

ACADEMY OF
MEDICAL ROYAL
COLLEGES

STAGGERING TRAINEE DOCTOR CHANGEOVER

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EXECUTIVE SUMMARY

There is a clear need for change in the process of trainee doctor changeover (the time when junior doctors rotate their position). The beginning of August brings an apparent increase in patient morbidity and evidence suggesting increased mortality. It is a time that trainee doctors find stressful and difficult. Royal Colleges, Deans and employers all say that greater uniformity at the time of changeover would enhance service organisation and would be welcomed by trainers.

Therefore the UK Medical Education Scrutiny Group asked the Academy of Medical Royal Colleges to explore the need for variation in the current system for trainee doctor changeover dates. It has responded to this request in two ways; firstly, through work with NHS Employers to produce practical guidelines – *Recommendations for a Safe Trainee Changeover* – published in June 2013; and also by this paper looking specifically at a system of staggered changeover start dates for trainee doctors.

This paper has been produced by the Academy’s Staggered Trainee Changeover Working Group (STCWG), which brought together representatives from the major stakeholders across the four nations of the UK involved in postgraduate medical training to take this work forward.

Concerns about patient safety and doctors’ experience are powerful drivers for considering change to the current arrangements for the changeover of doctors in training. This paper recommends that the most effective solution for safe trainee changeover is a roll forward model of staggering, where the more senior trainees rotate one month later. This model could take a number of formats, but a survey of Foundation doctors demonstrated support for a system where all Specialty Training Programmes start at the beginning of September, one month after the end of the Foundation Programme. These changes would ensure that new junior doctors in training would be supported by senior trainee doctors, who would have already been in post for five to 11 months. For uncoupled specialties a second staggered changeover between Core and Higher Specialty Training may also be desirable and these changes could be introduced later if a single staggered changeover was to be successfully implemented.

Recommended Option

Single Staggered changeover between Foundation and Specialty Training

1. F1 posts should continue to commence in August.
2. CT1 (ST1) posts should begin in September*, so that on the wards in August each year the new F1s will work with CT/ST1s who have been in the post for 5-11 months.

*Smaller, run-through specialties could continue to start at times other than September.

It is important to stress that from the viewpoint of the service this proposal would leave no gaps in patient care. Each position at every level of the medical rota would be continually filled by a doctor in training as they rotate. For the individual trainee doctor it would create a one month gap at a single point in their medical career. In the first year of implementation of the proposal only, doctors in Specialty Training could be contracted to work 13 months at that level so as not to compromise patient safety.

This model is placed within the context of other options that were considered, with an appraisal of their relative merits and disadvantages. The STCWG reached a degree of consensus across a number of issues and there is support for a solution that is standardised across the UK, which allows transferability of training and movement of personnel between the four nations. Although there was not universal support from the STCWG for one particular model, our recommendation represents the majority view.

The proposals in this paper have not been formally costed, as this is not within the remit of the STCWG. However, we consider that the main proposal would be broadly cost neutral, as it does not require employing any additional staff at any one time. Additional cost would be incurred if employment and training were offered to doctors during the gap between programmes, however, this could provide significant returns in terms of staff retention, enhanced skill base and improved morale.

We recognise that the central issue of providing continual safe care for patients will not be addressed simply by altering changeover dates. However, we do believe that if staggered trainee changeover is implemented it will have an important impact on this by improving the context and environment of patient care.

This work has been completed by the STCWG on behalf of the Academy and is submitted to the UK Medical Education Scrutiny Group for full consideration. This paper sets out the considered recommendations of the STCWG, but decisions about implementation ultimately rest with the relevant governmental bodies of each national administration.

1 INTRODUCTION

Since 2007 with the advent of Modernising Medical Careers¹ the majority of doctors in training change rotation in the first week of August. Considerable concerns exist about the detrimental effect of the simultaneous changeover of a large proportion of the medical workforce. The UK Scrutiny Group supported an approach which included an undertaking to further explore moving to staggered transition by grade. The Safe Trainee Changeover Working Group (STCWG) was established for this purpose.

1.1 Working Group Composition and Governance

Key organisations involved in postgraduate medical education were approached for representation on the group. This included the Academy Speciality Training Committee, Academy Patient/Lay Group, Academy Trainee Doctors Group, British Medical Association (BMA), Conference of Postgraduate Medical Deans (COPMeD), General Medical Council (GMC) and employers' organisations. As discussions progressed the UK Foundation Programme Office (UKFPO) and Medical Schools Council (MSC) were also approached for representation. A full list of members is available (Appendix A).

The terms of reference were mutually agreed at the first meeting of the group (Appendix B).

Guiding Principles

It was agreed that three principles should underpin the considerations of the STCWG:

- 1) To protect patients from any reduction in the standard of care they receive during periods of changeover
- 2) To ensure that doctors in training are able to deliver excellent care by being adequately supported and supervised at the start of rotations
- 3) To facilitate the effective and smooth management of the recruitment and transition of trainee doctors throughout their career pathways by deaneries/Local Education and Training Boards (LETB).

Aims

The STCWG's overall purpose was to consider the available options for staggering the start dates of doctors in training.

Questions considered were:

- Is a national policy on trainee start dates desirable?
- Should this take the form of guidance or would mandatory standards be preferable?
- What degree of local variation in practice/flexibility would be acceptable?

The following technical questions were also considered:

- How many different training levels should there be staggering between?
- How long should the period of staggering between levels be?
- To what extent should the system move towards single national start dates for particular grades?
- How could transition to a nationally coherent pattern be managed?

1.2 Background

At present the majority of UK doctors in training will change their clinical posts on the first Wednesday in August. A UK study has highlighted a 6% increase in mortality for patients admitted on this day,² which is in line with international evidence showing increased patient mortality of between 4.3-12.0% and increased length of patient hospital stay of between 0.3-7.2% around trainee doctors' changeover dates.³

To be able to practise safely, trainee doctors' must have access to adequate senior support.⁴ This includes senior trainees who have not only the clinical skills, but also familiarity with local practice.

There is widespread support for action on staggering the starting dates of trainees. A survey of the Royal College of Obstetricians and Gynaecologists fellows and members showed that 82% of respondents believed that there is deterioration in patient care at changeover time, lasting between two weeks and one month.⁵ A survey of all UK physicians by the Royal College of Physicians in Edinburgh and the Society of Acute Medicine reported that 93% of respondents perceived that patient care suffers during changeover and 82% supported staggered changeover by grade.⁶

Foundation, Core Medical and Core Surgical Trainees reported 7-14% lower satisfaction ratings than Higher Specialty Trainees in GMC data analysed in 2011.⁷ The additional stress placed on more junior trainee doctors by simultaneous changeover may contribute to their lower satisfaction ratings.

This paper examines options for staggering trainee doctor changeover dates and should be viewed in the context of the complimentary guidelines recently published by the Academy and NHS Employers.⁸ These provide practical advice around ensuring the following:

- 1) Consultants must be appropriately available. This may mean restrictions on leave for consultants and senior doctors in training
- 2) Flexible and intelligent rota design
- 3) High quality clinical induction at all units
- 4) Reduction of elective work at changeover times.

While these measures, if fully implemented, should go some way towards mitigating the negative effects of simultaneous changeover, it seems unlikely that they will adequately address problems with service efficiency and the stress to doctors in training that changeover causes. It is therefore necessary to consider this work on staggering trainee doctor changeover dates in parallel.

1.3 Current Practice

A snapshot of the extant pattern of rotational changeover was sought by writing to all medical deaneries (as they universally were at the time) and Colleges for details on current practices within their region or specialty. Responses were received from the majority of regions and collated to reveal a picture of current practice (Appendix C). Qualitative information on the experience of managing trainee changeover was also captured through a questionnaire template sent to all deaneries.

The picture that emerged from this exercise is highly complex, with significant variability across specialties, grades and regions. The vast majority of trainee rotations occur in the first week of August. This is particularly common in Core Training and appears almost universal in Core Medical Training, Core Surgical Training, Core Psychiatry Training, Acute

Care Common Stem and General Practice (GP). Greater variability of start dates was seen in Specialty Training 1 (ST1) entry for the run through specialties Obstetrics & Gynaecology, Radiology and Paediatrics, which elected for a later start in a number of deaneries, most frequently early September or October. Radiology showed the greatest variability, with London alone having 12 different start dates throughout the year, depending on specific sub-rotation.

Across the considerable number of individual Higher Specialty Training (HST) schemes there was much greater heterogeneity than at CT1/ST1 level. For uncoupled specialities, entry is either at Specialty Training 3 (ST3) or 4 (ST4) level, depending on the length of the Core Training Programme. Many deaneries already have a staggered start for a number of their HST programmes, although the national picture is highly inconsistent. It appears that run through specialties sometimes deliberately schedule the rotation of more senior trainees to avoid August. Again the most popular times for senior trainees to start outside of August are early September and October. Currently there is no verified data, but it is thought that overall around one quarter of doctors in training elect not to progress immediately to Specialty Training after Foundation Year 2 (F2), often going overseas. Of those who do progress around a third do not start in Specialty Training in August (Appendix C).

Many programmes also have a secondary changeover period in early February, when many Core Trainees on six monthly attachments will move post. In most specialities the impact of this changeover is mitigated by the four month long rotations of the majority of Foundation and GP trainees and the fact that many HSTs will only rotate yearly or in a more ad hoc fashion. This provides additional stability at this time, which is not the case in August.

It is important to note that a number of deanery responses to the request, expressed support for the status quo and concern that a blanket directive governing changeover dates would cause administrative complications and prevent them from tailoring programmes to local circumstances.

2 Progress of the STCWG

This section outlines the work of the STCWG and details the evolution of the discussions around ensuring safe trainee changeover.

January-April 2013

The STCWG met for the first time on 17th January 2013. The group considered a presentation from the Royal College of Obstetricians and Gynaecologists,⁵ which had surveyed its members' regarding the trainee changeover period. It had also reviewed the other evidence regarding the impact of changeover on patient safety, efficiency of hospitals and working conditions.^{2, 3, 6}

There was some concern that the evidence from the literature as it stands is insufficiently robust. Criticisms focused around the relevance of foreign studies to the UK, the ability to control effectively for confounders and the poor response rates of relevant surveys. Despite these perceived shortcomings there was almost universal agreement that the status quo is unsustainable and that change is necessary.

Uniformity was considered to be desirable, but this would need to allow individual exceptions where appropriate. Examples of exceptions might include those doctors re-entering training after parental leave or time out of training to gain additional experience. Recommendations should ideally apply across specialities and geographical regions of all four nations of the UK.

The two major models of staggering were considered; the roll-back and roll-forward models. The roll-back model is where more senior doctors in training would changeover before their junior colleagues, and the roll-forward model is where more senior doctors in training would changeover at a later date than more junior trainees.

The roll-back model was rejected by the STCWG. It was feared that it would lead to a truncation of training, which would endanger the opportunities for trainees to achieve all the necessary competencies within the allotted timeframe.

The roll forward model was favoured as advantages include:

- More experienced senior doctors in training, with familiarity with the immediate clinical environment, are available to supervise junior staff when they start new posts
- There is no shortening of training programmes.

However, the major concern with a roll forward model is what happens in any resultant hiatus between one component of training finishing and the doctor entering the subsequent, more advanced training programme. This is considered in greater detail below.

April-May 2013

At the second meeting of the working group it was agreed that an appraisal of the most promising options for staggered trainee changeover would be the best way forward.

There was recognition that the Shape of Training Review⁹ might recommend some radical changes to the structure of training, so the recommendations of the STCWG should include some clear principles that could be applied in any model.

It was considered that any change would need to be coordinated to ensure that there was not patchy, chaotic implementation. Any piloting would need to be very carefully orchestrated to ensure that those involved were not unduly disadvantaged. The implementation of any guidelines that required mandating would need approval by each of the four UK administrations.

There was an opinion expressed that staggering may be superfluous, in light of the guidance on the other measures for improving the safety of trainee changeover,⁸ others felt that these approaches were complementary.

The issue of hiatuses was discussed at length. It was noted that hiatuses are already occurring between many training programmes on an ad hoc basis across the country, particularly between Core and Higher Specialty Training (Appendix C). There are many activities that individuals pursue during these gaps, including locum work, study and holidays. There was not significant concern expressed about the impact of these arrangements within the current framework.

Concern was raised by the BMA Junior Doctors Committee (JDC) about the consequences of any hiatuses created between training rotations as a result of the group's recommendations. Their concerns centred on the potential loss of earnings during any gaps, the compound losses to pensions, uncertainty about increment date and extension of training. Particular concerns were voiced over the financial vulnerability of individuals who had completed medical school, but not yet started the Foundation Programme, who could struggle if the start of their employment was delayed. Additional caution was urged over altering the changeover patterns of more junior doctors in training, as they frequently have less job security, reduced geographical stability and more limited senior support.

It was considered important to get a Foundation doctor perspective on these issues and this was pursued via the UKFPO. The results are discussed in detail below.

Additional issues raised by other group members included a concern that, in more rural areas, gaps could put additional strain on rotas during the period of implementation, although this would diminish once staggering became embedded. There was also unease about the prospect of the need for repeated, time-consuming inductions for different grades.

The fact that August is the primary month of changeover was considered. A number of the group identified problems resulting from absence of staff during this time, especially consultants. It was noted that in Scotland school holidays fall before August, so it was not such an issue. It was also highlighted that August can be a relatively low activity month across the UK, with lower throughput due to the absence of winter related illnesses.

The length of time of any potential staggers was discussed and a period of one month was preferred, as this had been identified as optimal by both the Royal College of Obstetricians and Gynaecologists and Royal College of Physicians in Edinburgh surveys.^{5, 6}

Foundation Survey Results (Appendix D)

Foundation doctors were given the opportunity to give their views on the issues of trainee changeover via a survey disseminated by the UKFPO newsletter. The survey was designed to gauge opinion of those who would be most affected by the proposals. The group was fortunate to receive 202 responses in a short period of time, although this only represents a small proportion of the total number of Foundation doctors in the UK. Despite possible response bias, it does give some useful information about the junior trainees' views, which overall demonstrated great support for change.

'It desperately needs to change'

'Complete chaos'

'Having all junior staff changing over on the same day is a farce...on my first day...all the surgical registrars were in induction...so my first morning was spent seeing patient(s) on my own'.

The response to the question 'Should Foundation Year 1 commence at the beginning of September?' was equivocal, with as many supporting, as rejecting the idea. Concerns were strongly voiced that it would create *'too long a gap between graduating from medical school and starting work'* which was *'at that point in our careers we have literally no money to live off'.*

There was broad support for delaying the start of Specialty Training by a month so that it does not clash with the start of Foundation. *'Staggering is essential'* and would *'significantly improve patient safety'*. Of those who responded, 78.7% felt that Foundation and Speciality Training should not start at the same time and 78.0% agreed that Specialty Training should start a month after the end of the Foundation Programme.

Some comments reflected concerns about loss of *'accrued employment rights'* and *'one month's wages'*, but others felt it would provide a *'useful break for preparation/locum and avoid overlapping inductions'* and ameliorate a *'very stressful time for the hospital'*.

Overall these responses suggest that there is support amongst Foundation doctors for a staggered changeover between Foundation and Specialty Training Programmes.

May-June 2013

The initial options were circulated to the STCWG for comment along with the results of the Foundation doctor survey.

The importance of high quality induction and consultant availability during changeover were again emphasised. There was recognition that it may be easier to have people rotate at the same time, but that this ignores the risk associated with unfamiliarity. Uncoordinated gaps between different programmes starting at haphazard times can be challenging for employers to find locum cover to fill the gaps. Overall there was continued support for identifying a system which was universal.

The majority of comments from the STCWG echoed the response from the Foundation doctors in favour of at least one staggered changeover, with several favouring a second staggered changeover. In contrast to this, the BMA's JDC and Medical Student Committee response did not support staggered changeover. Although they recognised the stress caused by the current changeover arrangements, which they described as *'chaotic'* and *'deficient'*, their principal objection to staggering changeover between training programmes was concern that it might result in a hiatus of employment, which would be *'disastrous for*

doctors in terms of their employment rights and accrued benefits'. They also highlighted that if the start of the Foundation Programme were to be moved to September, it would have '*onerous financial implications*' for new graduates, who are unable to work as locums without full registration. There was also concern that the recent changes, including the introduction of the mandatory shadowing period for new Foundation 1 (F1) doctors needed to have time to bed in and should be fully evaluated before making any further adjustments.

The BMA and several other responses from the group focussed on how the impact of any gaps created between training programmes could be mitigated. These are discussed in greater detail below.

The deleterious effect on the education environment of the current simultaneous changeover and the need for better practical and psychological preparation for the job whilst at medical school were also discussed.

During subsequent discussions it was noted that in the first year of the change, there could be a reduced number of doctors working in any particular clinical unit during the period of the staggered changeover. A solution identified would be for all doctors in Specialty Training to work 13 months at a particular level in the first year of transition, to maintain safe staffing levels. This is described in greater detail below.

July-August 2013

A draft of this paper was presented to the STCWG for comment. There was concern that the proposal for staggered changeover would leave a gap in the service for patients. The STCWG does not consider that this will be the case and the visual models in the appendices to this report should clarify this (Appendices G, H & I). Similarly, worries about creating a hiatus in service provision during transition to the proposed model should be allayed by employing doctors at the same level of Specialty Training for 13 months in the first year of transition.

There were several comments that the proposal is not costed. This is not in the remit of the working group, but would be for governments to commission if the proposal is deemed worth progressing. It is anticipated that there should not be significant cost implications of moving to the new paradigm, as it would principally involve changing when trainee doctors move jobs, rather than increasing the number of people employed at any one time.

There was a view that the four recommendations already made in *Recommendations for safe trainee changeover*⁸ will be sufficient alone. Other concerns centred on the low response rate to the Foundation doctor survey. These issues have been addressed in the relevant sections above.

There were also concerns that the annual leave behaviour of doctors in training may change. Anecdotally, in some regions, more doctors in training take leave towards the end of their rotations than at the beginning. If this is translated to a staggered model, then more Specialty Trainees may choose to take holiday during August, when the new Foundation doctors are starting. This would need to be closely monitored.

The BMA has continued to be constructively involved with the work of the STCWG, offering solutions to issues that they view as potential concern to their members. In August 2013 they wrote that they were reassured that the option of delaying the start date of Foundation training was not to be recommended. They did however, raise three points that they felt should be addressed before they were able to support the proposal (Appendix E). These concerns are considered below:

- **Continuity of service will be affected, with deleterious effects on terms of employment.**

Advice was sought from NHS Employers about the effects of a possible break on continuity of service. Their advice referred to the *Terms and Conditions of Service NHS Medical and Dental Staff* highlighting that access to a small number of NHS conditions of service entitlements is dependent on having continuous (as opposed to cumulative) service. Where there are stipulations on breaks of service, the terms and conditions for junior doctors specify the length of break which can be disregarded. For example, for maternity pay a break of up to three months is permitted whilst for redundancy pay there cannot have been a break of more than a week. In overall terms it is not considered that any adverse effect on terms and conditions would be significant.¹⁰

- **Financial losses during the month of an unpaid hiatus between training programmes.**

A number of proposals were put forward by the BMA and others to mitigate the effects of a month long hiatus between rotations. Suggestions included the outgoing doctors remaining to help with the induction of new trainees, using the period for structured optional courses, deployment in paid quality improvement initiatives or additional community based training.

There would inevitably be a cost attached to any of these solutions, but potentially they could offer significant rewards in terms of doctors' confidence, training opportunities, job satisfaction and retention of medical staff.

- **The possibility of a gap in training leading to increased pressure on doctors in training to go abroad after finishing the foundation programme.**

Currently there is not a clear picture of how many doctors in training progress directly from Foundation to Specialty Training. The GMC has begun working on the 2013 recruitment data with Health Education England and should be able to identify the F2 trainees in England and Wales who did not apply to Core or Run-through Training in 2012 but have come back and applied in the first round of recruitment this in 2013.

Until the results of the next GMC National Training Survey¹¹ it will not be clear who has come back into training and it will take a few years to build up a reasonable picture.

It is believed that the majority of doctors who take time out of training to work abroad do return to the UK. Therefore if the current proportion of trainee doctors working abroad did increase as a result of the proposed hiatus, this is unlikely to represent a significant 'brain drain' of UK doctors in the long term. It is also conceivable that a break period of one month may just as well reduce the impetus to go abroad for a year, by providing a natural break after an intense two year foundation programme. This is supported by some of the responses to the Foundation doctor survey (Appendix D).

As the BMA highlight, it will be important that adequate warning is provided to doctors in training of any changes. This will allow them to make any necessary preparations, thus avoiding serious adverse financial consequences or more doctors choosing to leave the country to work abroad.

3 OPTIONS FOR SAFE TRAINEE CHANGEOVER

What follows is a list of the principal options for changes to trainee changeover dates that have been identified by the STCWG. These are not exhaustive, but represent broad models that offer the opportunity to consider the major issues associated with changeover dates. Each option is described in detail for clarity, but elements, such as the length of the staggered changeover, are not immutable and could be altered. Each option is described, with a discussion of any major relevant issues, followed by an appraisal of major advantages and disadvantages that have been identified by the STCWG. A health economics analysis has not been performed, but some potential financial issues have been highlighted where appropriate. A summary is available (Appendix F). Visual models are also provided for clarity (Appendix G).

The preferred option of the STCWG, 4a – single staggered changeover, is further illustrated by two visual models. The first shows the change from the point of view of the service, accentuating that there are no gaps created at any level of the medical workforce. It also demonstrates how the change could be safely implemented during the initial transition years, by employing doctors in Specialty Training for 13 months at the same level (Appendix H). The second is a representation of how the proposal would affect a doctor's career, if they choose to move directly from Foundation to Specialty Training Programmes (Appendix I).

1. Status Quo

Currently there is wide heterogeneity in the dates that trainees rotate (Appendix C).

Advantages

- Maintaining the status quo provides the least disruptive approach
- It allows deaneries/LETBs the flexibility to choose the most appropriate pattern to fit the locality.

Disadvantages

- Disparities between deaneries/LETBs and within specialties makes national recruitment more complicated
- Simultaneous changeover of large numbers of doctors in training threatens patient safety and increases stress for trainees.

2. Align all changeovers to August

The concerns raised around the problems caused by hiatuses between training programmes suggest that there may be benefits in removing those staggered changeovers that currently exist and aligning the start of all programmes to August.

Advantages

- No gaps in training or employment
- Easy for employers to provide a single annual induction
- Simple for national recruitment.

Disadvantages

- Risk of compromising patient safety and increasing the stress on doctors in training
- Simultaneous changeover of the entire workforce puts a considerable strain on rota cover and medical staffing teams
- School holidays in much of the UK mean that there may be less senior support at transition
- Junior trainees do not have the support of senior trainees who have experience of working in that specific clinical environment.

3. Move the Start Date of the Foundation Programme to September

The problems resulting from reduced senior clinician presence during August have led to the suggestion that the Foundation Programme could be moved to start at the beginning of September. Subsequent Speciality Training Programmes would then be aligned to follow on from the end of the F2 year, or could be staggered to start later. The merits and risks of these options are considered elsewhere in this paper. The advantages and disadvantages considered below refer specifically to the consequences for the Foundation Programme and knock on effects for medical students.

Advantages

- Starting in September potentially avoids problems caused by reduced staffing levels in August
- Some doctors and students feel that an extended break between the end of medical school and the start of the Foundation Programme would be desirable.

Disadvantages

- Newly qualified doctors would be unable to practice and earn for an additional month after completing medical school, increasing their financial burden.

4. Single Staggered changeover

Some specialties are run-through and others are uncoupled, with a Core Training Programme of two to three years, followed by a number of HST Programme options. In uncoupled specialties the HST Programme must be applied for separately through competitive entry. There is the possibility of introducing a single staggered changeover nationally between Foundation and Core/Run-through Training. In uncoupled specialties a staggered changeover between Core and HST is also possible. The period of one month was identified by the group as the most appropriate for reasons described above.

a. Between Foundation Programmes and Core/Run Through Training (RECOMMENDED OPTION)

Advantages

- This could improve patient safety and reduce the stress for doctors in training
- Foundation doctors would be supported for their first month by more experienced senior trainees
- New Speciality Trainees would start in September, supported by a high presence of consultants

- Supported by a survey of Foundation doctors
- This would apply uniformly to all doctors in training, regardless of specialty
- About a third of doctors completing the Foundation Programme do not progress immediately to Specialty Training, with many choosing a period of work overseas.

Disadvantages

- Potential hiatus for doctors immediately after completing the Foundation Programme
- More junior trainees could be financially vulnerable and have less access to support networks.

b. Between Core Training and Higher Specialist Training

Advantages

- Core Trainees are supported by more experienced Higher Specialty Trainees
- More senior trainees may have greater financial security and support networks
- This already happens in many specialties, so would be easier to implement.

Disadvantages

- The majority of trainee doctors continue to rotate at the same time, with problems for patient safety and increased doctor stress
- Only certain specialties are uncoupled, so it will not affect run-through specialties.

5. Double Staggered changeover

In this scenario there are two periods of staggered trainee Changeover. The first occurs between the end of the Foundation Programme and the start of Core or Run-Through Training, the second occurs in uncoupled specialties only between Core and HST.

Advantages

- This could improve patient safety and reduce the stress for doctors in training
- Ensures that junior doctors in training have the support of more experienced senior trainees at all levels.

Disadvantages

- Requires repeated inductions as doctors in training of each different level start their programmes
- Hiatuses could be financially difficult for doctors in training if provisions not made for alternative employment, such as providing mentoring to incoming trainees.

The above list is by no means exhaustive and these are not the only options considered by the STCWG. However, it outlines the most viable models for consideration. Other options could include staggering the changeover between individual years within training programmes or only staggering the changeover of certain specialties.

4 COSTING

Proposals within this paper have not been formally costed, as this is outside the remit or expertise of the group. The financial implications of this would need to be undertaken by the relevant experts and governments. However, the recommended option as proposed in this paper, if adopted, could be broadly cost neutral, as it does not require employing any additional staff at any one time.

However, if employment and training were offered to all F2 doctors during the month gap between the end of Foundation and Specialty Training programmes there could be associated costs. Although at present a significant proportion of F2 doctors do not move straight in to Specialty Training and would not necessarily want employment in that month, the STCWG acknowledge that the current situation is not static and therefore there could be financial implications.

The employment and conditions of services issues would need to be addressed but it is difficult to see these adding significant costs.

For the initial transition year Specialist Trainees would work 13 months at their current level before moving on in September as opposed to August. This would presumably initially represent a small saving as progression to the next pay level would be delayed one month. Formal training would theoretically be extended by one month finishing at the end of August rather than July. That is a paper increase to the cost of training but in practice doctors either move straight to consultant posts (at a higher cost) or remain in post for a period. Therefore it is unlikely that there would be real additional costs.

5 CONCLUSION

Recommended Option

Single Staggered changeover between Foundation and Specialty Training

1. F1 posts should continue to commence in August.
2. CT1 (ST1) posts should begin in September*, so that on the wards in August each year the new F1s will work with CT/ST1s who have been in the post for 5-11 months.

*Smaller, run-through specialties could continue to start at times other than September.

There is a strong view that a delayed start for the Foundation Programme would put too much financial pressure on newly graduated doctors, who usually carry a large debt.

The change to a September start for Specialty Training would provide significant advantages, in particular better senior support for doctors in training. Concerns about a hiatus in employment for doctors are mitigated by the fact that a significant number of trainees entering HST currently begin in September or October, in a system which varies widely between regions and specialties. This gap is not seen as problematic by the vast majority of trainees, a view supported by results from a survey of Foundation Doctors, who said that they would prefer a staggered start to Speciality Training. Additionally many doctors choose to go abroad for a period of time after completing Foundation Training.

For those who do choose to progress directly from Foundation to Specialty Training a hiatus of one month could be gainfully used by offering a number of paid opportunities that would benefit individual doctors and the system as a whole.

In the first year of implementation a gap in the service to patients is avoided by requiring Specialty Trainees to work for 13 months at the same level. In the second year Specialty Trainees would start one month later in September and stay at that level for the standard 12 months.

We recognise that the central issues of providing continual safe care for patients will not be addressed simply by altering changeover dates. However, context and environment do have an impact and we believe that if staggered changeover is implemented it will improve patient safety and quality of care. It will also reduce the stress on doctors in training, improve the educational environment at times of changeover and ensure the smoother running of the service.

On this basis we believe the proposals need full consideration by the UK Medical Education Scrutiny Group and the four UK Health Departments.

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