BAPIO SAS &
LED FORUM

SEPTEMBER 2022

CHARTER

FOR LOCALLY EMPLOYED DOCTORS IN THE UK NHS

PRESENTED AT THE

NATIONAL LED CONFERENCE

LEICESTER

24 SEPTEMBER 2022

MDS

MEDICAL DEFENCE SHIELD

A membership with Medical Defence Shield provides *Professional Support, Without Compromise*

CLINICAL DEFENCE

GMC/GDC REGULATORY:

Professional disciplinary defence

GMC / GDC advice & representation

Defence against patient complaints

EMPLOYMENT

ADVICE/REPRESENTATION:

Terms & Conditions of Service

Grievance procedure

Disciplinary proceedings

The MDS Comprehensive Plan combines both under one roof

JOIN TODAY

mdsuk.org

24-hour advice line 0300 30 32442

SAS-LED FORUM

CONTRIBUTORS

BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN

SAS-LED Forum

Kantappa GAJANAN, Forum Chair & The Christie Hospital
Ramesh MEHTA OBE, President, BAPIO

Authors

Indranil CHAKRAVORTY MBE, BAPIO Institute for Health Research
Afzal LATHEEF, St George's University Hospital London

Contributors

Biju SIMON, University Hospitals of Leicester
Charu DEVARAJAN, University Hospitals of Leicester
Gowtham M. VAYANKARAKUZHIYIL, University Hospitals of Leicester
Javed MOHAMMED, University Hospitals of Leicester
Latif RAHMAN, University Hospitals of Leicester
M.A. LAKHA, Nottingham University Hospital
Rinsa N.M. AMEER, University Hospitals of Leicester
Rohini KULANKARA, University Hospitals of Leicester
Sameer.Y. SHARIFF, University Hospitals of Leicester
Sharon FERNANDES, St George's University Hospital London
Shubhangi S. BARNWAL, University Hospitals of Leicester

FOREWORD

Kantappa Gajanan, Chair

The British Association of Physicians of Indian Origin (BAPIO) is a well-known national organization for its support of International medical graduates and its stand on inequalities. The BAPIO SAS & LED forum has worked hard to increase the profile of Locally employed doctors (LEDs) in the last three years. The forum Committee has doctors from a multinational, multicultural, multireligious and inclusive group and is led by more than 65% women. The forum aims to increase the profile of SAS & LED doctors and is open to any doctor who comes to work in NHS.

Its four pillars are,

- Improve the profile of the role
- Support for career progression
- Engage in education, teaching and research.
- Mentorship and pastoral care.

To improve the LED profile and raise awareness, we planned the first National LED conference to create a platform for these doctors to showcase their talent and exemplary work and learn from peers through presentation, networking and knowledge sharing. These doctors need more support in improving the working environment so they can thrive and get trained to treat patients safely. We want to bring all the stakeholders on this platform to work harmoniously to improve the life of LED. To make this happen, we have worked hard as a team with lots of input from various team members and devised the LED Charter with the first edition. This will be discussed, and further worked with diverse stakeholders to make it beneficial for LED doctors.

I welcome you all to this conference and thank you for helping and being part of this document to improve the working conditions of LEDs.

EXECUTIVE SUMMARY

Charter for Locally Employed Doctors in the UK NHS

Indranil Chakravorty MBE

Locally employed doctors have been described along with their compatriots as 'the lost tribe' compared to their peers who are either in formal training or consultant or general practitioner posts. Over the last decade, considerable progress has been made in improving the recognition, value, and respect given to doctors in Specialty, Staff Grade or Associate Specialist (SAS) roles with harmonised contracts, working conditions and support available. The vast majority of the cohort of over 127,000 doctors in the SAS-LED category as per the UK medical register (GMC 2022 dataset) continue to be lumped with their SAS historical counterparts, yet have a very different experience. These LEDs are unsung, unheard and remain voiceless members in the UK NHS medical staff, yet continue to provide service in delivering high-quality healthcare to the nation.

Most human resource departments, rota managers and consultants or GP Principals responsible for running safe services may consider them as 'rota fillers', where the employing organisations, education and training boards (i.e. Health Education England or Health Authorities), the regulator and even their trade unions do not demonstrate any consistent responsibility to providing them with the essential tools for delivering safe, effective service or support to pursue their career aspirations and have fulfilling working lives.

The NHS is not immune to the bias and discrimination rife in wider UK society; this phenomenon was better recognised during the COVID-19 pandemic. Nearly 60% of LEDs have a minority ethnic background, and most obtained their medical training and primary qualifications overseas. It has been shown consistently that these characteristics usually lead to a poorer experience while at work, a higher risk of burnout and for receiving a harsher outcome from investigations for breaches of professional standards.

The BAPIO SAS-LED forum was established to support, represent and improve the working lives of SAS and LEDs in the UK. In September 2022, the forum is organising the maiden conference for LEDs at Leicester. This is the first initiative of its kind. This conference also provides the perfect backdrop to launch the LED Charter, which aims to harmonise the whole spectrum from recruitment, employment contracts, working conditions, support, education, training, career support and wellbeing for the over 100,000 doctors in this category working in the UK health service.

This Charter is ambitious in its aspiration and aims to deliver the 'Gold Standard' for all LEDs. It was developed following a prolonged exercise of listening to the experiences of many LEDs both within the membership of BAPIO, across its affiliated organisations and social networks. It is unique in being developed and written by LEDs and IMGs early in their careers or by those that have transitioned to more established senior and autonomous roles. So it is grounded in the reality of lived experiences and ambitious in setting the bar at an equal level with other doctors in the UK NHS.

The LED Charter offers ten practical recommendations for implementation by all NHS employing organisations. Most of the principles of equality and inclusion described in this Charter should be embraced by the medical royal colleges, education and training agencies (i.e. Health Education England) in their committees and processes to provide a voice to this 'lost tribe'.

By implementing and supporting the uptake of the LED Charter, NHS organisations, education and training agencies, royal medical colleges, the regulator and trade unions can help to break the perpetual cycle of inequality, differential outcomes, poorer working experiences and consequences on health and wellbeing for these doctors. BAPIO SAS-LED forum will work closely with our partners and all stakeholders to undertake annual surveys of LED experiences from 2023, provide a national benchmark and assist NHS Employers in achieving compliance. If we need our NHS to survive and flourish, we must respect and value all our staff - remembering the NHS People Plan.

BAPIO TRAINING ACADEMY

BAPIO FACULTY OF LEADERSHIP

BAPIO INSTITUTE FOR HEALTH RESEARCH

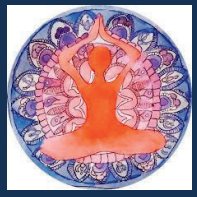
BINA British Indian Nurses Association

MDS MEDICAL DEFENCE SHIELD

BAPIO HEALTH & WELLBEING

BAPIO BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN 25 YEARS SILVER JUBILEE 1996-2021

The Physician
Journal of The British Association of Physicians of Indian Origin



© BAPIO Publications
ISBN 978-1-7399531-3-3

British Association of Physicians of Indian Origin
SAS & LED Forum
https://www.bapio.co.uk
admin@bapio.co.uk
DOI https://doi.org/10.38192/led.charter.22

CONTENTS

Introduction	1
Background	6
Recommendations	12
Next Steps	19

INTRODUCTION

Overseas doctors have been working in the UK even before the inception of the national health service (NHS) and continue to play a crucial role in successfully delivering healthcare. They represent one-third of the total number of UK doctors, including doctors from the European Economic Area and international medical graduates (IMGs).

Overseas doctors gain their primary medical qualification from about 150 diverse countries, with the inherent variability of medical regulations between the country of origin and the UK. In addition, the frequently inadequate information about the NHS and its structure makes the reality often differs from expectations.[1]

In 1972, following several concerns from the public and healthcare providers regarding the variability of the knowledge, skills, competencies and communication of a significant proportion of IMGs, the Merrison Inquiry was set up.

Dr AW Merrison concluded in his report published in 1975 that there was a need for a new regulatory authority responsible for registering the medical practitioner, quality assurance of education and training and assessing fitness to practice. [2]

The Temporary Registration and Assessment Board (TRAB) was set up to check that any IMGs could meet the requirements for practice in the UK before being granted registration. The formalisation of differential attainment perhaps commenced with only a third of applicants being successful in this assessment. [3]

IMGs usually do not have adequate information on individual posts, particularly for competitive specialities. They may not be made aware of the new regulations, e.g. requiring them to obtain medico-legal insurance during clinical practice in the UK, hence may miss this important support when most needed.

As the acceptable practice of medicine requires knowledge of language and culture, overseas graduates need time to become familiar with practice in the UK, mainly when their training in medical school is not in English. Even when English is the medium of instruction, the language learnt may vary in its day-to-day use for grammar, phrases and idioms. There are also the subtleties of language and dialect to misunderstandings of the nuances of non-verbal communication and social and behavioural norms.

- Lack of information about the UK health system;
- language and communication challenges;
- clinical, educational and
- work-culture challenges; and
- discrimination challenges are some of the difficulties that overseas doctors might experience.

The Merrison report recommended a national induction program for all IMGs and uniform support to be provided; it has taken till 2022 for this to be finally implemented. Understanding these challenges and providing support is essential in helping overseas doctors make a smooth transition. [1]

A lack of work-life balance in medical training negatively impacts doctors' learning and well-being. Women with children and International Medical Graduates (IMGs) are particularly affected.[4] There are additional challenges for IMGs and UK doctors who have either a protected characteristic and commonly face bias, discrimination and sometimes overt racism from colleagues and patients/ members of the public. [5–7]

1.1 Who are Locally Employed Doctors?

Locally employed doctors (LED) are a diverse group of doctors employed by organisations such as National Health Service (NHS) Trusts, private hospitals, and the community and primary care sector. Their core function is to deliver health care (often described as service provision) in partnership with consultants, doctors in training, Specialty doctors & associate specialists, and other health professionals.

They are distinct from the Specialty Doctors and Associate Specialists (SAS) grade and comprise doctors who are not in formal, designated training posts.

The General Medical Council register and NHS Digital data indicate that one-fifth of all the licensed practitioners working as Locally Employed Doctors obtained their primary medical qualifications (PMQ) abroad, therefore, are referred to as international medical graduates (IMG).

LEDs are known as 'Trust Grade' doctors and cover many contracts and job titles, often of fixed term duration.

1.2 Inferior experience

Locally employed doctors are a cohort of doctors with a wide range of clinical experience at different stages of their careers. They choose this role for a host of diverse career or life aspirations. A sizable proportion starting their career in the NHS fall under this group. They may have completed Foundation or Core training and choose to take a gap in their formal training.

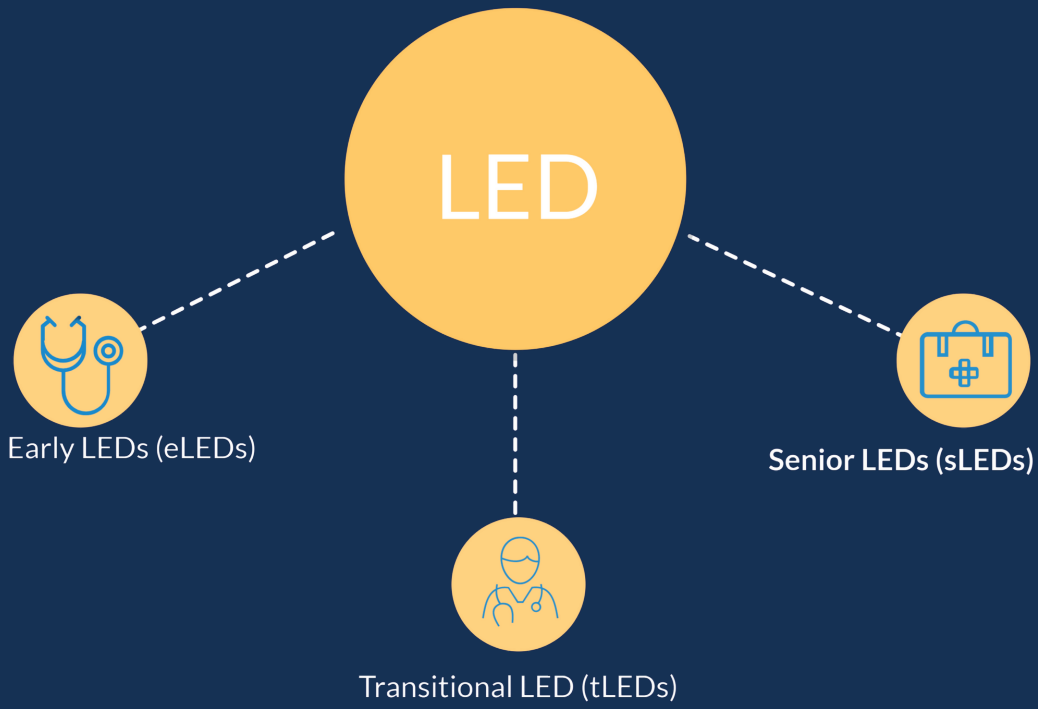
Many LEDs are IMGs, some on a Medical Training Initiative (MTI) programme, European Union doctors undertaking fellowship or overseas doctors looking for employment and experience in a different health system.

Despite their variable backgrounds, clinical experience and aspirations, they have a unity of having challenging and often substantially inferior employment support, workplace experience, differential opportunities for career progression and a higher likelihood of being investigated, blamed for errors and reported to the regulator.

This manifests mainly due to a lack of access to structured educational or learning opportunities and professional support and adversely impacts their wellbeing. Despite the absence of a national agreement, there are pockets of good practice.

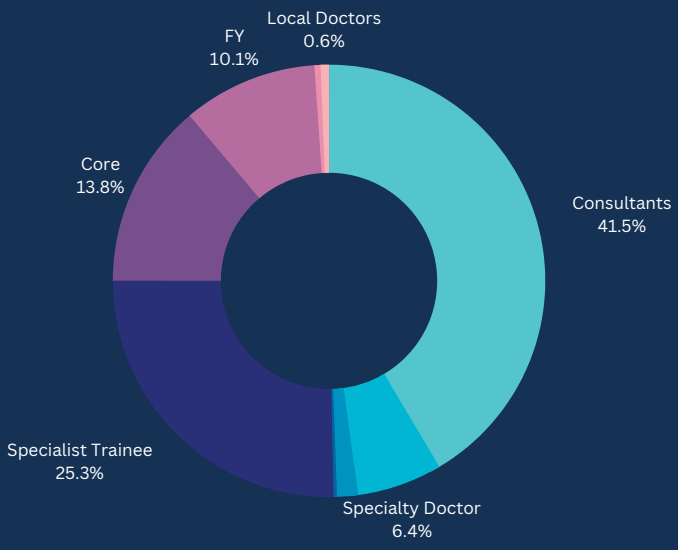
However, it is widely recognised that there is an urgent need for improved employment contracts, equality in induction, structured education-training opportunities, a supportive workplace environment, and career progression.

In addition, recognition of the diversity of backgrounds, career or life aspirations, and inclusion as valued members of the employing organisations and their respective professional bodies (i.e. Medical Royal Colleges and Specialist Societies).

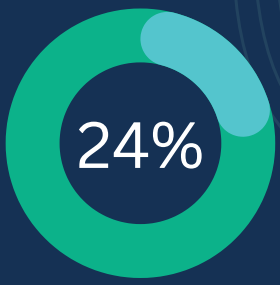


DATASETS

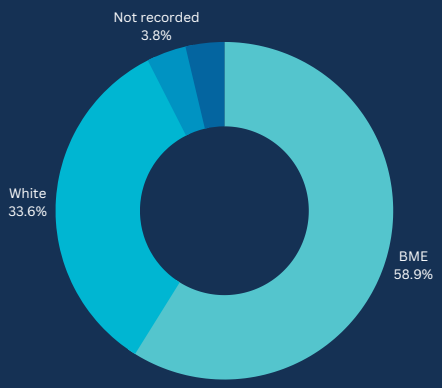
UK NHS WORKFORCE



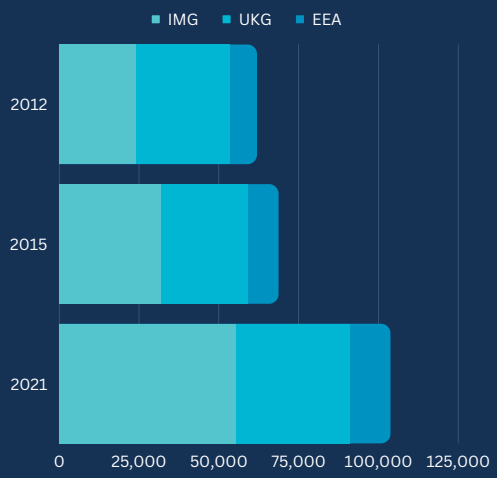
NHS hospital workforce data by grade; May 2022 | total; 128,027



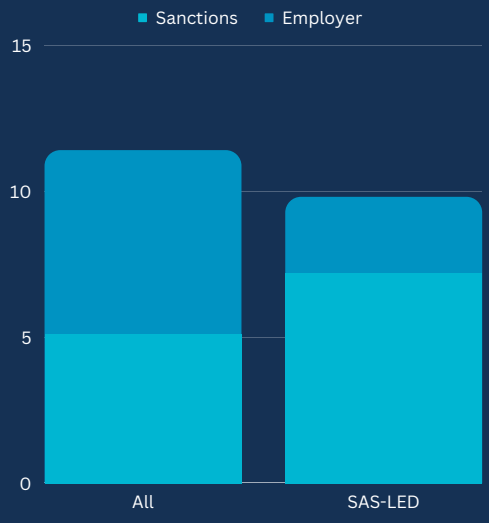
GP Workforce Permanent vs Locum; Total 35,257 | July 2022



Ethinicity of SAS-LEDs from GMC Register 2022

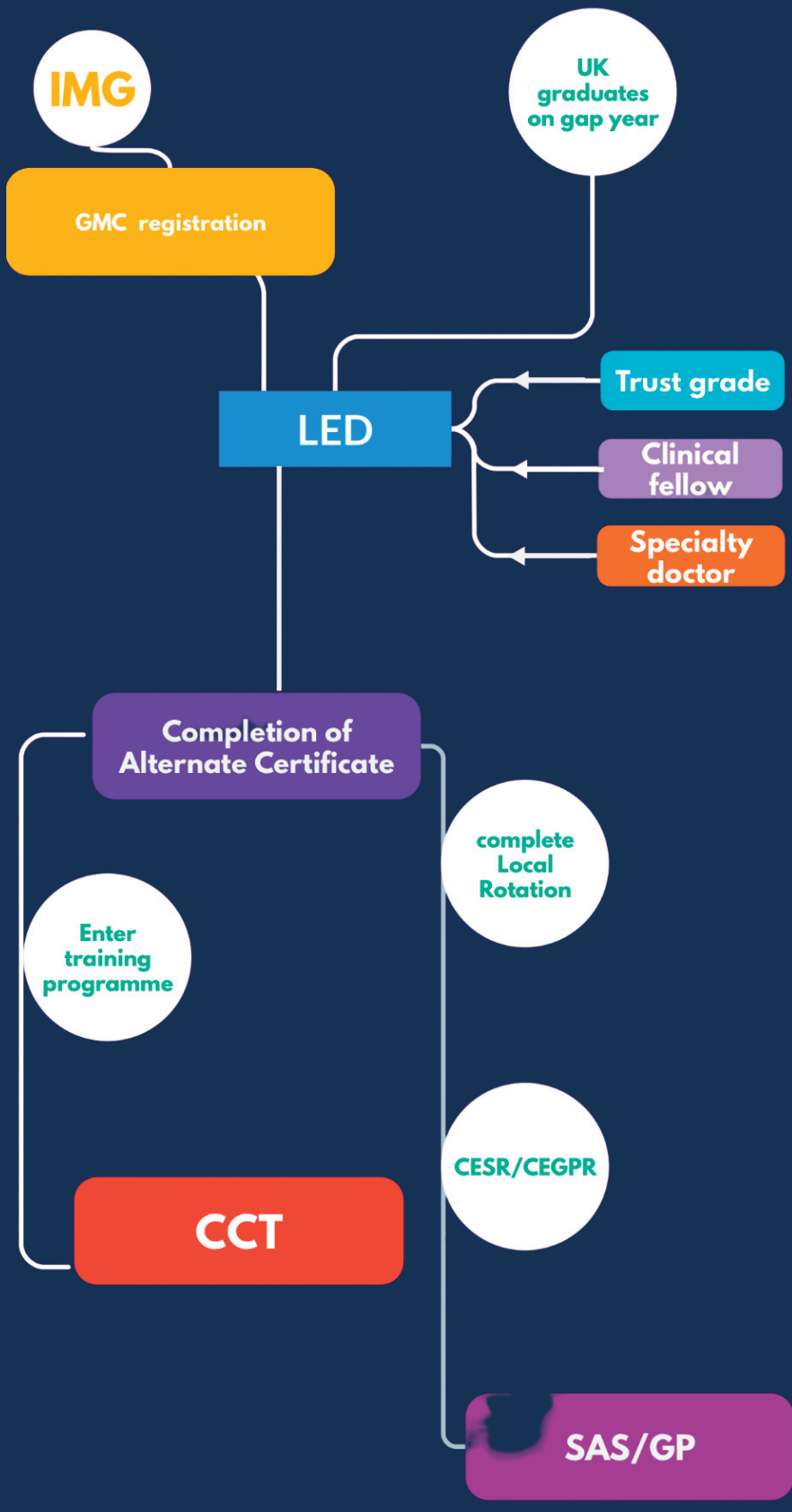


GMC Registration dataset for SAS-LEDs based on PMQ UK, IMG & EEA | Total 104,571 in 2021 out of 354,583 doctors in the register



Proportion of complaints and their outcomes- Sanctions vs being referred to employer | GMC Data 2017

LED CAREER PATHWAY



BACKGROUND

2.1 Types of LEDs careers

Locally Employed Doctors come from various backgrounds, have a wide range of clinical experience, and entertain a range of career aspirations and lifestyle choices. There are three distinctive subgroups:

2.1.1 Early LEDs (eLEDs)

This group comprises doctors within the first five years of their careers in the UK healthcare system. These are primarily UK-trained doctors who have completed their foundation or core training periods and are taking time out of formal training for career, research or lifestyle considerations.

They also include IMGs who are new to the NHS (newly registered with an approved practice settings restriction) or have worked in the system for less than five years.

A large subset of LEDs who are IMGs needs to procure a CREST (Certificate of Readiness for Specialty Training) to enter an approved training program in a hospital or primary care.

Recent or Periodic LEDs -
The UK General Medical Council (GMC UK) report also refers to them as Recent SAS and LEDs – doctors registered less than three years ago and have not entered an approved training programme. They are typically IMGs and younger doctors from the European Economic Area. Periodic SAS and LEDs – doctors who have started a training programme and then taken a break, predominantly young UK graduates in the early stages of their careers. [8]

2.1.2. Transitional LEDs (tLEDs)

Include doctors in the UK healthcare system for more than five years who have had breaks from training to pursue out-of-program career activities in research, leadership, management or alternative/ additional qualifications or have family commitments and caring responsibilities.

This includes IMGs who have postgraduate experience in their home countries. They often try to enter into formal training unsuccessfully and therefore require an alternative CESR (Certificate of Eligibility for Specialist Registration) or (CEGPR) to register as a specialist or general practitioner.

2.1.3. Senior LEDs (sLEDs)

These doctors have worked in the UK healthcare system for more than ten years. These doctors are usually proficient with the design and may or may not have previous formal training. They may be in temporary or fixed-term contracts, sometimes providing cover for substantial doctors on employment breaks (locum posts for maternity, sabbatical or health-related holidays) in various specialities or primary care.

They may also include IMG doctors with postgraduate or specialist experience in their home countries and significant UK experience to hold a CESR (Certificate of Eligibility for Specialist Registration).

GMC UK survey described them as Career SAS and LEDs – typically 30-50 years of age- mostly IMGs and have never entered a training programme.

BACKGROUND | 2

2.2 Transition from LEDs to SAS

SAS or Specialist and associate specialists include speciality doctors and specialist grade doctors with at least four years of postgraduate training. Locally employed doctors can progress their careers by either entering a training pathway, completing a substantive alternative path through CESR/ CEGPR route or becoming SAS doctors.

Several factors, including portfolio preparation, interview performance, application scoring, training rotation, geographical preference etc., influence the decision to pursue a training programme. Surveys have shown that the LEDs receive minimal support and supervision to either get appointed to a formal training post or progress in their career compared to trainees, especially for IMGs.[9]

2.3 Impact of Regulation & Complaints

As a regulated profession, doctors are held to high expectations based on the principles of Good Medical Practice, which the GMC enforces as per the provisions of the Medical Act (1983). Through the Maintaining High Professional Standards (MPTS) investigations, the GMC and tribunals implement their powers to warn, suspend, and restrict the practice of doctors or permanently remove them from the register.[10]

LEDs are not known to receive more than their fair share of complaints or be subject to MPTS investigations by their employers (relating to professional performance, honesty and fairness) compared to all doctors.

However, when these complaints are received or MPTS breaches are reported, they have a disproportionately high number being either reported to the GMC or given harsh outcomes against the NHS Complaints regulations (2009) encouraging local resolution.

Many doctors report being victimised after whistleblowing, bullied, or unable to work due to mental health trauma. Such complaints and investigations seriously affect all doctors, mainly LEDs. Almost 32% of doctors who receive complaints experience anxiety and depression.

Understandably, distress increases with complaint severity, with the highest levels after a referral to the regulator. Doctors with current/recent complaints were two times more likely to report thoughts of self-harm or suicidal ideation; several doctors have taken the final step. An internal report by the GMC investigating 28 cases of doctors who committed suicide while under fitness to practice investigation concluded these deaths were preventable and that the GMC has a legal duty to take positive actions to ensure fitness to practice proceedings do not damage the physical or mental health of doctors.[11,12]

Due to complaints or MPTS code breaches, almost 90% of doctors report defensive practices, including avoiding high-risk patients or procedures. [10,13] Due to an inherent lack of effective induction, employer support and often, in the case of IMGs, a lack of understanding of local systems, including culture and language, many end up facing the tribunals without legal representation or defence - thus facing harsher sanctions. [8]

BACKGROUND | 3

2.4 Induction & Support

The fundamental values of medicine may be universal. Still, how they are expressed will differ according to the social, cultural and organisational context in which care is delivered. It is, therefore, imperative that the proper support is in place to enable them to integrate successfully as quickly as possible, both professionally and personally.

The NHS People Plan [14] and the future of NHS human resources development report [15] recommend a welcoming culture and a safe and inclusive environment that engenders a sense of belonging for recruits into the NHS. The GMC has called for a standardised, supportive induction for doctors new to UK practice; they have already initiated an online pre-induction session (Welcome to UK Practice).

However, the induction provided to IMGs and often to LEDs remains variable, and there is no standardised, comprehensive induction with continued support for doctors coming to work in the UK. This is vital to ensure they can adapt to the NHS system and live in England as quickly as possible to reach their full potential and deliver safe, high-quality care.[16]

NHS Workforce Race Equality Standard (WRES) team received feedback from IMGs; many had not been allocated supervisors or appraisers and were instructed to start working independently soon after they arrived in the UK.

Most were pressed to frontline work without acclimatisation, relevant knowledge of healthcare systems, processes, procedures or policies, e.g., safeguarding or safe discharge arrangements, or briefing about social services or integrated care.[16] The survey conducted by GMC found that only 1% of LEDs and 2% of SAS doctors are involved in the induction of other SAS and LE doctors.

The GMC's State of Medical Education and Practice report identified, as far back as 2011, the need for a meaningful and comprehensive induction to reduce the disproportionately higher risk of IMGs being referred for fitness to practise investigation. So far, little has changed.

2.5 Linguistic & Cultural Competence

The most common challenge reported by IMGs in a 2019 study led by the Medical Adviser, Workforce Race Equality Strategy (WRES) Implementation Team, NHS England, was communication with patients, the public and colleagues, entailing common problems such as understanding colloquial English.

Professional medical practice in 2022 is highly complex and demanding, requiring considerable expertise, specialist knowledge, and the ability to communicate sensitively. These are essential requirements to ensure safe and effective doctor-patient or interprofessional exchange of information. [17]

BACKGROUND | 4

Research suggests that IMGs benefit from focused training in everyday medical language, fluency, idioms, pronunciation, humour, and local dialects. IMGs often felt confident in their communication skills (and thought others saw them as competent). Still, their colleagues report several concerns, including difficulty with small talk, nonverbal communication, and observance of (related) local cultural norms. Communication training programs targeting IMGs should address communication with colleagues and include instruction about language-related issues and explicit discussion of local cultural standards and expectations.[18]

Yet most new IMGs do not get adequate induction into this and are often expected to start work without it. If they have arrived from a country with a very different health system and cultural norms, with other medicines and technology, a completely different online patient record system, and very different rules around data protection and what information should be communicated to patients. [16]

2.6 Incivility & the work environment

One in four doctors in SAS-LED roles experiences challenging behaviours, bullying, belittling, and humiliation at the workplace. Rudeness and incivility in interactions with colleagues are the most common experience. In 1 in 10 doctors who have ceased to practice in the UK, bullying and harassment contribute to a high workforce turnover.

Almost a third perceive that the working environment is not supportive. These results are significantly worse than those reported by doctors in formal training posts (<6% in 2019) compared to the GMC National Training Survey results.

2.7 Leadership

Leadership at every level of an organisation is essential for a high-performing organisation such as the NHS. Leadership is more effective when it is trained and aligned with the values and goals of an organisation. [19] Hence, medical professionals at all levels must be formally educated and trained in leadership principles, become aware of their strengths and limitations and become effective agents for change and a cycle of constant improvement. A narrative analysis suggested that medical leadership, directly and indirectly, influences outcomes, safety and team performance at all levels. Doctors must also be supported in transitioning across different levels of autonomy and leadership roles.

While leadership is now considered essential for doctors in formal training and substantive consultants or GPs, this is not so for LEDs (and SAS doctors). There is a need to do things differently in healthcare, including better diversity and leadership distribution and fully utilising LEDs' potential. These skilled, experienced medics have much to offer yet are frequently overlooked, with little guidance or support from central organisations, medical royal colleges, or NHS Trusts and Primary care Clinical Commissioning Groups (CCGs).

BACKGROUND | 5

Opportunities are frequently missed to involve the more experienced doctors in the grade who would be well-placed to lead activities like appraisers and induction facilitators. There is a wide range of potential leadership and management roles in healthcare organisations: some might be more formalised, and some informal, such as joining and contributing to committees. Individuals will have varying motivations, including professional interests, curiosity, and personal development.[20] The system must therefore be designed to encourage inclusion from all doctors (SAS and LEDs) in leadership training, thus ensuring that the organisation benefits from the diversity of distributed leadership.

2.8 Challenges - Contracts/ Education & Training

LED doctors are employed through contracts which vary depending on local terms and conditions and job descriptions and are set for short-term contracts. Unlike SAS, Consultants, GPs and other doctors in formal training, there is no national agreement or direction regarding the contract for LEDs. There are no nationally recognised career or pay progression thresholds for these posts.

LEDs must engage in appraisals and revalidation processes like other doctors in training posts and yet have no formal time allocation for developmental activities. LEDs must receive training and develop skills to deliver high-quality patient care, as defined by good medical practice guidelines. Unless otherwise agreed in the employment plan, the employing organisation is under no duty to provide any formal training.

Those who wish to progress to a training post or pursue a CESR-CCT/ CESR-CGP route do not have any standard support or allocation of resources to meet their career aspirations. In some instances, LEDs are restricted from attending formal training sessions designed for doctors in formal training, often required to maintain a safe service.

Almost half of the LEDs report difficulties despite being more likely to have somebody to support them. LEDs are likely to be at an earlier career stage, perhaps changing employers more frequently, which may affect their ability to take advantage of opportunities available. [8]

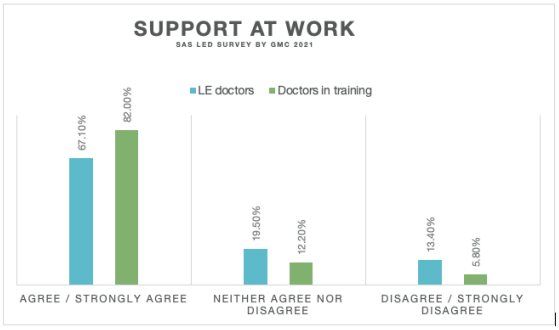
2.9 Wellbeing

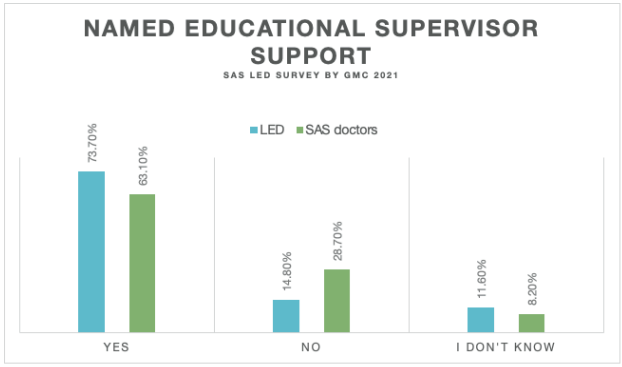
A study by GMC found that 41% of LEDs report emotional exhaustion, a third burnout and one-fourth experience physical and psychological exhaustion - mainly attributed to unsustainable rota hours, inhumane rota design, poor working relationships, and being asked on many occasions to undertake tasks that a doctor usually completes in a more senior role.

2.10 Mentorship

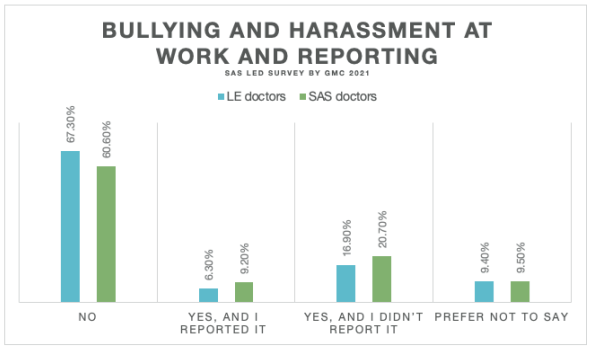
Confidential mentoring is essential for all doctors throughout their careers, especially during transition points, such as changes in role. Mentoring is vital for LEDs whose career choices and challenges are particularly stressful. However, mentors need to be trained and aware of the specific aspirations and hurdles. [21]

TABLE 4:The working environment is fully supportive (GMC, 2021)

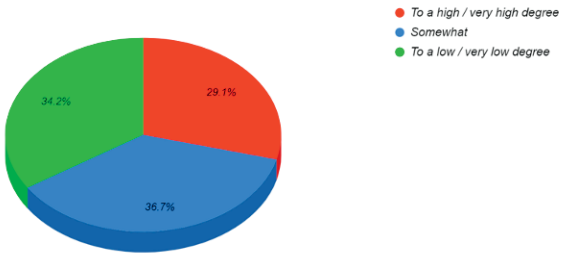


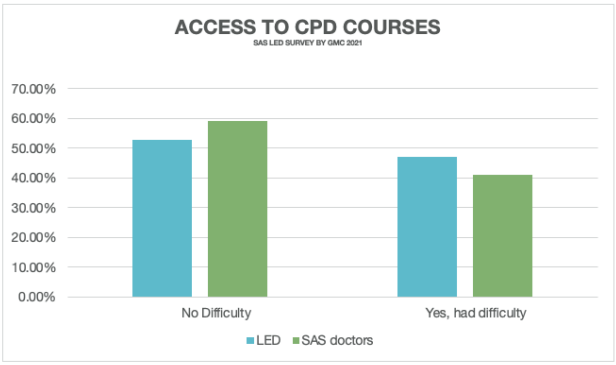


SAS-LED survey by GMC, 2021

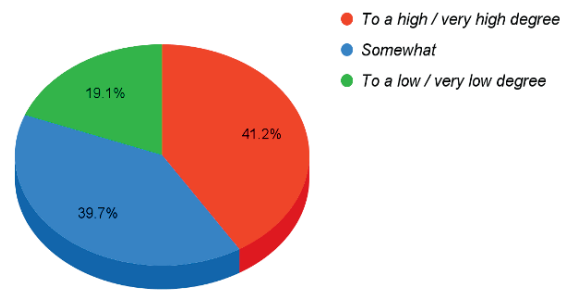


Degrees of Burnout among LEDs





Emotional exhaustion among LE doctors



RECOMMENDATIONS

Locally Employed Doctors Charter

1

National harmonised nomenclature, job description, criteria for recruitment and employment contracts.

a. Nomenclature

1. All names describing the LED roles, i.e. Trust Fellow, Clinical Fellow etc., should be replaced by the consensus nomenclature of Clinical Fellow. Based on seniority, these should be;
    a. Junior Clinical Fellow (JCF) in 'x' speciality (0-4/5 years post-qualification- thus equivalent to Foundation and Core training periods)
    b. Senior Clinical Fellow (SCF) (⅘ to <10 years post-qualification- therefore equal to Specialist training or registrar grades ST4-7/8)
    c. In primary care, these should be designated as Junior GP Fellow (0-4 years) and Senior GP Fellow (In year 5, thus equivalent to GPST3 and above)
    d. Speciality Doctor - is suitable for those in LED roles equivalent to SAS.

b. National consensus terms and conditions which offers

1. Equal employment terms and pay - compared to trainee grades, including access to NHS pension and pay protection when moving between NHS organisations as per time in employment and roles. JCFs will be equivalent to Foundation and Core trainee roles, while SCF will be equivalent to the specialist trainee pay scales.
2. Annual and study leave access should equal trainees working on the same rota.
3. After two years of continuous employment with an employer (back-to-back one-year contracts count as continuous), LEDs have the right not to be unfairly dismissed and to compensatory payment if made redundant. (BMA Checklist)
4. Recruitment - should be by standardised job descriptions which will model a 10-session job plan.
5. Out-of-hours work will be scheduled per the current working time directives and remunerated per national terms and conditions using the 'unsocial hours' formula agreed upon by NHS Employers and the trade unions.
6. When recruiting, IMGs should adhere to the WHO Global Code of Practice.
7. Job plans should provide a minimum of 1 session per week for continuing professional development, including appropriate funding for mandatory courses per speciality training schedules for JCFs and an additional Supporting Professional Activity session for SCFs.

RECOMMENDATIONS

Locally Employed Doctors Charter

2

2. LED Lead or Champion

Every healthcare organisation will appoint or delegate a senior clinician, preferably with appropriate experience or training to be the LED Lead/ Champion. The LED Champion will oversee the Job descriptions, ensure the quality of induction, supervision, and resources for career development, and seek and report on LED feedback to the HR Director of Trust Board annually.

3

3. LED Forum & Representation

Every healthcare organisation should resource and support a regular forum for LEDs to provide representatives from each speciality/ care group/department to discuss issues related to clinical work, governance, support, culture, education-training and career progression. This forum should be chaired by an LED representative duly elected/ appointed and will be attended by members of HR, trade unicorn, education and clinical leads.

4

4. LED Induction

1. UKGs - The fundamental principles of a comprehensive, meaningful induction at the corporate and speciality/ department levels will apply to any LEDs joining an organisation.
    a. This should include an introduction to/ refresher on the Good Medical Practice Guidance from the regulator and how to avoid common pitfalls.
    b. Importance of joining a medical defence body
    c. The role of medical royal colleges in curricula and training (portfolios)
    d. The part played by speciality societies and voluntary professional organisations in career development

RECOMMENDATIONS

Locally Employed Doctors Charter

4

4.b. Induction for International Medical Graduates

1. IMGs - should receive enhanced induction, which will include
    a. an appropriate introduction to NHS processes, management, structure,
        i. Names of key people in the organisation/departments.
        ii. Information about rota, working hours, and exception reporting. Ensure adherence to NHS Good Rostering Guide for unified work schedules and rota involving; safe shift swapping, shadowing and checking the system to avoid on-call duties in the first few months until LED settles, enables breaks and off-duty periods.
        iii. Access to appropriate handbooks (print or electronic) and e-learning modules.
        iv. Clinical Attachment period for two weeks to get accustomed to the NHS system.
    b. Governance processes and how to raise concerns
    c. Locally relevant linguistics, cultural competency and
    d. communication training, including safe use of social media/ networks
    e. Introduction to concepts of equality, diversity and inclusion - i.e. how to be aware of and tackle - differential attainment, bias, bullying and harassment
    f. Signposting to available support from employers, voluntary organisations, and trade unions.
    g. Wellbeing resources for self, family and social networks and sources for help in settling in the UK
    h. How to get an NHS number and register with a GP
    i. Initial accommodation assistance, relocation allowance and priority for hospital accommodation while relocating.
    j. Provide services and/or information on setting up banking, help with pay slips, pension contributions and taxation

RECOMMENDATIONS

Locally Employed Doctors Charter

5 Supervision and appraisals

5

1. All LEDs will be appointed an educational supervisor who will provide support for clinical training, agree on personal development plans, oversee access to and use of relevant speciality portfolios and provide career support/ signposting to developmental resources.
2. The ES will have allocated time in their job plans (equivalent to 0.25 PA) and be fully trained and accredited as a named supervisor meeting the GMC seven domains.
3. All LEDs will access their relevant portfolio and appraisal software/ toolkit to meet their annual appraisal and revalidation goals.
4. There will be minimum documentation of an induction, mid-term and end-of-placement meeting between ES and LED.

6 Education & Training

6

1. LEDs will have access to all the relevant education and training opportunities that are considered.
2. Statutory and mandatory for their employment by the employer
3. Content (generic, core and speciality related) that is within requirements for revalidation as per the relevant speciality curriculum or as laid down by the medical royal college or the regulator
4. A minimum of 50 hours per annum of documented training, including external or formal accredited courses amounting to 50% of the annual allocation
5. Supporting supervisors to give prompt, tailored and real-time formative feedback
6. Specific support for speciality examinations, CESR applications

RECOMMENDATIONS

Locally Employed Doctors Charter

7 Leadership

7

1. LEDs should have access to leadership and personal development training at different levels, either as foundation courses, middle grade and senior level depending on their roles and experience.
2. Access to funded or part-funded NHS Leadership Academy programs based on seniority and roles
3. Opportunities to undertake leadership and service level roles within the organisation, e.g. representatives, joining committees and project teams as per interest and expertise
4. Opportunities to undertake service improvement, audits and quality improvement projects will be provided with support, training, and resources to deliver.

8 Teaching

8

1. LEDs will have equal opportunity to develop as a teacher, train the trainer courses and additional teaching qualifications per personal interest, opportunity and organisational objectives.
2. LEDs will be provided training and resources to undertake roles as supervisors for doctors and healthcare staff (e.g. Physician Associates, Medical Assistants etc.) at the appropriate level, including formal roles as educational and clinical supervisors.

RECOMMENDATIONS

Locally Employed Doctors Charter

9 Career Support & Mentorship

9

1. LEDs will be encouraged to consider their career options and provided expert career guidance, taster sessions and support to take the next step in their career progression pathways.
2. Where relevant LEDs will be encouraged to consider the SAS career options
3. CESR application processes must be efficient and online. Flexible and proportionate methods should be implemented for gathering required education and training evidence from several institutions in the UK and abroad.
4. LEDs must be offered trained mentors by their employing organisations with appropriate awareness of the aspirations and hurdles.

10 Civility, Raising Concerns & Wellbeing

10

1. Employers should have systems that encourage a culture of inclusion, recognise diversity and offer a value-based team/ working environment.
2. Provide timely opportunities to raise concerns, and hold discussions without fear of repercussions
3. Provide anonymised and safe platforms to report issues with assurance to be dealt with and resolved promptly
4. Encourage a culture of zero-tolerance of incivility, participation in proactive awareness programs for EDI and signposting to specific guidance on culture and behaviour values.
5. Wellbeing
    a. National minimum standards for facilities in healthcare organisations must be introduced and followed to provide doctors with safe and effective means of transportation, hospital canteens,well-planned parking facilities, rest spaces and on-call rooms.
    b. To ensure the well-being of LEDs, they should have timely and efficiently accessible resources, e.g. well-being tools or questionnaires, which can recognise warning signs of stress or mental health issues.

BIBLIOGRAPHY

1 Jalal M, Bardhan KD, Sanders D, et al. INTERNATIONAL: Overseas doctors of the NHS: migration, transition, challenges and towards resolution. Future Healthc J 2019;6:76–81. doi:10.7861/futurehosp.6-1-76

2 Group BMJP. Report of G.M.C. inquiry. Br Med J 1975;2:183–8. doi:10.1136/bmj.2.5964.183

3 Group BMJP. Editorial: Tests on overseas doctors. Br Med J 1975;4:542–3. doi:10.1136/bmj.4.5996.542

4 Rich A, Viney R, Needleman S, et al. 'You can't be a person and a doctor': the work-life balance of doctors in training—a qualitative study. BMJ Open 2016;6. doi:10.1136/bmjopen-2016-013897

5 Esmail A, Everington S. Racial discrimination against doctors from ethnic minorities. BMJ 1993;306:691–2. doi:10.1136/bmj.306.6879.691

6 Simpson JM, Esmail A. The UK's dysfunctional relationship with medical migrants: the Daniel Ubani case and reform of out-of-hours services. Br J Gen Pract 2011;61:208–11. doi:10.3399/bjgp11X561230

7 Esmail A, Simpson J. International medical graduates and quality of care. BMJ 2017;356:j574. doi:10.1136/bmj.j574

8 sas-and-led.pdf. https://www.ouh.nhs.uk/education-centres/training/documents/sas-and-led.pdf (accessed 20 Mar 2021).

9 Noaman I, Dhahri AA, Mohammed E. Another lost tribe: Quantifying the experience of international medical graduates applying for a national training number (NTN) in the United Kingdom with a cross-sectional study. Annals of Medicine and Surgery 2021;69:102665. doi:10.1016/j.amsu.2021.102665

10 Bourne T, Wynants L, Peters M, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. BMJ Open 2015;5:e006687. doi:10.1136/bmjopen-2014-006687

11 Bourne T, Vanderhaegen J, Vranken R, et al. Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data. BMJ Open 2016;6:e011711. doi:10.1136/bmjopen-2016-011711

12 Horsfall S. Doctors who commit suicide while under GMC fitness to practise investigation. ;:83.https://www.gmc-uk.org/-/media/documents/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf

13 Ortashi O, Virdee J, Hassan R, et al. The practice of defensive medicine among hospital doctors in the United Kingdom. BMCMedical Ethics2013;14:42.doi:10.1186/1472-6939-14-42

14 NHS England » We are the NHS: People Plan for 2020/2021 – action for us all. https://www.england.nhs.uk/ournhspeople/ (accessed 28 Sep 2020).

15 Issar P. The future of NHS human resources and organisational development. ;:44.

16 Welcoming-and-Valuing-International-Medical-Graduates-A-guide-to-induction-for-IMGs-WEB.pdf. https://www.e-lfh.org.uk/wp-content/uploads/2022/06/Welcoming-and-Valuing-International-Medical-Graduates-A-guide-to-induction-for-IMGs-WEB.pdf (accessed 12 Sep 2022).

17 Solet DJ, Norvell JM, Rutan GH, et al. Lost in Translation: Challenges and Opportunities in Physician-to-Physician Communication During Patient Handoffs. Academic Medicine 2005;80:1094–9.https://journals.lww.com/academicmedicine/Fulltext/2005/12000/Lost_in_Translation__Challenges_and_Opportunities.5.aspx (accessed 13 Sep 2022).

18 Gasiorek J, van de Poel K. Divergent Perspectives on Language-Discordant Mobile Medical Professionals' Communication with Colleagues: An Exploratory Study. Journal of Applied Communication Research 2012;40:368–83. doi:10.1080/00909882.2012.712708

19 Clay-Williams R, Ludlow K, Testa L, et al. Medical leadership, a systematic narrative review: do hospitals and healthcare organisations perform better when led by doctors? BMJ Open 2017;7:e014474. doi:10.1136/bmjopen-2016-014474

20 Cordoba EL, Shale S, Evans RC, et al. Time to get serious about distributed leadership: lessons to learn for promoting leadership development for non-consultant career grade doctors in the UK. BMJ Leader 2022;6. doi:10.1136/leader-2020-00039

21 McCrossan R, Swan L, Redfern N. Mentoring for doctors in the UK: what it can do for you, your colleagues, and your patients. BJA Educ. 2020 Dec;20(12):404-410. doi: 10.1016/j.bjae.2020.07.005. Epub 2020 Sep 8.

NEXT STEPS

CHARTER IMPLEMENTATION

The BAPIO SAS-LED forum will lead the work with all stakeholders to propose and implement a national job description, contract, terms and conditions and minimum standards per the Charter recommendations.

This will be followed by the design and delivery of a LED national survey collecting the experiences and comparing against the recommendations.

The team will develop and publish a self-assessment toolkit, an annual self-assessment schedule for all participating organisations and a national benchmark.

Once this has been accepted and necessary changes implemented, we expect this to become business as usual.

01 CHARTER Launch

02 LED National Contract & Terms of Service

03 LED National Survey

04 Benchmarking & Self-assessment

05 Business as usual

THE BAPIO

BIHR

INSTITUTE FOR HEALTH RESEARCH

bapio.co.uk/bihr

9 781739 953133

BAPIO
PUBLICATIONS

bapio.co.uk
admin@bapio.co.uk