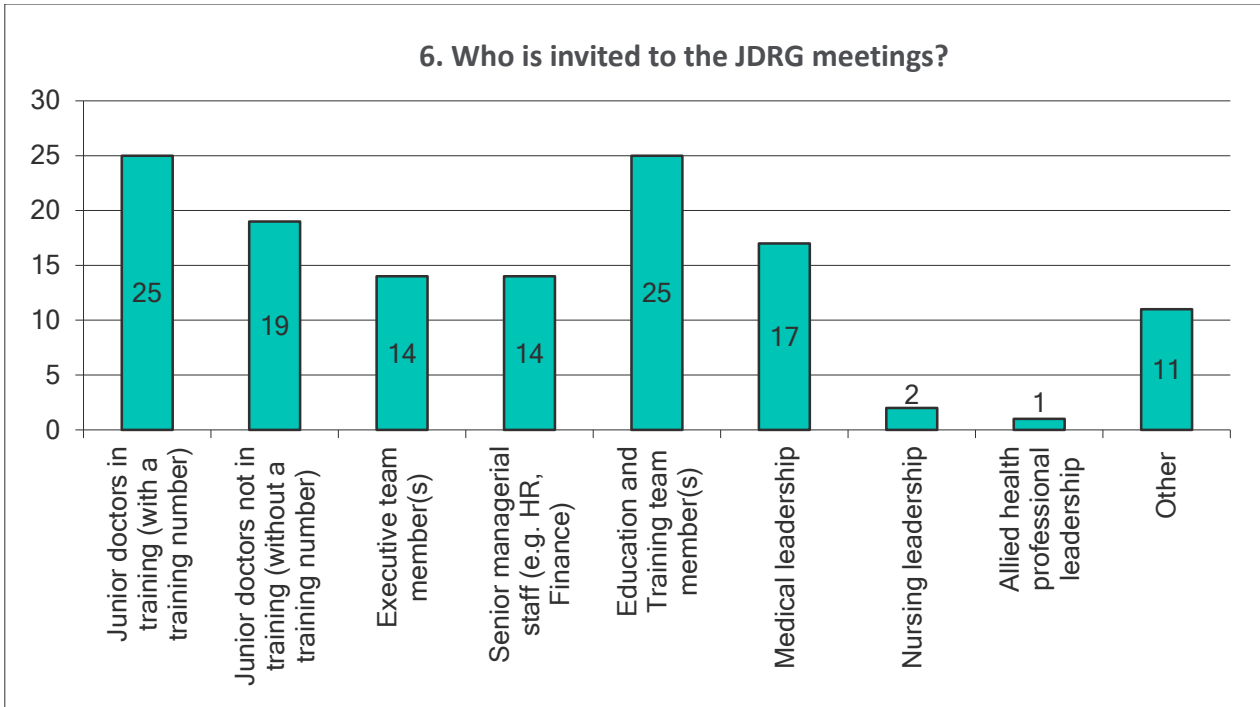
Among the trusts which have multiple sites, around half of them have site-specific arrangements for their JDRGs (eg a specific group dedicated to a specific site).

### 3. When was the JDRG established?

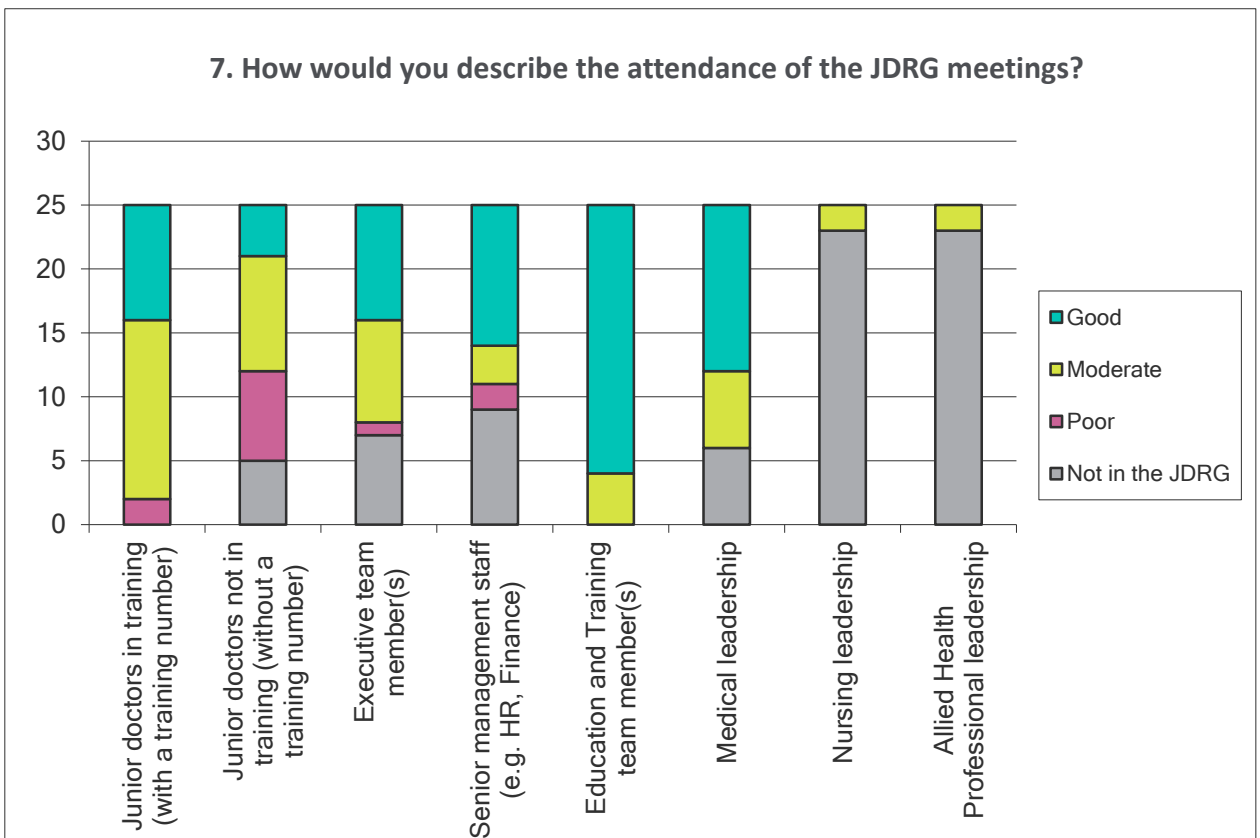
Most of the JDRGs had been set-up in their current form within the previous three years.



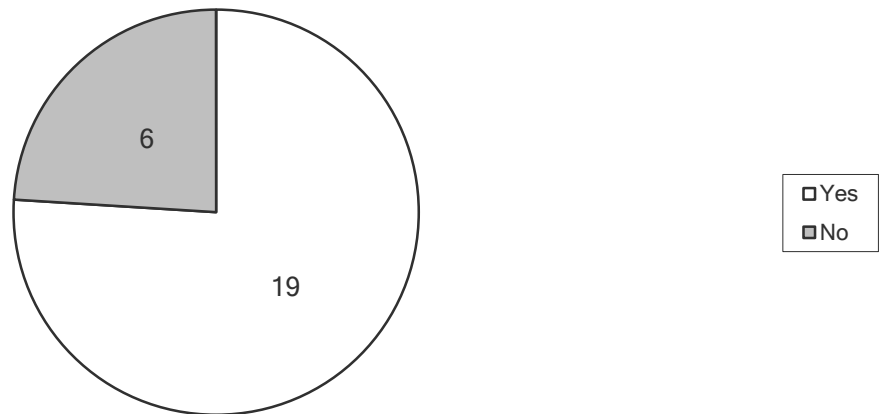
The graph above is based on the responses of the 25 trusts which have JDRGs. Trusts could select multiple answer options.



While junior doctors in training, and educating and training team members are invited to all JDRGs, some JDRGs do not invite junior doctors not in training (ie without a training number). Around half of JDRGs include a member of the executive team. Most JDRGs do not have nursing and AHP leadership within their membership.

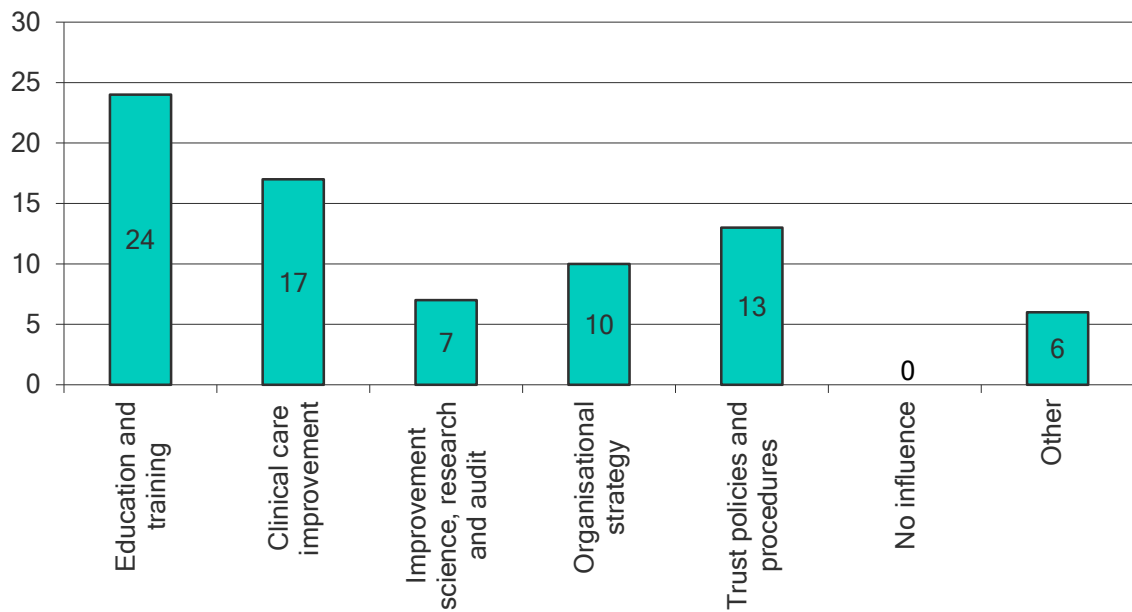


### 8. Does your trust provide administrative support for the JDRG



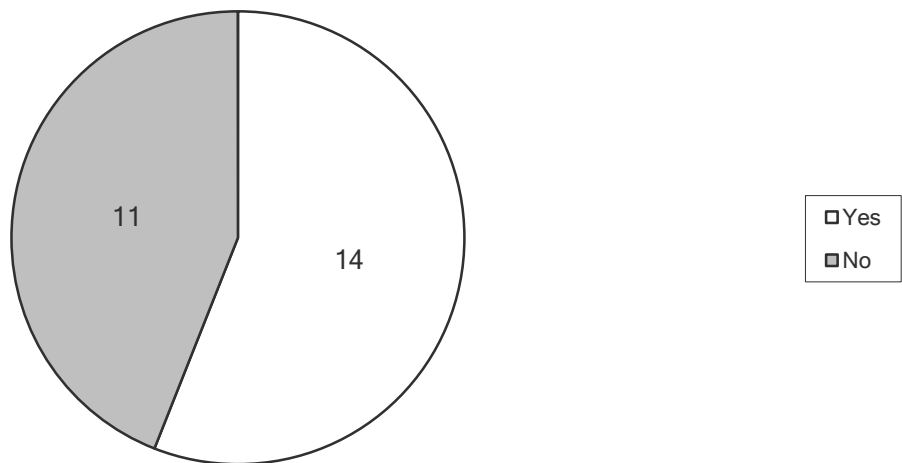
Most trusts provide administrative support for their JDRGs.

### 9. What areas of the trust does the JDRG have influence on?



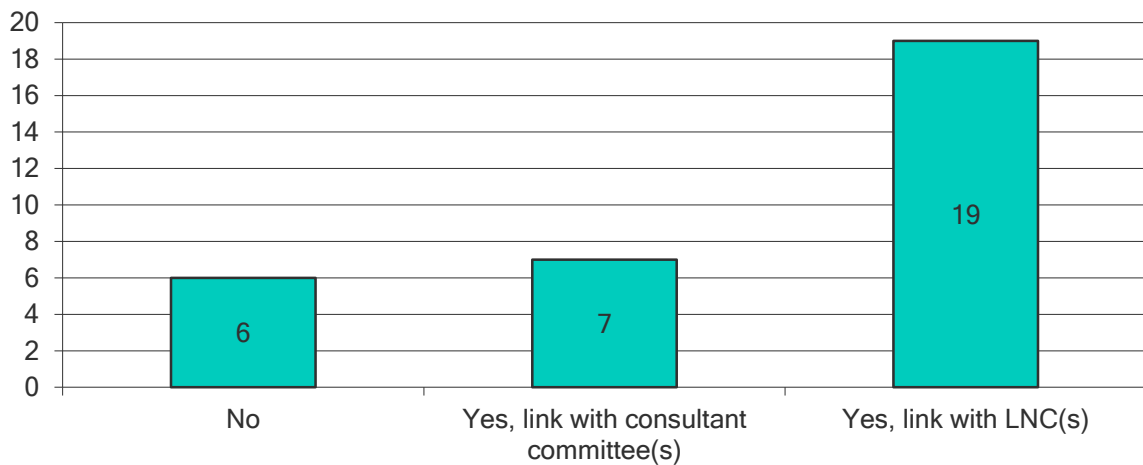
All JDRGs have some level of influence, particularly on education and training and improving clinical care.

**10. Does the JDRG have any links with other groups within your trust or other JDRGs in other trusts?**

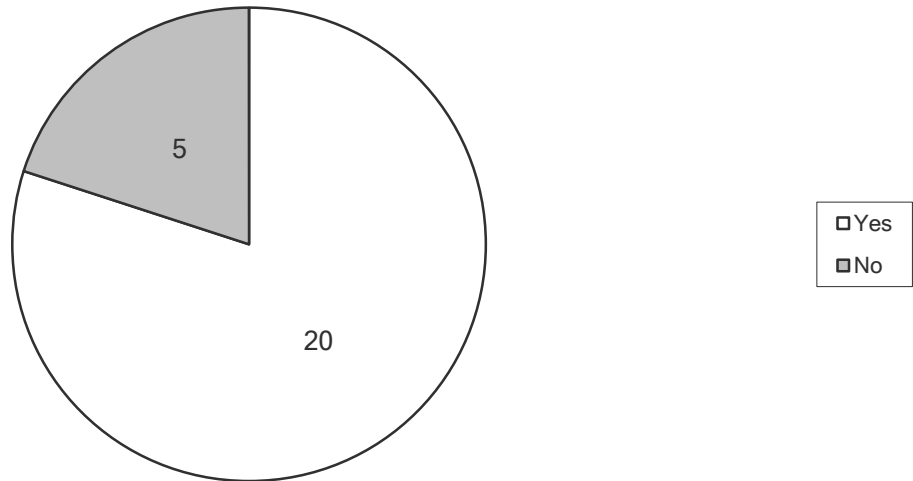


Trust Partnership Committee, Hospital Management Team, Medical Education Board, Contract Steering Group and National Medical Workforce Forum are amongst those linked with JDRGs.

**11. Does the JDRG have any formal links with consultant committees or local negotiating committees (LNCs)?**



**12. Does the trust have agreed Terms of Reference for the JDRG?**



All trusts with Terms of Reference were swilling to share them.

**13. Please give your thoughts on the effectiveness of the JDRG (eg does the JDRG meet its objectives? What has been achieved as a result of the JDRG that would otherwise not have been achieved?).**

Most trusts feel positive about the effectiveness of their JDRGs. Suggestions on how the Senate and FMLM might help in engaging with junior doctors across London include organising network events for JDRG lead reps to attend and establishing a London junior doctor forum.

# Appendix 2

## Further discussion about the issues affecting junior doctors raised during the listening exercises

### The disruptive impact of regularly changing rotations

Junior doctors commonly described a sense of being moved around, as if on a conveyor belt. The frequency of training rotations, in some cases as often as every three to four months, leaves junior doctors feeling in a constant battle of unfamiliarity with a new environment which negatively affects their training, the care they provide patients and their morale. Many junior doctors find it hard to seek support from colleagues as they do not work with the same people for long enough periods of time to develop meaningful relationships through which they feel comfortable seeking guidance. Additionally, lack of continuity within a specific hospital or department means it is difficult for junior doctors to contribute to making sustainable improvements or maintain the momentum for change. Anaesthetist trainees have also reported frequently changing rotations as one of the main reasons leading to low morale<sup>37</sup>.

### Frequently changing rotations also impact significantly on junior doctors' personal lives

Examples included very little notice of next placements and new rotas, making it difficult for junior doctors to plan and organise their living arrangements, personal and family events. This has been recognised in national reports. Health Education England (HEE) highlights difficulties that arise from late rota notification and fixed leave as one of 10 key training issues to address<sup>38</sup>. Others include adequately facilitating caring responsibilities or the maintenance of relationships and family life<sup>39</sup> and addressing the need for trainees to move home repeatedly during training where this lacks educational justification or support from trainees<sup>40</sup>. The Royal College of Psychiatrists identified that having ergonomic rotas co-designed with trainees that are issued in a timely fashion (minimum 12 weeks' notice) and accommodate pre-existing leave arrangements would improve the working lives of psychiatry trainees<sup>41</sup>.

<sup>37</sup> Royal College of Anaesthetists (2017) Morale and welfare survey [Online] Available from: <https://www.rcoa.ac.uk/sites/default/files/Newsletter17-Feb2017.pdf> (accessed 19/01/18).

<sup>38</sup> Health Education England (2017) Enhancing junior doctors' working lives – A progress report [Online] Available from: <https://hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%20working%20lives%20-%20a%20progress%20report.pdf> (accessed 03/01/18).

<sup>39</sup> *Ibid*

<sup>40</sup> *Ibid*

<sup>41</sup> Till A, Milward K, Tovey M, Bailey A, Evans C, Howson S, Thom V (2017) *Supported and valued? A trainee-led review into morale and training within psychiatry*. Psychiatric Trainees' Committee, Royal College of Psychiatrists, UK.



Frequently changing placements puts considerable administrative strain on both junior doctors and hospitals. With every new rotation junior doctors need to provide proof of address, complete occupational health checks, update their payroll details, and complete mandatory training. Some junior doctors reported difficulties in claiming travel expenses as their 'base hospital' was recorded as their initial placement and not updated when they started a new rotation. The need for improvements to induction and mandatory training including an end to unnecessary repetition has also been highlighted as a key issue by HEE<sup>42</sup>.

### **Decreasing contact with seniors affecting the formation of positive professional relationships**

The frequently changing rotations experienced by junior doctors lead to difficulties in building relationships with and among teams as they change frequently. Additionally, some trainees feel that growth in the size of teams in recent years has contributed to the deterioration in relationships, as despite the ratio of junior doctors to consultants staying around the same, the larger teams make it harder to form relationships. It was commented that while seniors are willing to help and train the juniors, they simply do not have time to do so. The lack of recognition and support from senior doctors can lead to self-doubt amongst juniors about their progress and abilities.

### **Lack of flexibility in training**

At several JDRGs, junior doctors raised the issue that taking a break from training (such as taking a year out to explore other specialties or research opportunities) is not encouraged by clinical leaders and that the current training scheme does not support such arrangements. It was also felt that the training system does not support trainees who are unsure about which specialty they want to go into as it does not provide adequate opportunities to try them out. This issue was also identified by HEE as one of their 10 key training issues, which they specify as: 'limited opportunities for doctors to train flexibly, including structural and cultural barriers to less than full time training' and another of their issues is 'inequality in time out of training – the need to help doctors with improved, and more individually tailored, support upon their return to training'<sup>43</sup>. A lack of autonomy in their training was also identified by HEE as one of the three main issues affecting junior doctor morale<sup>44</sup>. Additionally, the Royal College of Psychiatrists found that psychiatry trainees value flexibility and autonomy in their training<sup>45</sup>.

---

<sup>42</sup> Health Education England (2017) Enhancing junior doctors' working lives – A progress report [Online] Available from: <https://hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%20working%20lives%20-%20a%20progress%20report.pdf> (accessed 03/01/18).

<sup>43</sup> *Ibid*

<sup>44</sup> Health Education England (2016) Junior doctor morale: Understanding best practice working environments [Online] Available from: <https://www.hee.nhs.uk/sites/default/files/documents/Junior%20Doctors%27%20Morale%20-%20Understanding%20best%20practice%20working%20environments.pdf> (accessed 04/01/18).

<sup>45</sup> Till A, Milward K, Tovey M, Bailey A, Evans C, Howson S, Thom V (2017) *Supported and valued? A trainee-led review into morale and training within psychiatry*. Psychiatric Trainees' Committee, Royal College of Psychiatrists, UK.

## Service provision outweighing training

Junior doctors feel that at departmental level providing training is not given as high a priority as service provision, with some junior doctors describing their roles as ‘firefighting’. Junior doctors often commented that clinics are routinely overbooked and understaffed, which is exacerbated by rota gaps. Junior doctors also stated that their administrative tasks are excessive, creating further pressures on their already stretched time.

Comments covered junior doctors being involved in a lot of admissions and discharges but few procedures to the extent that as much as two-thirds of their work comprises activities that are not recognised as part of their training. The issue of junior doctors being unable to take study leave (to which they are entitled) due to rota issues was also raised. The Royal College of Physicians have also found that the wellbeing of junior doctors is suffering, with four out of five reporting that they sometimes or often experience excessive stress as a result of their job. They also found that many junior doctors also reported that workforce pressures limit the time available for their training<sup>46</sup>. Varying equity in study leave provision was also identified by HEE as one of their 10 key training issues<sup>47</sup>.

## Implications of understaffing

Many junior doctors expressed concerns over rota gaps and the excessive work pressure that this puts them under. The Royal College of Physicians also reported similar concerns from junior doctors, with six out of 10 junior doctors reporting that patient safety is being put at serious risk due to poor availability of out-of-hospital services and a shortage of available hospital beds and half of junior doctors reporting that patient safety is seriously compromised by gaps in their rotas<sup>48</sup>. Moreover, the Royal College of Anaesthetists confirmed previously identified understaffing issues among anaesthetist trainees in their survey which found that the average trainee across the UK fills a rota gap six times per month<sup>49</sup>.

## Good working relationships with hospital management

Junior doctors felt more valued when they perceived that management genuinely wants to listen, help and make improvements. Supporting junior doctors to run a JDRG is one example.

---

<sup>46</sup> The Royal College of Physicians (2016) Being a junior doctor – Experiences from the front line of the NHS [Online] Available from: <https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor> (accessed 14/12/17).

<sup>47</sup> Health Education England (2017) Enhancing junior doctors’ working lives – A progress report [Online] Available from: [https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report\\_0.pdf](https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20junior%20doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report_0.pdf) (accessed 03/01/18).

<sup>48</sup> The Royal College of Physicians (2016) Being a junior doctor – Experiences from the front line of the NHS [Online] Available from: <https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor> (accessed 14/12/17).

<sup>49</sup> Royal College of Anaesthetists (2017) Morale and welfare survey [Online] Available from: <https://www.rcoa.ac.uk/sites/default/files/Newsletter17-Feb2017.pdf> (accessed 19/01/18).

## Challenges in speaking up

Some junior doctors were concerned that they may anger the trust or management team if they speak out or raise issues. They felt the voice of junior doctors should be encouraged and appreciated more by trusts. Furthermore, not feeling valued was identified by HEE as one of the three main issues affecting junior doctor morale<sup>50</sup>.

## Reduction in trainees entering core or higher training

Many JDRGs expressed a concern about the increasing number of junior doctors who are leaving the NHS. Increasing numbers of junior doctors who have completed their foundation training are also choosing to work as 'F3 Clinical Fellows' rather than commencing core or specialty training (ie work in variety of locum or staff grade roles for the year, often in a mixture of specialties, to gather more of a feel for what they would like to pursue later in their careers). Many junior doctors feel that working as an 'F3' gives them the opportunity to work out their interests and improve their clinical competency and that such jobs offer the best of both worlds, as they gather more experience yet are not tied to a specific specialty. HEE also acknowledge this as a concern as one of their 10 key training issues is "the need to support an increasing number of doctors as the post foundation/pre-specialty level who are looking for a more flexible approach to career progression"<sup>51</sup>.

## Lack of a mess

A commonly raised issue which was deemed to have had significant negative impact on the working lives of junior doctors is the lack of a mess. These not only provide a space for staff to eat and relax away from patients (some junior doctors expressed the awkwardness they felt when having to eat in public canteens nearby patients who they had just delivered bad news to) but they also help to build team relationships as staff can eat together. The Royal College of Physicians also found that the working environment of junior doctors could be much improved, as the majority of junior doctors report working at least one shift in the previous month without drinking enough water or eating a meal<sup>52</sup>. A similar finding was found by the Royal College of Anaesthetists as their survey of anaesthetist trainees showed that that three-quarters of trainees reported working a shift without adequate hydration, while 62% of trainee colleagues had worked through a shift in the previous month without a meal<sup>53</sup>. The Royal College of psychiatrists have also identified that 24-hour

<sup>50</sup> Health Education England (2016) Junior doctor morale: Understanding best practice working environments [Online] Available from: <https://www.hee.nhs.uk/sites/default/files/documents/Junior%20Doctors%27%20Morale%20-%20understanding%20best%20practice%20working%20environments.pdf> (accessed 04/01/18).

<sup>51</sup> Health Education England (2017) Enhancing junior doctors' working lives – A progress report [Online] Available from: [https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20Junior%20Doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report\\_0.pdf](https://www.hee.nhs.uk/sites/default/files/documents/Enhancing%20Junior%20Doctors%E2%80%99%20working%20lives%20-%20a%20progress%20report_0.pdf) (accessed 03/01/18).

<sup>52</sup> The Royal College of Physicians (2016) Being a junior doctor – Experiences from the front line of the NHS [Online] Available from: <https://www.rcplondon.ac.uk/guidelines-policy/being-junior-doctor> (accessed 14/12/17).

<sup>53</sup> Royal College of Anaesthetists (2017) Morale and welfare survey [Online] Available from: <https://www.rcoa.ac.uk/sites/default/files/Newsletter17-Feb2017.pdf> (accessed 19/01/18).

appropriate provision of working and rest facilities, including hot food and drink is a change that would improve the working lives of psychiatry trainees<sup>54</sup>.

### **Staff feeling valued and having a sense of belonging**

Trusts with staff who felt valued and that they belong had achieved this by doing things such as having well-staffed rotas where junior doctors' requests are (generally) granted. Junior doctors also have a better sense of belonging in trusts where everyone has a clear purpose and works together in the same direction; trusts were also praised by junior doctors where they were made to feel respected, engaged and listened-to and where there was not a hierarchical atmosphere.

### **Safe travel**

A couple of trusts provide a free taxi journey to A&E staff when they finish a shift during the night (when public transport is less available).

### **Facilities for food and drink**

Junior doctors appreciate it when trusts provide adequate facilities for refreshments; for example, one trust has small rooms with kitchen appliances available in most some departments to provide space for junior doctors to eat and rest. Another trust has two dedicated rooms for doctors on-call to rest and has introduced vending machines to provide 24 hour access to hot food and drink. At several JDRGs it was discussed that having a staff mess in a hospital makes a great positive difference since it provides a private place to eat, socialise with their peers and rest.

### **Good quality training**

Junior doctors value placements that provide a good quality of training, with particular examples including trainees valuing the teaching sessions that they receive in psychiatry as they receive two afternoons of training a week, far more than in other specialties.

### **Good level of clinical support**

Junior doctors feel better supported when their clinical leaders are approachable, open to new changes and committed to quality improvement. A good example of clinical support was given at one trust which has an outreach team who are called for patients at risk of deteriorating and are available at all times. The team provides support to junior doctors in managing unwell patients when their seniors are not present.

---

<sup>54</sup> Till A, Milward K, Tovey M, Bailey A, Evans C, Howson S, Thom V (2017) *Supported and valued? A trainee-led review into morale and training within psychiatry*. Psychiatric Trainees' Committee, Royal College of Psychiatrists, UK.

## Morale

Junior doctors' morale is undoubtedly lower since the new contract dispute. Some feel that despite standing together they did not achieve any positive results. They feel undervalued by the contract. A particular issue is that the new contract adds a lot of rest days to the rota, which makes it hard for trainees to care for the same patient. Junior doctors discussed the impact on their learning and on the continuity and quality of patient care. Anaesthetist trainees have also reported the new terms and conditions of service as one of the main reasons leading to low morale<sup>55</sup>.

Junior doctors sometimes feel inadequately involved in decision-making about patients they are caring for. They feel they have to comply with the decisions of others, yet are having to accept the risks and responsibilities of these decisions. Some described a sense of lost autonomy and decision-making abilities.

## Challenges in availability of accommodation

Short notice of their next placement location puts unnecessary time pressure and stress on junior doctors to make living arrangements. Additionally, junior doctors find the cost of living in London too high. Consequently, some junior doctors live in outer London and face long commutes; one also gave an example of having to rent a room close to their hospital specifically for their non-resident on calls so that they comply with the trusts' policy on living within a certain travelling time and distance from the hospital while on call.

## On-site accommodation

Junior doctors value when the hospital helped to make provision for accommodation, for example one trust provided accommodation post-night shifts via the JDRG.

## JDRG function and form

The final question asked during the visits to the JDRGs was to identify examples of good practice in the function and form of JDRGs. A summary of these points is given below:

- not preoccupied with contract issues
- junior doctors treated as equals to hospital executive team. The most effective seemed to be those that were run by the junior doctors and fully supported in their attendance by senior hospital clinicians, such as the director for medical education and administration support
- junior doctors bring solutions to forum, not just problems
- multidisciplinary, including membership from nursing leadership and allied health professional leadership

<sup>55</sup> Royal College of Anaesthetists (2017) Morale and welfare survey [Online] Available from: <https://www.rcoa.ac.uk/sites/default/files/Newsletter17-Feb2017.pdf> (accessed 19/01/18).