# Updated Guidance for managing postgraduate medical trainees whose clinical activity has significantly been altered by Covid-19

**(Previously Guidance on Shielding Trainees)**

## What is New

1. This guidance updates the guidance published in July 2020 and takes into the account the following:
   - A number of trainees will be displaced from their normal clinical activity who do not fall into the clinically vulnerable or highly clinically vulnerable group.
   - The second surge of COVID-19 will prolong the time many trainees will need to shield for.
   - The prolonged nature of the pandemic has had a significant impact on a number of trainees who are now considering future career options.
   - Changes have been made to the section on pregnancy.
   - This updated guidance also incorporates key messages from the 'Support for Shielding Trainees' document produced by the shielding trainees group and the SuppoRTT program.

## Background

2. Shielding is a measure to protect people who are deemed to be at high risk from Coronavirus coming into contact with it, by minimising interactions between them and others.
3. The government advices those who are clinically extremely vulnerable (CEV) to shield, which means staying at home as much as possible and keeping outside visits to a minimum. These include, for example, recipients of solid organ transplants, people receiving radical radiotherapy, chemotherapy or immunotherapy for cancer, people with severe respiratory conditions such as cystic fibrosis and women with significant heart disease who are pregnant. A full list of indications for classification of CEV individuals can be found on the government website https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19#who-this-guidance-is-for
4. Clinically vulnerable (CV) people are at increased risk due to coronavirus but are not covered by the government advice to shield for CEV individuals. Nevertheless, these individuals are at increased risk in the clinical environment and, following an occupational health assessment, may not be able to continue in their usual clinical roles. Clinical vulnerable groups would include BAME individuals, pregnant women (especially beyond 28

weeks), and staff who have health issues that fall outside the CEV group e.g. diabetes, obesity. Further advice regarding vulnerability is due to be published based on work by the University of Oxford www.phc.ox.ac.uk/covid-risk-prediction in which age is the biggest determinator.

5. Other trainees will also have been displaced from normal clinical activity. This would include, for example, trainees that rely on lip reading to communicate or trainees who live with clinically vulnerable people, for whom the risk of contact with COVID-19 outweighs any risk to their training. The term shielding does not cover these trainees, yet the consequences of the pandemic are similar. HEE should use the umbrella term COVID-displaced to cover all trainees who are unable to continue their normal clinical work due to the pandemic.
6. Trainees shielding (and other COVID-displaced trainees) are not classed as on sick leave and may still be able to undertake work and gain competencies.
7. The employer, usually the NHS, is required to support all staff to enable them to stay well and to continue to contribute to work where reasonable adjustments can be made to accommodate them. Trainees who are clinically or highly clinically vulnerable may choose not to shield but they must be aware of any risks they take in doing so. Where it is not possible for a shielded NHS employee to work safely their employer will need to "exercise discretion and use the flexibilities available to support staff during the pandemic."[1] An excellent FAQs on shielding has been produced by Hill Dickinson.
8. Trainees, as with other members of healthcare staff, might be unable to undertake their normal clinical work long-term during the pandemic – e.g. if they are immunosuppressed, or short term – e.g. if they are pregnant. They might be 'shielding by proxy' to protect a member of their household, in which case there might be the possibility of alternative accommodation for the trainee to allow them to continue to work and train.
9. A number of trainees will not be shielding but may have their work pattern changed because of increased risk e.g. BAME trainees. They will face many of the same challenges as shielded trainees and any policy should also be sensitive to their needs.

## Challenges

10. COVID-19-displacement will cause significant disruption to trainees, affecting their ability to gain clinical competencies, deliver service and reducing access to other training opportunities. These challenges are likely to be exacerbated if further waves of the pandemic occur and further episodes of shielding are necessary.
11. The GMC has recently published relevant guidance on enabling doctors with health-related issues thrive within service provision and education and training: GMC Welcomed and Valued, Looking after Doctors Looking after Patients

[1] https://www.nhsemployers.org/covid19/staff-terms-and-conditions/staff-terms-and-conditions-faqs/pay#Shielding

12. In approaching these challenges, the interested stakeholders are:
    - Covid-displaced trainees need to maintain engagement with their training programme, need financial stability through continuity of service and employment and need access to appropriate advice and support to guide them through the pandemic.
    - Their employer supported by their occupational health resource to respond reasonably and fairly to their employee's need.
    - Their Postgraduate Dean and Responsible Officer (or nominated deputy i.e. Head of School / TPD) with responsibilities to ensuring access to quality managed training opportunities in line with curriculum requirements and to provide oversight that any reasonable necessary support is available.
    - The HEE local office in providing support to trainees who will be isolated and anxious both about their own health and the training and other implications of shielding. This may involve mental health support.
    - The wider education network involved in supporting and quality managing their training including DME and clinical / educational supervisors. Educational supervisors will play a critical part in determine with the trainee the impact of shielding on their training.
    - Their Royal College: changes made by the Royal Colleges, to decision aids as part of the Covid response to continue to apply to trainees who are coming out of shielding.

## Scale of the issue

13. We know that during the first surge 1343 trainees were shielding, with 284 of these shielding due to pregnancy. At least 310 felt that this was likely to impact on their ability to rotate at their next rotation point, which, for many, was August.

## Recommended approach

14. HEE needs to develop a robust policy to support trainees who are COVID-displaced and address the issues detailed above. This policy must cover the needs of those that remain displaced, those that are returning to work (some of whom may be placed at some future point) and those whose feel uncomfortable about returning to their original role.

15. It is currently uncertain how these trainees will be affected when formal shielding comes to an end. Some trainees may still feel uncertain about returning to their previous clinical environment and those that do return will have been away from the clinical environment for at least three months. This may be early on in their programs or at critical transition points and any policy must reflect these issues.

The following guidance is therefore proposed.

## Trainees currently displaced

16. All regions should ensure robust log is kept of all displaced, with the reasons for displacement. This information should be collated nationally to determine whether any adjustments could be made for specific groups of displaced trainees.

17. All regions should ensure that displaced trainees have regular reviews documented to cover circumstances, support needs and training / employment options.

18. Displaced trainees should be able to acquire competencies through non-clinical work such as quality improvement projects, educational projects and leadership and management work.

19. A certain number of clinical competencies can potentially be gained through virtual clinics, remote imaging reporting, remote reporting of physiological tests etc. Many of these skills will be particularly appropriate as these become a standard part of clinical practice. There are a number of training modules on virtual clinical activity already available and these, as well as examples of best practice, should be made available to both trainees and their supervisors. Educational and clinical supervisors should ensure that the trainee is able to fully take up the opportunities for virtual work.

20. A PDP should be agreed between the trainee and educational supervisor that reflects the clinical and non-clinical training opportunities available.

21. Trainees need to continue with remote clinical (if appropriate) supervision. te e-portfolio should continue to be completed and will be the record of competencies gained during this period. Displaced trainees currently report that the quality of clinical supervision is very variable and local offices should consider whether this requires upskilling of clinical and educational supervisors and how this can best be achieved. Many trainees report using their own equipment for virtual clinics and there is poor availability of software to allow for robust supervision. HEE local offices need to work with trusts to ensure that trusts provide the equipment needed to undertake virtual clinical work safely, and in a manner compatible with their training needs.

22. Displaced trainees also report variability in educational supervision. Trainees report feeling uncomfortable approaching educational supervisors remotely being concerned that they are busy clinically and should not be disturbed. There is a feeling of 'out of sight, out of mind'. This natural response needs to be acknowledged and educational supervisors and schools will need to be more proactive in engaging with shielding trainees. Assigning senior educators, for example associate deans or TPDs, to support those who are supervising shielding trainees should be considered by local offices, together with a lead educator to support this work and enable sharing of best practice. Displaced trainees also report (unintentional) inappropriate advice and comments from some educational supervisors. Upskilling of supervisors may be appropriate and HEE is currently developing an e-learning program for educational supervisors of displaced trainees.

23. Trainees remain on training programs so will be subject to an ARCP. The 'no fault' COVID 10.1 and 10.2 outcomes are likely to be appropriate for many displaced trainees, though some may still gain an outcome one, and other non-standard outcomes may be appropriate.

24. Having to stay away from the clinical environment is very isolating and, in conjunction with the distress caused by interruption in the training, may lead to significant well being problems. Local offices will need to develop policies for regular pastoral support for trainees, either through the regular educational supervision or through additional routes. Educational supervisors may require upskilling/guidance in the detection and initial management of well-being issues in shielding trainees. All PSW teams should be aware of

specific resources available for displaced trainees. These resources address some of the unique issues faced by shielding trainees such as guilt and anxiety.

25. As well as support from PSW trainees should be made aware of the support available through the shielding trainees advisory group S-STAG who can advise on current resources and other peer support, for example, through social media.

26. Coaching should be made available to all displaced trainees, through their local Professional Support and Well Being Units or SuppoRTT team.

27. The decision as to whether the trainee remains out of their normal clinical environment will be made by the employer in discussion with the trainee (specifically, the decision to offer shielding is an employment one guided by occupational health and government guidance). Whereas it is likely that most trainees will be displaced for a period of a few months it is possible that some trainees e.g. those undergoing active treatments that impact on immune function, may be shielding for considerably longer. Gold Guide recommendation, (GG8:1.15), which states that it is for 2 years maximum before their PGD assesses whether to continue holding their NTN or to remove it, should be followed. However, trainees in this situation may feel uncomfortable with their present career choice and may wish to explore how they should progress. Detailed and documented discussions should be held with these trainees by senior members of the educational faculty e.g. TPD, Head of School, APD at six-monthly intervals, which if appropriate should include career advice and appropriate signposting.

28. If a trainee is unable to temporarily undertake a patient facing role consideration could be given to granting an OOPE during this time. This will not need the usual amount of notice since displaced trainees will be making less (if any) contribution to rotas and approval (if appropriate) of such requests should be expedited.

29. Plans will need to be in place to ensure that trainees can return to program once they are no longer displaced and resume normal clinical activity. The decision as to whether these trainees are ‘put on pause’ and return to their previous post, enter what would have been their next post and are otherwise fitted back into the program is a complex one that will be managed by the local office.

30. Consideration will need to given to trainees who are due to rotate whilst displaced. Changing work environments whilst displaced will be difficult, leading to problems with induction and familiarity with a new work environment whilst working virtually. Most trainees are likely to be best served by remaining within their current posts, though exceptionally a trainee may benefit from by moving to another post. This should be dealt with by local offices on a case by case basis and in consultation with the employer, with consideration given both to the experience the trainee is currently getting whilst training and the opportunities offered by the new post.

## Return to Clinical Work

31. Trainees should meet with their educational supervisor as soon as they have a return to work date. This meeting could be virtual and held in advance of the return to work. The following should be covered.

    - A check -in of wellbeing matters.

- A review, and if appropriate, sign off, of competencies gained whilst displaced.
- An assessment of immediate return to clinical training needs including need for formal return to training program. Local officers should provide information on all return to training courses/ support to inform this meeting. The SuppoRTT programme has been expanded specifically to accommodate the needs of trainees returning to work after Covid and should be considered for all trainees who have been off work for more than three months, as well as any returning trainee who feels they will benefit. Trainees who have been shielding for more than three months should be strongly encouraged to attend the SuppoRTT program.
- A discussion of how missed competencies can be gained during the rest of the training program (see below) to include those competencies potentially lost during shielding.
- To review any OH and employer recommendations regarding ongoing adjustments to work and assess the impact on training.

32. Following this meeting the educational supervisor and trainee are likely to be able to assess whether there is a likelihood that training will need to be extended. For planning purposes, the Head of School and Postgraduate Dean should be informed if there is a likelihood training time will need to be extended.

## Gaining missed competencies

33. For many trainees who are shielding towards the beginning of their training programs it would be reasonable to assume that competencies could be made up in their time remaining. However, from a purely practical perspective, these may not occur in an order that aligns with the decision aid and trainees may not meet the requirements for an outcome one for a number of years. Consideration should be given to either extending the current 10.1 option or adding a descriptor to the outcome 2. This, of course will be apply to all trainees affected by COVID.
34. For trainees nearing critical progression points catching up on clinical competencies may be difficult and it is important that we mitigate the impact of this. This will made more difficult by likely capacity problems within programs but possible options for consideration would be;

- Extending training by a period up to the number of months they were shielding.
- Considering dual-site working, for example being based at one site but undertaking procedures at another.
- Temporary fast track OOPT applications. This would be more complex to arrange but would potentially benefit all trainees who have missed competencies due to COVID. Most OOPT in these circumstances is likely to occur in training sites already recognised by the GMC, avoiding the need for GMC approval.
- Encouraging use of OOPP (but this both carries a risk that competencies are only assessed on return and the trainee may not have time on return to demonstrate these). Any OOPP should only be taken after the trainee has been back in the program for three months to allow re-familiarisation with their specialty in a training program. This time will also allow the ES and trainee to discuss whether they are at a stage where working outside a formal training program will be beneficial.

- Prioritising these trainees in the training program (this is essentially part of the holistic approach to program management. Assigning program allocations on the basis of recruitment scores may be inappropriate.

### Pregnancy

35. Some trainees who are shielding because of pregnancy may return to work if recommendations on shielding change, whereas others may progress straight through to parental leave. Any guidance would apply at the first point at which they return to clinical work.
36. Many pregnant trainees will have been off work for longer than they originally planned and may have experienced high levels of concern and difficult decisions regarding leaving clinical work early which can have significant psychological and wellbeing effects. These trainees may need additional support (over and above that usually given following parental leave) and this must be recognised in their return to work process. Educational supervisors should be specifically alerted to these issues and seek support from the lead educator.
37. Trainee who have been shielding due to pregnancy should not be made to feel under any pressure (perceived or otherwise) to shorten the period of their parental leave to compensate for the time they were out of the clinical environment whilst pregnant.

## Career Decisions

38. Many trainees will face uncertainty about current career choices. It is important to give trainees the space to discuss these uncertainties without seeming to apply any pressure to make premature decisions.
39. Any trainee who wishes to explore a career change should be supported in doing so and it should be made clear that taking this action does not prejudice their future in their current specialty.
40. Should a trainee remain displaced from their normal clinical activity for over a year, and there is no obvious prospect of return, then it is important for the educational supervisor to prompt a discussion about their future career. It is unlikely that the educational supervisor will have the expertise to fully advice and support the trainee in this discussion, which should be held with a senior and informed member of the postgraduate team.
41. HEE should work with the Royal Colleges and regulatory authorities, as well as the other four nations, to determine the possible transfer of curricular competencies for those displaced trainees who change specialty. The gap analysis tool, being developed by the Academy of Royal Colleges, would be the most effective way of documenting these competencies.
42. HEE should consider whether there should be any adjustment to the recruitment process for those trainees, on an outcome 1 or 2 (or 10.1/10.2), on a normal training trajectory, who have had to change specialties as a consequence of likely further restrictions to their clinical practice.

## Employment Issues

43. There are a number of employment challenges, that are beyond the scope of HEE, but that are necessarily causing concern to trainees. HEE have worked together with NHS employers and have agreed to following recommendations:

44. Trainees can remain within a program for up to two years before the Postgraduate Dean is required to assess whether they should retain their NTN. During this period they should remain in employment, with their placement managed as described above.

45. Trainees who are displaced will still be entitled to a period of grace. We are awaiting guidance from NHS employers on their status once the period of grace comes to an end.

46. Many trainees are reporting a lack of information regarding return to work and implications with regard to issues such as death in service. Advice to employees is not within the remit of HEE and NHS Employers should work with the BMA to ensure that this advice is available on a single website and that trainees are signposted to it. The NHS Employers website does contain some information https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/supporting-our-most-vulnerable-people

47. It is possible that some trainees may finish their training program and no longer be able to work. This will be the same for other professional groups and work needs to be done to determine the support the NHS can give to these individuals.

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