Flexible working: policies are supportive but culture and finances are not

Helen M Goodyear, Finola Lynch

There is now an inverse correlation between the number of women entering medicine and the availability of flexible working

It was widely assumed that the "feminisation" of medicine would increase demand for flexible working practices.¹ Nearly 70% of medical students are female and by 2012 male doctors will be outnumbered. However, since 2004 the number of UK flexible trainees has remained consistent at 2000 and places on the flexible careers scheme (FCS) have disappeared. We now have a situation where there is an inverse correlation between the number of women entering medicine and flexible working.

It all started so promisingly 6 years ago when the National Health Service (NHS) Plan was launched, pledging its support for more flexible working patterns.²⁻³ This was followed by the Improving Working Lives standard in which NHS Employers committed to a host of policies and practices designed to help staff maintain a healthy balance between their work and outside commitments.⁴ As if to underline its significance to the future of workforce planning, the Improving Working Lives standard was one of seven key work areas identified by NHS Employers where real progress was predicted in the next 5 years.

FLEXIBILITY UNDER THREAT

Yet in reality flexible training had been under threat since the new junior doctor pay deal in 2000, the same year the NHS Plan was launched.⁵ The new pay deal made flexibility unaffordable to trusts and generated widespread malcontent towards flexible trainees, who were perceived as grossly overpaid for the hours they worked.

The structure of the 2000 pay deal was such that flexible trainees received a full basic salary if they did any work outside standard hours and an on-call banding supplement. A trainee working at 50% of full-time hours received the same salary as one working at 80%. Furthermore, in trusts where flexible trainees participated in rotas not compliant with recommended guidelines, they received twice the full-time basic salary. Pay is always an emotive issue, but imagine the feelings of colleagues when flexible trainees were

receiving a salary that exceeded the pay of most full-time junior doctors and consultants in their first 5 years of qualification.

An extra £7 million per year was found to support flexible training between 2002 and 2004, and in 2005 a further pay deal for flexible trainees was negotiated by the British Medical Association and NHS Employers. This deal created uncertainty about the duration of pay protection for those already working under the 2000 pay deal.

It also failed to simplify the calculation of a flexible trainee's salary, whose basic pay was dependent not on the percentage of full-time hours worked, but on counting every hour worked (days, evenings and night shift hours). A banding supplement topped up the final salary. No wonder bad feeling increased.

RECRUITMENT TO FLEXIBILITY SCHEME FROZEN

There was still optimism about the future of flexible training in 2005 when it was anticipated that the number of flexible trainees would double in the next 3–5 years.⁶ Yet on New Year's Eve 2005, NHS Professionals, the body set up to enable more flexible working practices, ceased to manage both hospital and general practice FCS. Funding was devolved locally and almost immediately dried up. This year recruitment to the FCS has been frozen due to lack of strategic health authority (SHA) and primary care trust funds.

Similarly flexible training budgets have been cut and associate deans have been forced into providing ever more creative working patterns with their diminishing funds. Slot shares, reduced hours in a full time slot and three flexible trainees occupying two full time slots are now the norm. These are hardly resounding illustrations of flexibility and explain why the preferred term for flexible trainee is now "less than full time".

Information about the current state of flexibility within the NHS is hard to find. Few examples of annualised hours exist

and a Medical Women's Federation (MWF) survey in 2004 failed to uncover a single example among its members.

Another survey sent by the MWF to all SHAs this year asked how many doctors were on the FCS. Most SHAs could not give a precise answer. Of those that did, between 76–96% of doctors on the FCS were female. However, a Royal College of Physicians survey of junior doctors found that 51% of men anticipated working flexibly at some stage in their career. If this is true, then flexible working practices are also failing them.⁷

While the waiting lists for flexible training in some deaneries might suggest a high level of demand, the lack of a waiting list in others is not necessarily a case of supply meeting demand. Anecdotally it is acknowledged that many junior doctors are not applying for flexible training because they are put off by the scarcity of funding.

PERIOD OF CHANGE IN TRAINING

We are in a period of immense change in UK medical training with Modernising Medical Careers,⁸ specialty training run through grades starting in August 2007, and European Working Time Directive (EWTD) compliance with the 48 h working week to be achieved by 2009.⁹ Flexibility must be a part of the future. It is imperative that the opportunity to introduce more flexible working practices at this time of flux is not lost.

The solutions are out there. EWTD implementation advice suggests team working, redesigning working patterns and new service models.⁹ Instead of counting the number of full time posts, the number of hours in those posts could be calculated so that flexible trainees, doctors on career breaks and those seeking a reduced number of working hours before retirement are included in workforce planning.

The principles and policies needed to create a cultural and practical shift in working practices are there. What is missing is the will (and consequently the funding) to achieve it. This approach is both short-sighted and unforgivable at a time of profound change in UK medical training. Nothing less than a cultural revolution is required within the NHS if flexibility is ever going to be accepted as a viable option.

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