Academy of Medical Royal Colleges

AoMRC Trainee Doctors' Group

Academy Trainee Doctors' Group
Self-Development Time – exploring the benefits and logistics of implementation

Summary

The Academy Trainee Doctors' Group (ATDG) represents trainees in postgraduate training. The ATDG comprises over 60 representatives from across the different medical royal colleges and faculties, all of which are at different stages of their respective training pathways. We are continually looking to improve the support given to doctors in training throughout their postgraduate education and work. We work collaboratively to identify particular issues and challenges, and strive to implement improvements across the whole NHS to enhance training, recruitment and retention of this crucial component of the workforce.

Doctors in training engage with a variety of activities/opportunities to enhance their training progression and development. Due to clinical pressures, availability of adequate time is often challenging. Self-development time ('SDT') is the provision of protected non-clinical time for engagement with these development activities. As part of the Foundation Review, HEE (now NHSE) recommended this time be used for activities including meetings with educational/clinical supervisors, reflection, ePortfolio input, preparing/delivering teaching, quality improvement, and/or career exploration. It has been successfully implemented in the Foundation Programme, with trainees given two hours per week pro-rata or flexibly consolidated into one day per month. It has proved very beneficial to these doctors. However, there have been challenges with regards to implementation, including SDT cancelled due to staff shortages/ward pressures, and some trainees have not been allocated SDT at all.

The ATDG has been exploring the value and benefits of SDT to doctors in training and seeking examples of where SDT has been successfully implemented into specialty training rotations. The aim was to provide examples of good practice to share with those specialties which may not currently make provision for SDT, or where there have

been significant challenges. This document provides a series of case studies to share learning points related to implementing SDT.

Case studies were provided by doctors in training from the following specialties: clinical radiology, general surgery, core surgical training, trauma and orthopaedics, paediatrics, emergency medicine and general practice.

Conclusions and learning points

- There is variability across specialties in what SDT can be used for.
- SDT is of significant benefit to doctors in training, providing them with valuable time to undertake work important for the progression of their training, but also important for improved mental health and wellbeing.
- SDT provides benefits to the organisation, supporting trainees to engage with audit, quality improvement etc.
- The utility of SDT is best felt when it is incorporated into the rotas of the doctors in training.
- There is variability in the implementation of SDT between different Trusts for the trainees in the same specialty i.e. trainees in a particular specialty will have access to SDT in one Trust, but not when they move to work in another. Trainees in the same specialty, in the same Trust, also experience variable access to SDT.
- In many cases, SDT is not protected; there is a significant risk that trainees can be called back into clinical work due to clinical pressures, particularly when the SDT sessions are conducted onsite.
- Greater flexibility to have SDT is found in district general hospitals where there are fewer on-call commitments, opposed to tertiary centres where trainees are more likely to called back in to support clinical work.
- Doctors in training report that they are less likely to be called back in to a clinical session if the SDT session was the equivalent of a whole day, as compared to a half-day or a few hours.
- Some centres have used trainees who are making use of SDT as a pool of doctors to cover staff sickness.
- Some doctors in training have found it difficult to advocate for the use of SDT when they are currently struggling with being granted their study leave and annual leave.
- Self-rostering is a possible way that SDT could be incorporated into training rotas, but this requires recognition by departments of SDT as protected time.

— Training leads have encountered problems with influencing hospital departments who are delivering training to provide SDT time for the trainees.

Speciality case studies

Case studies were provided by doctors in training from the following specialties: clinical radiology, medicine, general surgery, core surgical training, trauma and orthopaedics, paediatrics, emergency medicine and general practice. They provided responses to the following questions, where they felt able to.

1. What is your specialty?
2. Describe how SDT has been implemented in your specialty/trust.
3. Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
4. Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
5. Have there been any barriers to implementation? If so, please describe how these have caused problems and how they were overcome?
6. How has SDT been beneficial to you / other trainees in your specialty?

Each response has been summarised in the tables below.

Clinical Radiology
Describe how SDT has been implemented in your specialty/trust.
SDT availability is variable across deaneries and Trusts across the country. Whilst some Trusts do not have this in place at all, other Trusts have implemented protected SDT, ranging from two hours up to half-a-day per week.
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
This is variable across deaneries and Trusts. Some Trusts have weekly time for SDT, at others, trainees may need to work around their work schedules to find time for supervisor meetings, audit/QIP, teaching presentations etc. Unfortunately, this quite often falls into personal time outside of working hours.
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
Trainees will be allocated weekly SDT at some Trusts as part of their weekly rota, which makes it much easier to ensure protected time is available for self-development. Typically, Trusts that have weekly SDT tend to be district general hospitals where the on-call burden is lighter in comparison to tertiary centres.

Clinical Radiology
Have there been any barriers to implementation? If so, please describe how these have caused problems and how they were overcome?
SDT is more challenging in busy tertiary centres where the on call frequency is greater and variable week by week. Therefore it is more challenging to provide a consistent day/time for protected SDT on a weekly basis. An option to tackle this would be to empower trainees to schedule their own SDT outside of service provision lists.
How has SDT been beneficial to you / other trainees in your specialty?
It has been very beneficial by allowing time to be allocated for self-development and reflection, away from service provision activities. It creates flexibility within trainee rotas and overall improves training satisfaction.

Core Surgical Training
Describe how SDT has been implemented in your specialty/trust.
It has been implemented variably and without consistency. Often the allocation of SDT has only been provided once all clinics, theatre lists and other clinical commitments are covered.
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
Typically, if SDT is provided, this amounts to half-a-day. For example, throughout core training, this time could be used to coordinate the rota, ISCP admin and project work (audit/research within the department).
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
1. To have a clear amount of time per week/month dedicated to SDT. 2. Clear guidance on alternative strategies/timelines if SDT is not allocated based on clinical need (e.g. time off in lieu, should be reallocated within a set amount of time).
How has SDT been beneficial to you / other trainees in your specialty?
The additional time to work on portfolio requirements is particularly valuable, and can be challenging to achieve in a timely fashion alongside existing clinical commitments.

Medicine
What is your specialty?
1. Geriatric medicine/general internal medicine 2. Respiratory/GIM 3. Rheumatology/GIM
Describe how SDT has been implemented in your specialty/trust.
1. Higher Specialty Training ('HST'): There is a mandate for two sessions per week SPA time for all geriatric medicine trainees. The Training Programme Director ('TPD') checks that trainees are being given this time and will approach Trusts that are not delivering it. All other grades: The Trust has mandated SDT for all doctors (both trainee and locally employed) which has been motivated by the addition of SDT to FY training. 2. HST: No SDT is routinely provided. It can be taken if there is sufficient staffing and has been arranged between HSTs (though the default is always to spend more time on the ward). It would usually be used for attending clinics or clinic admin; most audit/QI is still completed in the trainee's personal time if needed. IMT: One "training week" (five shifts) every four months is provided, on the rota. It can be used for clinics/procedures/other – the trainee is not expected on the ward, and it is mostly used for core clinical competences rather than audit/QI which continues to be undertaken in the trainee's personal time. FY: 1 x SDT day per month, on rota. The trainee is not expected on the ward. 3. Three sessions per week; they are a mix of CPD, admin time for clinic letters and seeing urgent/ward referrals. Due to the time required for the latter two, the time actually available for CPD is limited. This arrangement is specific to rheumatology HSTs.
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
1. HST: 2 sessions per week All other grades: 1 session/day per month depending on grade 2. As above 3. As above
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
1. When SDT is added to rotas, and when minimum staffing is set, taking SDT and clinic attendance into account i.e. doctors are not expected on the ward when they are rostered for SDT. 2. Incorporation of SDT into rotas is the only way it works. Providing clear guidance from training programmes that it is mandatory is the only way for it be delivered. Proactive leadership from TPDs/college tutors for institution of IMT training weeks was effective and has been maintained. 3. SDT has been incorporated into rotas.

Medicine
Have there been any barriers to implementation? If so, please describe how these have caused problems and how they were overcome?
1. Supportive senior leadership has helped. We have also taken the same approach as consultant job planning i.e. all doctors are rostered into half-day sessions regardless of specialty. 2. Generally SDT leaves the ward understaffed/below minimum staffing as locums are not procured to cover FY/SHO gaps, thus meaning ad hoc training/learning is even more challenging. There is no real consequence for Trusts not delivering SDT at a HST level. 3. The burden of administrative work and urgent/ward referrals eats into CPD time (especially when there is a shortage of registrars, which means that there is no one to share referrals with).
How has SDT been beneficial to you / other trainees in your specialty?
1. This stops doctors doing unpaid work and enhances their contribution to the organisation. Portfolio work, QI work, research, leadership development, service improvement can all be done during this time, all of which are activities which are expected requirements for trainees to progress in their roles. Previously, doctors would do this activity in the evenings/weekends/on non-working or rest days. 2. Allows professional/adult learning and exploration of clinical interests for FYs/IMTs as well as completion of portfolio requirements. a. N/A for HSTs – and trainees are generally unhappy as a consequence. 3. It highlights to consultants that dedicated time for CPD during working hours is expected. In theory, it reduces the amount of time spent on audit/QI etc. in own time.

Paediatrics and Child Health
Describe how SDT has been implemented in your specialty/trust.
The Trainees Committee at the Royal College of Paediatrics and Child Health (RCPCH) developed a Trainee Charter outlining the standards trainees should expect from and within their placements. This was then agreed and endorsed by the RCPCH. In the charter, it states that SPA (Supporting Professional Activity) time should be eight hours per month for ST1-3 trainees and 16 hours per month for ST4+ trainees and pro rata for less than full time (LTFT) trainees. This should be in addition to departmental teaching and clinical administrative time. It is therefore the responsibility of individual Trusts to implement this. As SDT is not contractual, it is technically not mandatory. However, it is recommended by the RCPCH, and the trainee charter states that "trainees expect to have adequate time within their work schedule to complete Supporting Professional Activity, for example QI (quality improvement), audit, leadership, ePortfolio. If this needs to be completed outside of rostered hours, trainees should be encouraged to exception report."

Paediatrics and Child Health
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
It has not always been easy to get SDT implemented, despite the Heads of School being supportive of the trainee charter and the SPA recommendations. Representatives from the RCPCH Trainees Committee have completed a recent survey to see how it is implemented and some Trusts are managing it better than others. The vast majority of trainees do not get the recommended SPA time although more and more are getting at least a proportion of it. Comments from the survey about how it could be implemented more easily included that it is more likely to be available if it is provided as part of the rota as a whole day; when given as a half-day or a few hours, trainees are likely to be called back into clinical work or unable to leave the clinical area to undertake the SPA time.
Have there been any barriers to implementation? If so, please describe how these have caused problems and how they were overcome?
Barriers to implementation from the survey included: - It is not acknowledged by departments that it should be included in rota planning. - There is no capacity in the rota. - It is not scheduled or allocated. - It can be used as "back up" shifts in case of sickness, so trainees are often called back into clinical work. - It is not protected. - Trainees were not aware that they can exception-report (in England) if they are doing SPA-related activities needed for their training in their own time. - It is difficult to push for SPA time when trainees are struggling to even get annual leave, clinic time and study leave. We have been reviewing the logistics of self-rostering and the opportunities this can give to build SPA time into rotas, with the use of more personalised and bespoke rotas. Some departments/trusts are demonstrating that this can work.
How has SDT been beneficial to you / other trainees in your specialty?
Trainees that are able to access SPA time have fed back very positively and there have been some great examples of people using it to access clinics, complete projects, explore interests within their specialty, as well as complete mandatory tasks that they have to do such as ePortfolio etc.

General Practice
Describe how SDT has been implemented in your specialty/trust.
SDT has been in place for a number of years within the GP practice-based years of GP training (across the UK). It is expected to be available to trainees, as stated by the RCGP but also via the COGPED/BMA 2011 guidance for such sessions. There is widespread awareness (including educational supervisors, trainers and practice managers) and is a prerequisite for recognition as a training practice. It possibly helps that in both the 2002 devolved nations contract and 2016v11 contract in England, GPTs in practice-based (but not hospital-based) centres are supposed to have supernumerary status. In hospital-based posts, it was often found that there was no SDT during GP training. For example, in one speciality rotation, a trainee was provided with about 2-3 'admin' half-days for each six-month period, but these were not protected and we were often asked to return to the ward due to work pressures. They had to sit in the main MDT office for this session, with limited Wi-Fi and ambient noise etc. and often consultants would come in and ask us to do tasks. SDT would have been much appreciated, but the trainee did receive more study leave (up to 30 days per annum, although variable access to departmental teaching) in hospital-based jobs compared to GP practice posts. SDT (called EDT, Educational Directed Time) has now been introduced (in theory, for all hospital-based trainees in Wales) equating to two hours, or four hours per full-time working week if a senior specialist registrar. This was a HEIW-wide initiative. Implementation has been variable, due to departmental awareness and issues with rota gaps/clinical demands. There has also been variable governance at a senior level. Of note, outside of Wales, a single area (Mersey and Cheshire) has secured SDT for their hospital-based GP trainees. This was via lobbying and negotiation at the single lead employer local negotiating committee level by a number of BMA representatives.
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
Within Wales and most areas of England, SDT is in place for two years, and for other areas in the UK this would be for 18 months. It equates to one session or four hours per full-time week. Sometimes trainees can arrange in advance for two SDT sessions in one day if they can justify this. What SDT can be used for varies somewhat via training location. It is supposed to be mapped to a trainee's professional development plan, and plans for SDT sessions discussed and agreed with educational supervisors (ES) (who work in the same GP practice as the trainee). However, many ESs trust the trainee as an adult learner, especially if they are progressing as expected. Generally (not exclusively), SDT is supposed to be used for self-directed learning, shadowing in clinics, undertaking QIP, portfolio logs and other portfolio projects such as our prescribing competency project. However, as the study leave allowance for GP trainees is heavily 'top sliced' when in practice-based posts due to the mandatory half-day release for group teaching most weeks, this results in study leave quotas of between seven to 15 days (at most) per annum (full time), meaning that many trainees are compelled to use SDT for exam-based revision purposes.

General Practice
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
The COGPED/BMA guidance (and the RCGP stance of inclusion of SDT in practice-based placements) has been important, as has the support of SEBs. It is notable that RCGP suggests SDT should be accessible for GPTs in all placements (i.e. including hospital-based placements) but there is no stance from COGPED or SEBs (apart from, more recently, Wales) and SDT is limited in hospital posts, and frequently is not available at all. Implementation in hospital-placements (from the Welsh perspective) has reportedly been challenging due to pressures on rotas, clinical workload and GPTs not being supernumerary in their hospital placements. Even when there is support from senior colleagues to implement SDT, rotas are a barrier to this (i.e. rota gaps, little capacity for sickness etc.). Interestingly, there have been some examples where speciality trainees (e.g. in obstetrics and gynaecology, or paediatrics) receive SDT, and GPTs either receive much smaller amounts or not at all. GP programme directors also informally seem to suggest they have less influence over hospital departments who are delivering the training.
Have there been any barriers to implementation? If so, please describe how these have caused problems and how they were overcome?
In practice, some trainees do not receive the full four hours due to GP administration workload overrunning or home visits. The protection trainees have varies by practice, and can be excellent, but can also be less than desired. LTFT trainees can face challenges as the ratios may be rounded down for SDT and rounded up for clinical time. If a trainee takes part of the working week as annual leave, existing guidance is that surgeries should readjust educational sessions to reduce SDT time for that week (and actually reduces the education to clinical session ratio in some instances). Some regions allow trainees to take SDT away from practice settings, but others do not, with some requiring it to be taken in a practice setting which restricts what it can be used for. SDT cannot be used for leadership activities outside of the practice setting, or to our understanding, for research, attending conferences, events or teaching. Trainees are asked about access to SDT in our six-monthly deanery TRAP trainee surveys in Wales, but it is uncertain if this is covered by the NTS in England. However, trainees would be unlikely to highlight any issues via this route due to concerns regarding identifiability, due to limited / no other GPTs in the specific practice. Trainees often raise issues when they see the local Programme Directors (often weekly) at half-day release training, but often the trainee is encouraged to resolve this themselves. However, in previous experience, where the PDs become involved, changes are seen more rapidly. In Wales, trainees work under the 2002 TCS, so for us, any mandated SDT time isn't contractually enshrined (as it is in England, especially for GP trainees in GP posts) as there is not a model or personalised work schedule, exception reporting (ER) etc. Most trainee colleagues in England in practice posts do not use ER due to concerns about the impact on their close and dependent relationships with their surgeries.

General Practice
How has SDT been beneficial to you / other trainees in your specialty?
The significantly lower study leave allocation in practice-based GPT years, due to half-day release teaching (which trainees report to be of variable quality), means SDT is invaluable. It allows us to address self-directed learning needs identified during our clinical work, weekly portfolio learning logs, requirements for GP training programme-based projects (QIP, prescribing, leadership within a GP practice) and, unofficially, revision (two out of three years of GP training carries a membership examination). It can be difficult to build in other experiences (e.g. attending conferences) during training with the limited study leave in practice-based posts and SDT, in its current form, doesn't address this. The amount of portfolio work etc. required per week is significant but SDT gives protected and paid time to undertake some of this. Time to attend clinics and community-based programmes through SDT is also important to cover curriculum capabilities. As mentioned above, research, education and leadership-based aspects of the RCGP curriculum rarely appear to be supported in terms of use of SDT which appears to be an unmet need. However, GP trainees are encouraged to explore these opportunities soon after gaining their certificate of completion of training (CCT) (partnership, involvement in LMCs, neighbourhood clusters in DNs/PCNs and ICSs in England, trainer status), and may contribute to the decreasing numbers taking up partnership opportunities post-CCT.

Surgery – Trauma and Orthopaedic Surgery
Describe how SDT has been implemented in your specialty/trust.
This is a relatively new initiative that has been implemented within some departments and rota structures. Conventionally trainees have been extremely busy with the service provision element of jobs, and when working at a major trauma centre, the impetus has always remained upon the trainees to actively search for additional training opportunities that are available. The recent implementation of R&D time/SDT equivalent has seen a session built in where the trainee has not been rostered onto any other external activities. Utilisation for professional development however is variable in nature. In the majority of cases, you may still be required to step in to cover a busy clinic or alternatively, take the opportunity to undertake extra operative experience.
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
SDT normally takes place once a week where you're not rostered to an on-call session, clinic or theatre activity.

Surgery – Trauma and Orthopaedic Surgery
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
The most significant step in allowing SDT to be implemented within the working environment has been a significant overhaul of rota structure so as to maximise the workforce potential, rather than the previously implemented multi-tier on-call system. Having sufficient numbers of clinicians available to staff the rota is central to being able to progress and deliver the aspiration of having available SDT or equivalent.
Have there been any barriers to implementation? If so, please describe how these have caused problems and how they were overcome?
The capabilities of any department to implement this is based on the available workforce and the structure of the rota that is implemented. In order to make this achievable within our own department, we rationalise the on-call services to a two-level on-call system as opposed to having a four-level on-call system which was previously quite simply unachievable to address the need for SDT.
How has SDT been beneficial to you / other trainees in your specialty?
SDT has been of phenomenal value to the trainees and registrars within departments. It delivers increased flexibility to pursue professional development activities within working hours. This may ultimately consist of more clinical activities, but this will be as per the individual's interest. For example, if there are more complex and interesting cases taking place, then you can take that opportunity during the SDT to attend and learn. If there are academic or research activities that you wish to pursue, then having the daylight hours to make the relevant communication and contacts, as well as to undertake regular reviews are challenging if you have a full rota without any available time for this activity. Personally, it has also provided time to pursue leadership activities and attend national meetings. For those across the specialty, there is variable implementation of such a system as SDT. Those who have received the opportunities have consistently provided excellent feedback to suggest it is a highly valued and useful provision within the training system.

General Surgery
Describe how SDT has been implemented in your specialty/trust.
This has not been implemented into all Trusts in the deanery, but was timetabled for all general surgery registrars in Milton Keynes Foundation Trust (part of Thames Valley).
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
A half-day session was timetabled each week for trainees who did not have on-call commitments. During weeks where only elective commitments were scheduled, there would be an SDT morning or afternoon timetabled on the rota. This could be used for anything a trainee felt was appropriate.
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
It was successful and extremely useful particularly as it was fully incorporated into rotas for all members of the team. Rotas were created by the administrative team, and therefore it was fairly protected. They would ensure a minimum of 1.5 days theatre, 2 x clinics and 1 x SDT session were scheduled per elective week.
How has SDT been beneficial to you / other trainees in your specialty?
It was extremely beneficial to ensure trainees could complete mandatory work; audit, research, teaching, online courses and further learning. "I really felt it benefitted my mental health and work-life balance."

Surgery: Trauma and Orthopaedics
Describe how SDT has been implemented in your specialty/trust.
All juniors get a half-day session every week for SDT.
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
Some trainees use SDT for catching up on portfolio work/ISCP, or to attend theatre if there are interesting cases taking place. Some trainees use it to catch up on areas of work that they would otherwise have to do during the evening/weekends.
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
It is on the formal electronic rota for all juniors every week. There have been no issues in accessing the SDT. However, to note, some Trusts do not have any SDT available.

Surgery: Trauma and Orthopaedics
Have there been any barriers to implementation? If so, please describe how these have caused problems and how they were overcome?
Some trainees have not had access to SDT weeks when they have been allocated to set activities for the full week. For example, during trauma week, where there had already been plans to undertake the ward round each morning and theatre sessions each afternoon. During a 'normal' week, this is not an issue.
How has SDT been beneficial to you / other trainees in your specialty?
"I have never had access to SDT before and have found it really beneficial, as I was previously doing all of this work in my unpaid spare time. I definitely think it should be implemented everywhere!"

Emergency Medicine
Describe how SDT has been implemented in your specialty/trust.
Within Emergency Medicine, all HSTs are entitled to 8 hours FTE of SDT.
Describe the format that SDT takes in your specialty (e.g. the frequency and duration of sessions etc.) and what it is used for.
Four hours of this time is advised to be patient facing i.e. opportunities to attend theatre lists to maintain airway competencies, opportunities to attend specialist clinics or time in paediatrics, while four hours can be non-patient facing; on portfolio, delivering teaching, attending management and governance meetings; enabling trainees to meet the generic specialty learning outcomes of the curriculum. Trainees are asked to keep an SDT diary and discuss plans with their educational supervisor.
Please describe any factors that have supported the successful implementation of SDT (e.g. incorporation into rotas) or how it could be implemented more easily.
Where it has worked best, SDT has been allocated into existing rota patterns.
How has SDT been beneficial to you / other trainees in your specialty?
This has universally been met with enthusiasm by trainees. Given the service provision pressures of ED it has enabled trainees to have protected time to ensure training opportunities are maximised.