

Flexibility in Training

LTFT and OOP



Spring 2026

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LTFT – Less than Full Time Training

- Since 2023; ALL well-founded reasons to undergo LTFT will be considered.
- i.e. NO Categories. The Gold Guide gives an indicative but not exhaustive list

Disability or ill health

Caring responsibilities

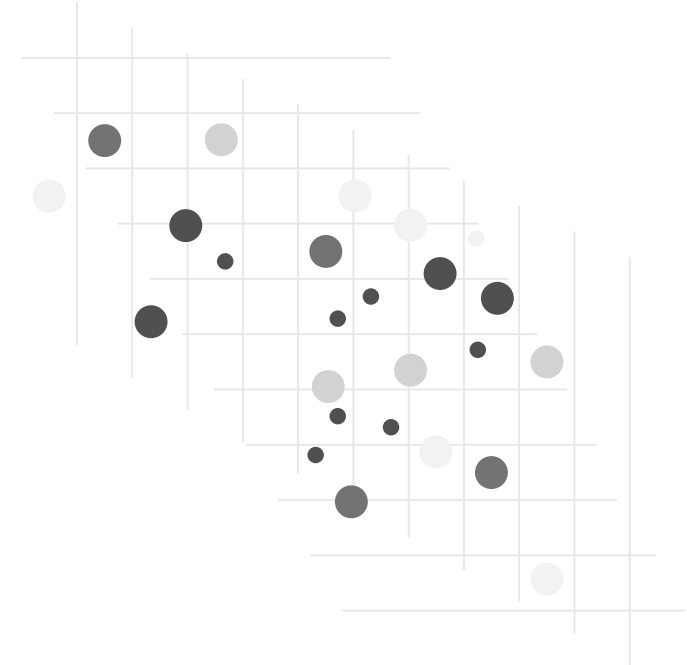
Welfare and well being

Unique career opportunities

Religious commitments

Non-medical development e.g. law degree

Development of a broad portfolio



Aims of LTFT Training

Retain doctors in the workforce who are unable to continue their training on a full-time basis for a well-founded individual reason

Promote career and personal development as well as work/life balance and wellbeing

Ensure continued training in programmes on a time equivalence (pro rata) basis*



(*but understanding that progression is competency based)

General principles

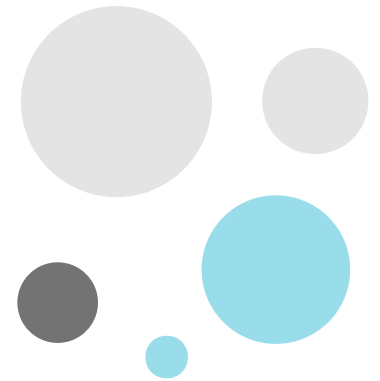
All residents including academic doctors can apply

Must meet the same requirements as FT residents

LTFT training reflects the same balance of work as WTE; generally,*
pro rata

Balance of LTFT training arrangements, the educational needs of
WTE and LTFT residents, and the needs of the service.

LTFT residents should have an ARCP every 12 (calendar) months,
assessed on a pro rata basis



Eligibility – Considerations

Employment legislation describing the statutory right to request flexible working sets the minimum standards with which an employer must comply.

The legislation does not set a priority order around any reasons for requesting flexible working.

Support to progress the application may be dependent on the capacity of the programme and available resources as well as compliance with relevant legislation relating to CCT requirements

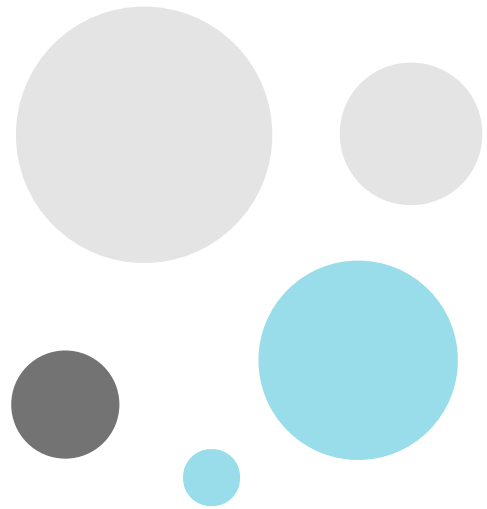
(some) stats

Currently, 21% of residents in EoE are LTFT– up from 15% few years ago

35% of applications received are from GP residents

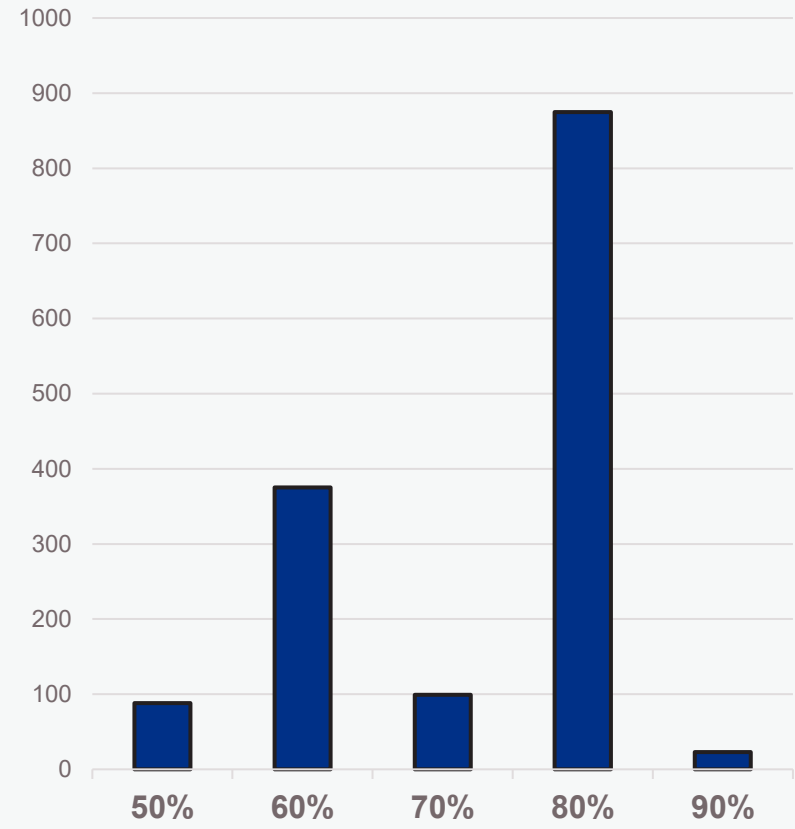
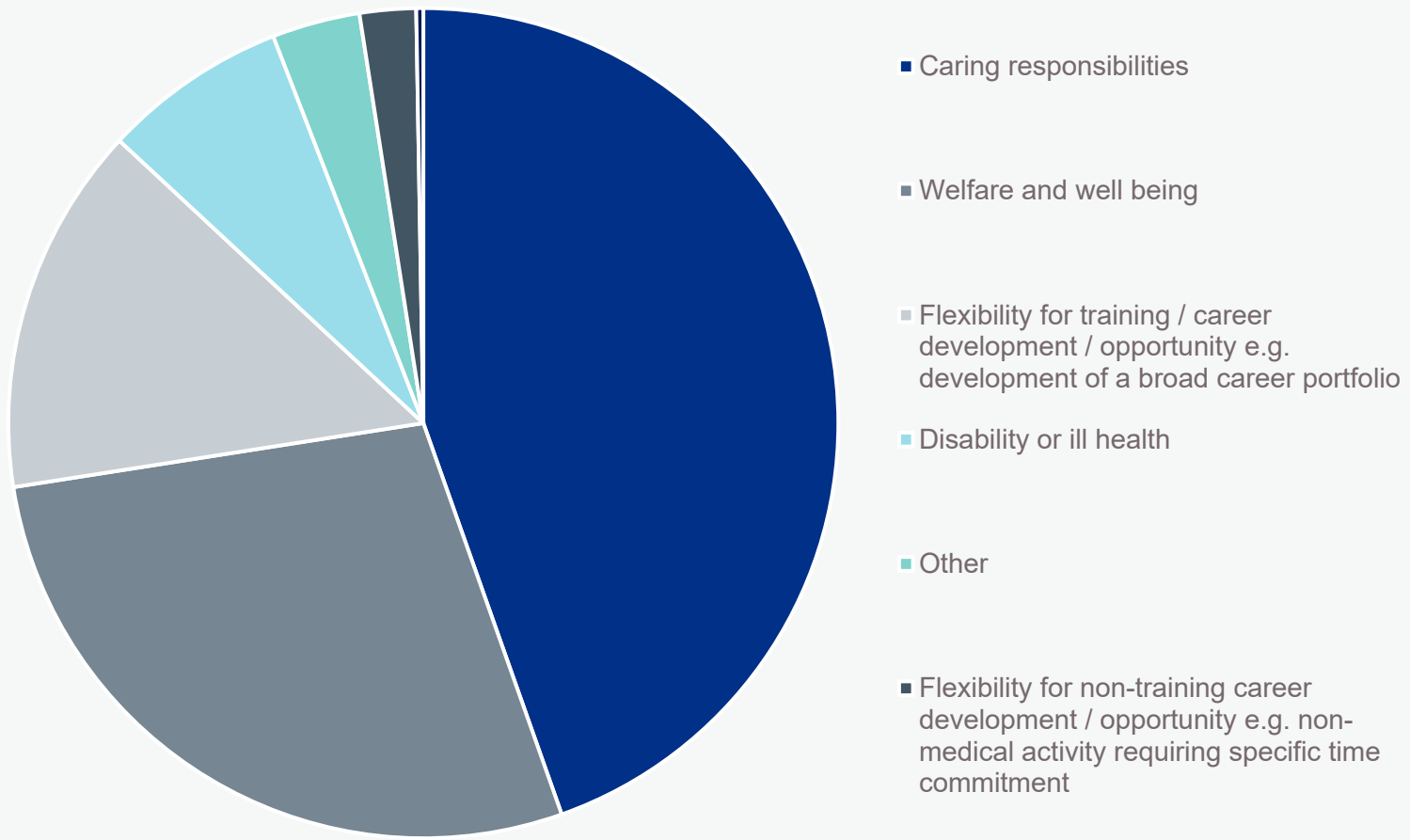
80% commonest % requested

Increasing applications but very limited comparable data prior to 2024 due to change in methodology



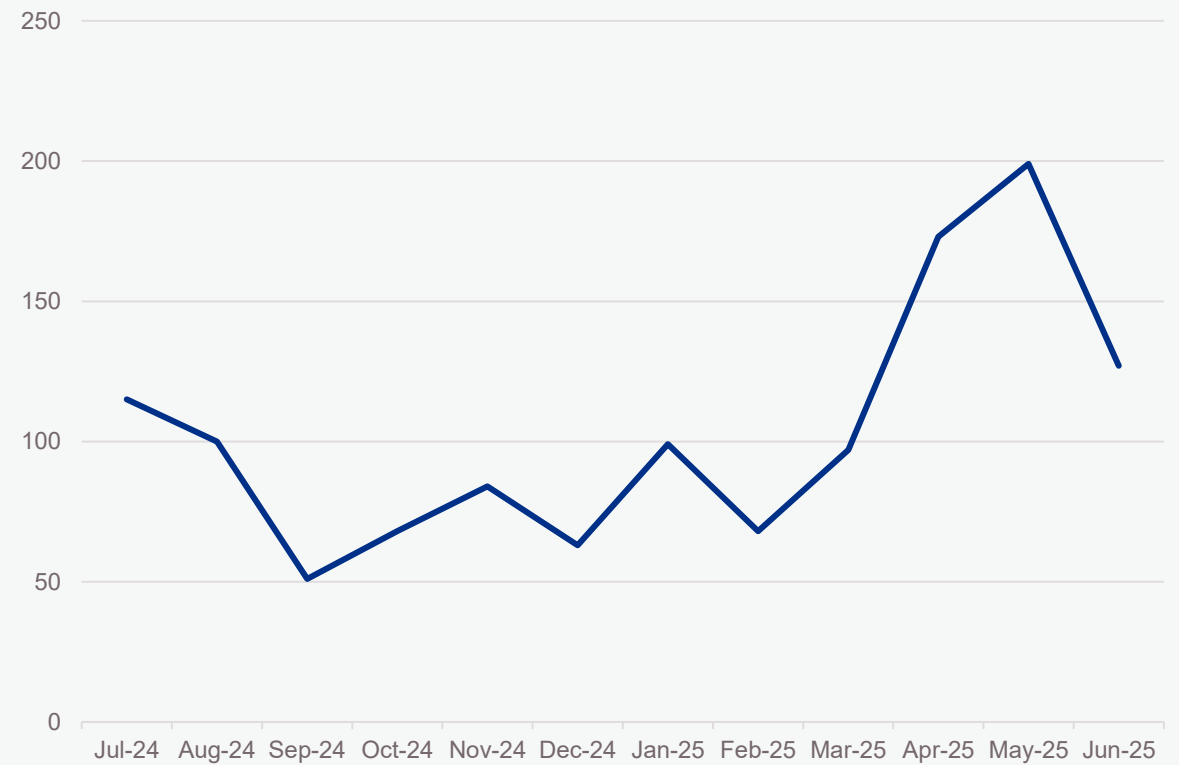
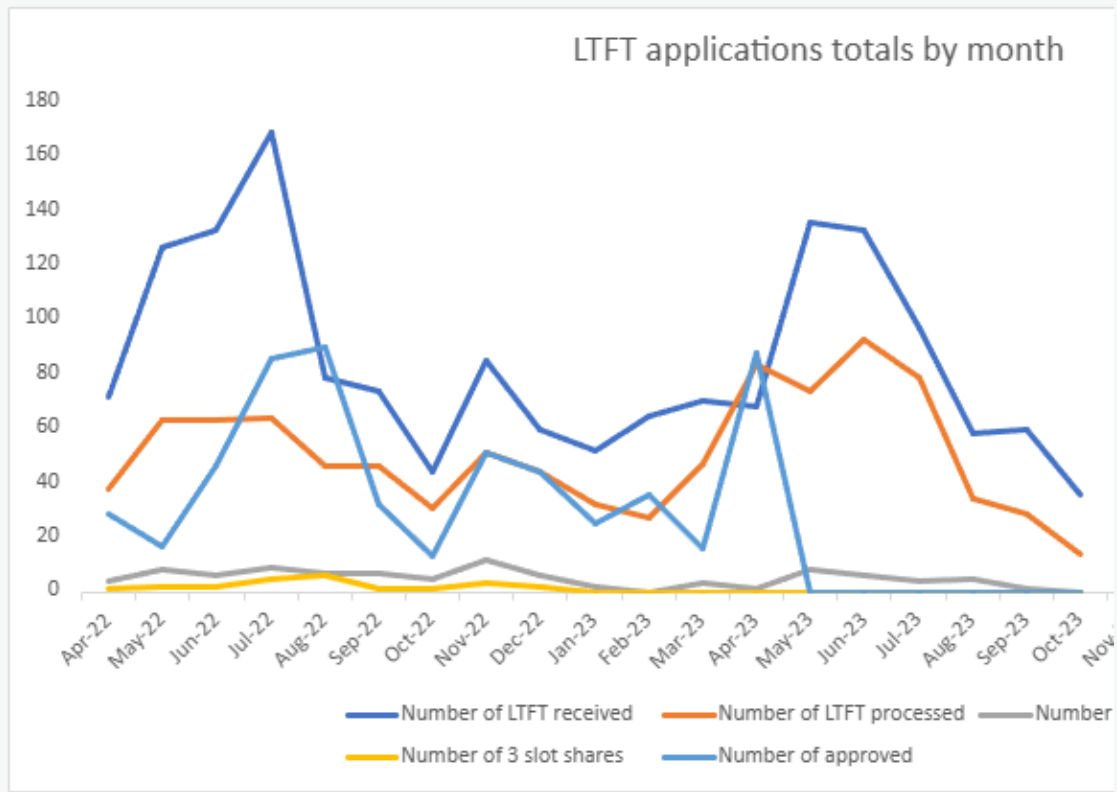
Request and %

Total

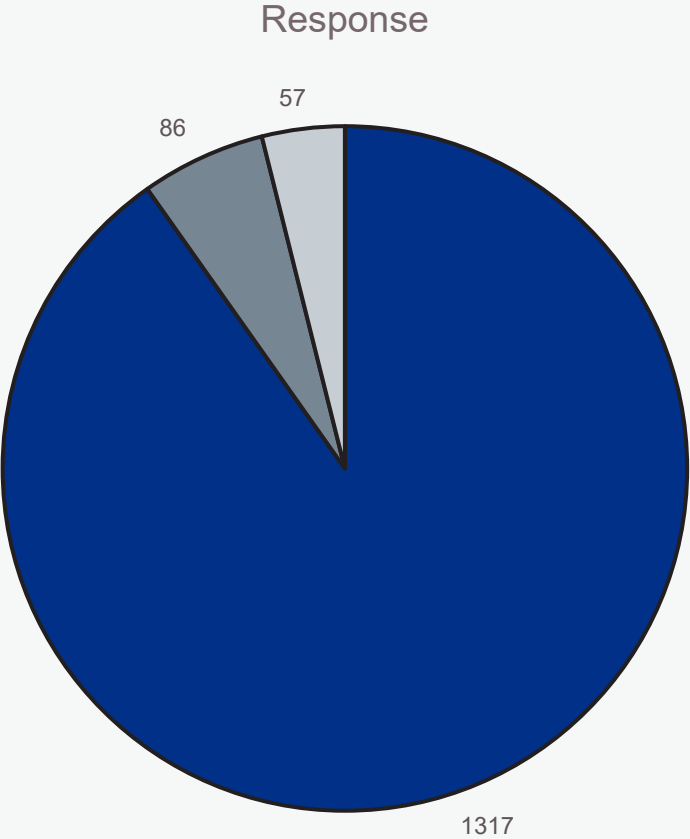


Month breakdown

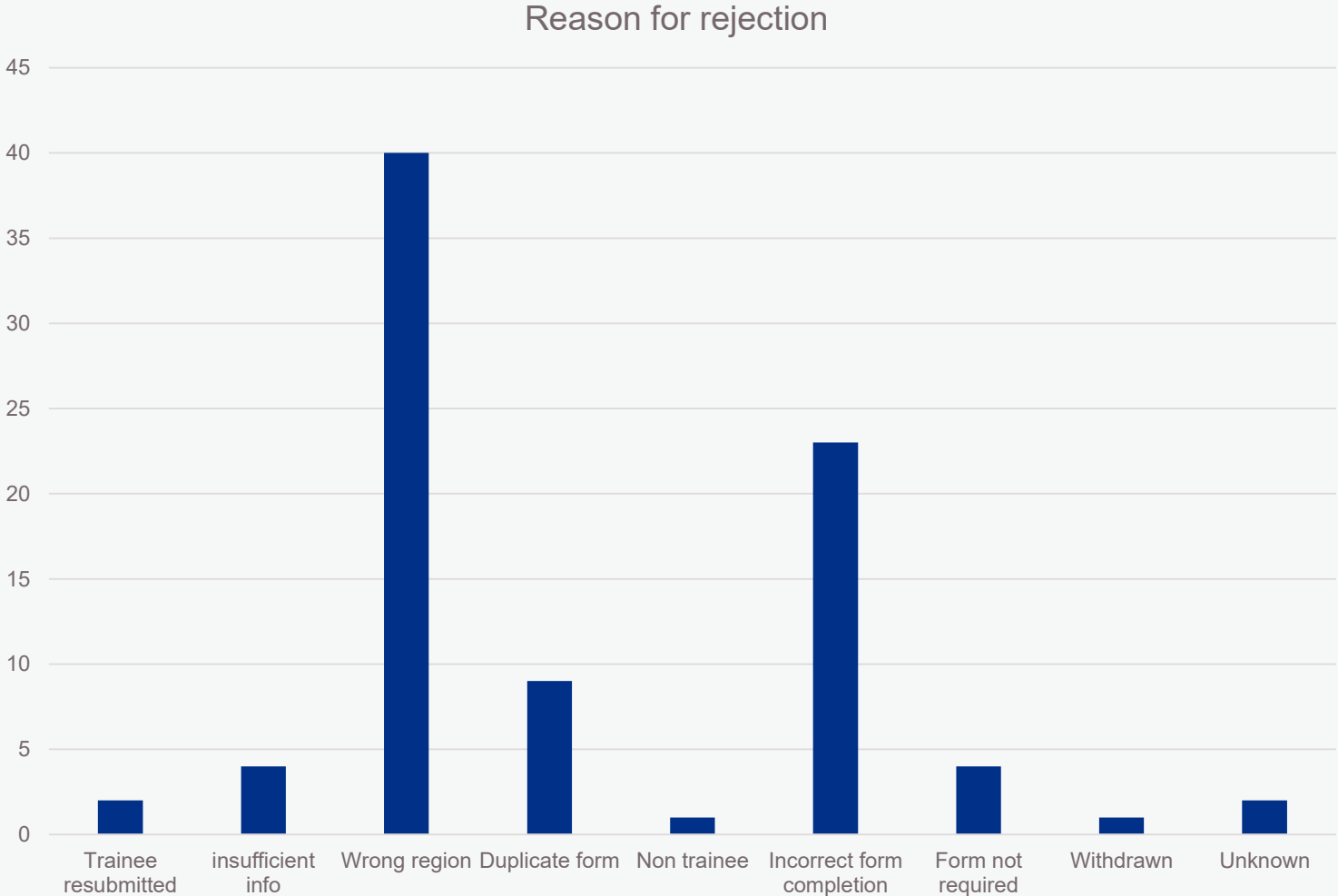
1460 total claims 17.05.24 – 02.07.25



Application Outcome



■ Approved ■ Rejected ■ Pending



Organising LTFT Placements

Percentage

- 50-90%*

Slot Shares – Wherever possible!

- Guidance is on the LTFT website
- Top up of the salary contrib. where WTE > 1.0
- Top up of the placement tariff where the WTE > 1.0
 - E.g 2x 60% in 1 post (1.2 WTE) – 20% top up, 3x 80% in 2 posts (2.4WTE) 40% top up.
 - No restrictions in what % LTFT can go in a slot e.g. can have 80% +60% in one
 - NHSE will fund normal salary (not on calls) – on calls shared within slot or agreed with trust locally

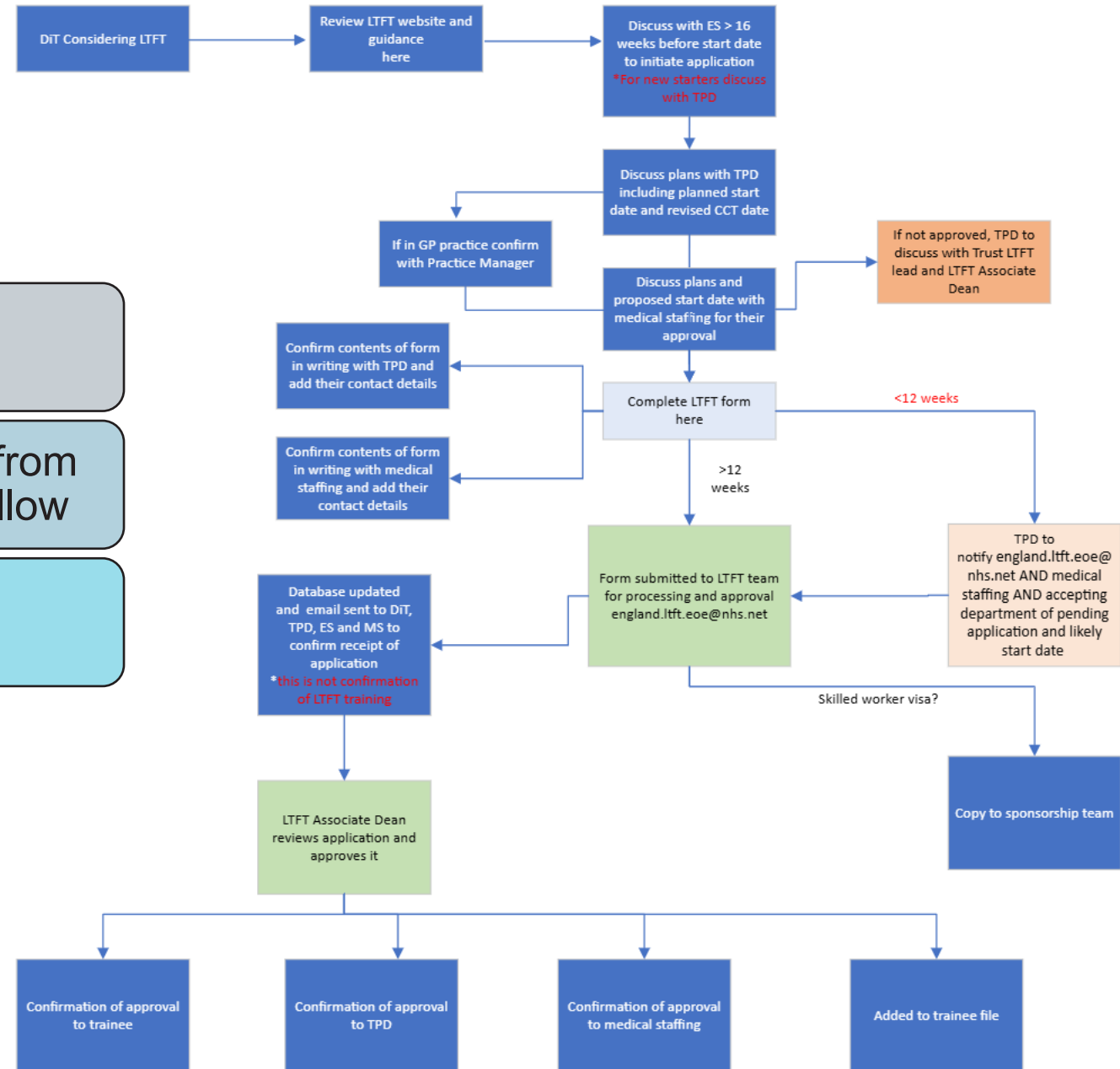
LTFT Process

New MS Forms LTFT form since 2024

Process and form developed with stakeholders from NHSE, Trusts, educators, trainees and LTFT Fellow

Form and process is (mostly) automated

[How To Apply | East of England \(hee.nhs.uk\)](https://hee.nhs.uk)



LTFT Process

Step 1: >16 weeks in advance)

- Discuss with educators and host site
- Confirm %, dates/timetables, new CCT date



Declined Applications

"All well-founded reasons will be considered, however support to progress the application may be dependent on the capacity of the programme and the effect the request may have on the training available to other doctors in training on the programme. "

"It is expected that all those applying due to disability or ill health and caring responsibilities (i and ii above) will be accommodated."

7. Refusal of LTFT application

Where a request to work LTFT is rejected a member of the HEE Faculty (HoS, TPD, Postgraduate Dean or nominated deputy) should meet with the doctor in training to explain the reasons for the decision. The reason should align to the business reasons set out in the legislation: -

- the burden of additional costs
- an inability to reorganise work amongst existing staff.
- an inability to recruit additional staff.
- a detrimental impact on quality
- a detrimental impact on performance
- a detrimental effect on ability to meet service demand.
- insufficient work for the periods the employee proposes to work.
- a planned structural change to the business

If following discussion, there is new information or an omission it may be possible to accept the LTFT request with modifications. This may include working a different WTE or a change to the proposed start date or a change in the location of training.

8. Appeal

Where a request to work LTFT has been rejected the doctor in training has the right to appeal that decision. It is recommended that trainee first attempt to resolve any issues informally via discussion with TPD and the Associate Dean for LTFT. If a doctor in training has had their application to train LTFT declined, they may appeal in writing to the relevant Postgraduate Dean sending the email to ltft.eoe@hee.nhs.uk. The Postgraduate Dean's decision will be final.

FAQs

- **Can LTFT undertake additional work?**

Yes but must be in accordance with Good Medical Practice and not have a negative impact on training. Should be acknowledged on Form R

- **Can you do an LTFT and OPP simultaneously?**

No

- **Can Foundation Trainees work LTFT?**

Yes. The only time limitation is that provisional registration (i.e. F1) can only be held for 3 years and 30 days but most trainees can complete their Foundation programme within that time working at e.g. 60% LTFT.

- **Can I choose which days I work?**

This needs to be negotiated with the local employer, and renegotiated each time the LTFT doctor rotates.

- **If I undertake an NHSE Fellowship do I have to go LTFT?**

Depends on speciality/curricula and personal choice

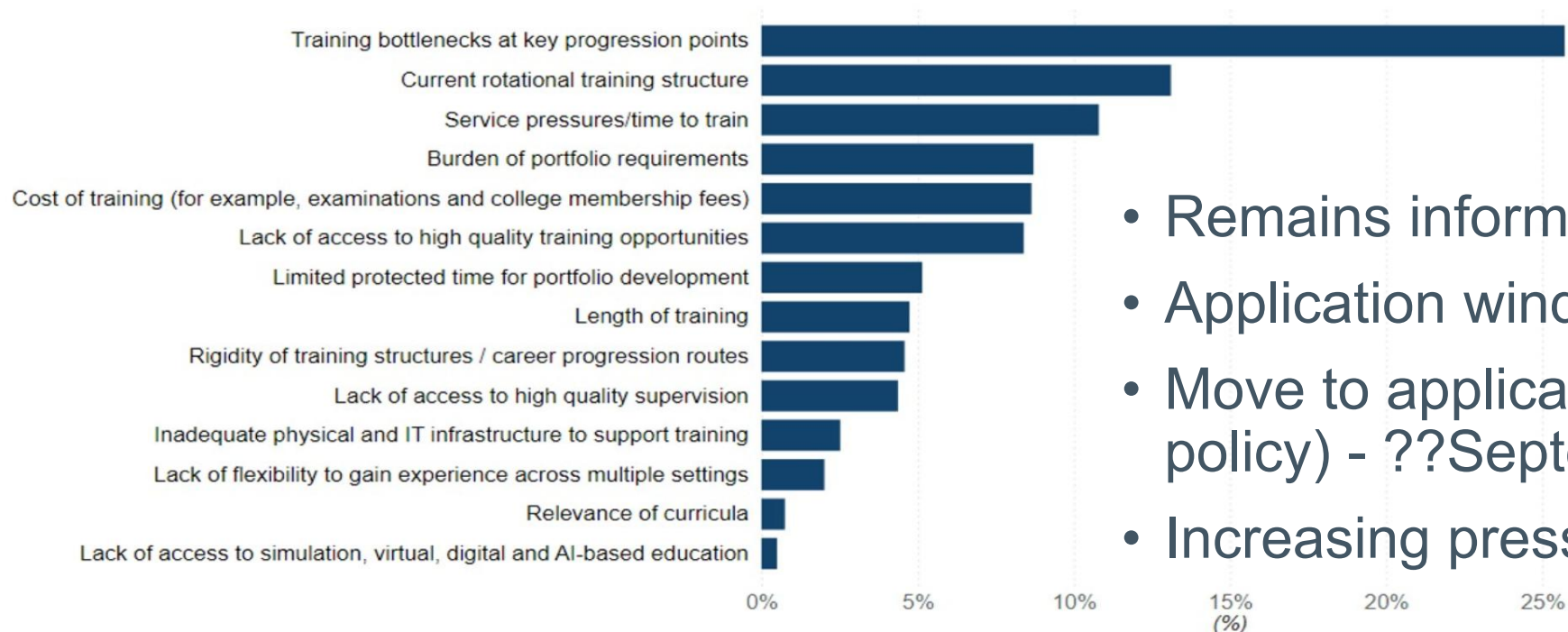
- **How does on call work with slot shares?**

Slot share should cover the line on the rota on a pro rata basis (between slot sharers). On call above this can be negotiated with the local department (on calls funded by trust – national stance is that on call is service provision not training...)

What next for LTFT?

[NHS England » The Medical Training Review: Phase 1 diagnostic report](#)

1. Training must become more flexible
2. We must build on excellence beyond formal training routes
3. Current training bottlenecks are damaging and must be addressed
4. We need to rebuild inclusive team structures where doctors at every stage of training feel valued



- Remains informed by national policy..
- Application windows?
- Move to applications on TSS (national policy) - ??September 2026
- Increasing pressure on trusts/expansion

Out of Programme (OOP)



What are OOPs used for?

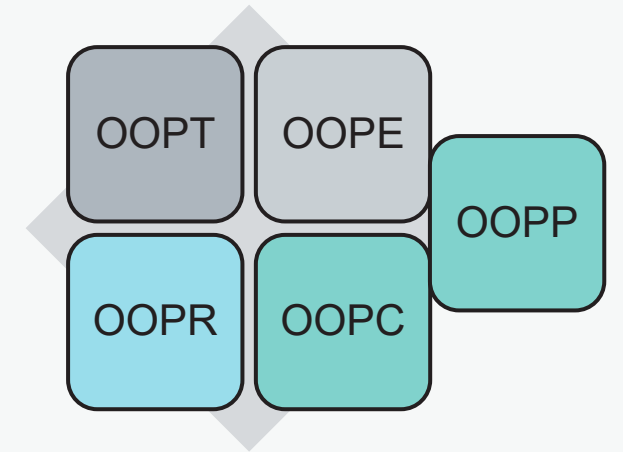
Undertaking clinical training that is not part of the programme (OOPT)

Gaining other professional skills (OOPE)

Doing research (OOPR)

Taking a planned career break (OOPC)

Undertake other work as supportive measure (OOP-P)*



OOPT

Up to a year

Counts towards training

- (which might need additional approval)
- Need to submit in good time!

Usually restricted to training not available in the region

- (if applying for out of region training)

Acting-up posts at end of training

- (if allowed by College/Faculty)
- 3 months, or pro-rata for LTFT trainees(usually)



OOPE

For other professional skills

- e.g. clinical placement in non GMC approved setting
- Education, leadership etc.

Doesn't count towards training time

Up to 1 year

Might have visa implications



OOPR

For research ...

Normally for a higher degree

Normally not more than 3 years

- Can be extended to 4 (PGD exceptionally)
- Pro rata
- Clinical skills maintained?

Might count towards training

- (would need prospective GMC approval)

Not normally in final year



3.171 Many individuals undertaking such research retain a clinical element, which will allow them to maintain their existing capabilities while on OOP. The extent of this clinical element will guide HEE, NES, HEIW or NIMDTA and the relevant College/Faculty in making a recommendation to the GMC on whether the clinical and research capabilities attained during OOPR should be used to contribute towards the award of a CCT. The trainee should seek advice from their TPD and named academic supervisor to ensure that the proposed clinical element is appropriate.

OOPC

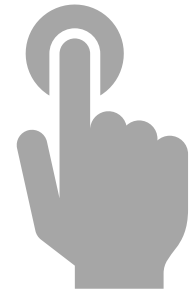
For domestic responsibilities, other interests

Up to 1 year (can be exceptionally extended to 2)

Not to manage sickness* or defer the start of training

Pitfalls

- Visa impact
- Impact on employment/contractual rights/CCT date
- Very late applications
- Maintaining Clinical Skills
- Sickness vs recovery



OOP-P

Supportive measure piloted pre COVID

- Now business as usual

Post identified and suitability discussed with educator IN ADVANCE

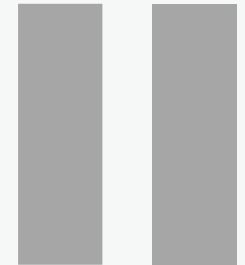
- NHS or non NHS
- patient or non patient facing
- UK or non UK!

Up to 1 year

Might count to training, determined **after** return at ARCP

Guidance on website

Visa implications



OOP-P Changes

Headline – increased flexibility...

*Gold Guide not yet updated...

Out of pilot → Business as usual*

NO LONGER needs to be in a patient facing role **OR** in the UK

The **potential** for programme directors to recognise competencies gained from outside of an approved programme on return to the programme is **confirmed**.

In place for 2 years from August 2024, then 12-month limitation will be reviewed

Evaluation to continue...

Planning an OOP



OOP form is only part of the process!

- PSW
- Thinking through needs of rotation
- Longer term plans
- **Supported Return to Training**

Other Points

- Must maintain license to practice
- Must participate in ARCP process (Form R)
- Must consider impact on continuous NHS service and visa (if applicable)
- Requirement to maintain contact with deanery

Discuss alongside OOP application

Postgraduate doctors in training will normally need to participate in a 'return to work' package at the end of OOPC. After a prolonged absence from clinical practice, a period of additional support may be beneficial on return. Employers may not have been aware or have considered the implications of prolonged absence and this may have implications for patient safety. Postgraduate doctors in training returning to clinical practice should access support by way of an appraisal of their needs to ensure a safe and timely return to training, whether this is full-time, LTFT or a phased re-introduction to clinical practice.

Thank You



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