Restarting training for trainees that have been shielding or are displaced

INTRODUCTION

The concept of "shielding" has become well defined during the COVID-19 pandemic and suggests that individuals and groups who are identified as being potentially at increased risk of severe disease if they become infected should take more intensive efforts to avoid becoming infected. Given that the efforts taken may include staying at home and/or avoiding the workplace, these may have a very significant effect on training. As the COVID-19 pandemic has progressed, it has become apparent that some groups are at more risk than others, and it is possible to make a more nuanced and individualised risk assessment based on more current knowledge. Similarly, there are trainees who have not had to shield because of personal issues but due other circumstances have been displaced away from their normal work-place. The progress of such trainees with their programmes may have been compromised and their situation may be considered in parallel to trainees who are or have been shielding.

RISK GROUPS

The government advises 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 may include recipients of solid organ transplants, people receiving cancer therapies, people whose underlying condition or therapy results in immunosuppression among may other groups which are listed at 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

These conditions do not include the groups who have been subsequently been identified as clinical vulnerable and it has become apparent that the truly clinically vulnerable have older age, obesity, hypertension, pregnancy beyond 28 weeks gestation, type 2 diabetes, pre-existing severe liver disease and come from a BAME ethnic background.

DISPLACED GROUPS

There are some trainees who are not vulnerable but for whom the pandemic has significantly altered the way in which they function. These include trainees who suffer from hearing disability and rely on lip reading but will also include trainees who care for vulnerable people and have had to be displaced to minimise the risk to the care for individual.

Similarly, trainees may have been displaced from their usual place of training due to redeployment. This latter group is considered under the redeployment guides published separately by JRCPTB and the SEBs.

EFFECT ON MEDICAL TRAINING

It is possible that trainees who have moved away from patient facing care can be involved in other aspects of care including virtual outpatient clinics and telephone advice. This type of activity should be recognised as leading to acquisition of relevant capabilities and thus count towards training. Nevertheless, it is likely that for many trainees there will be a significant effect both on training and service delivery. It is critical that such doctors continue to feel valued in the NHS and that there wellbeing is catered for. The GMC has already provided guidance about how this:

GMC Welcomed and Valued:
https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/welcomed-and-valued/how-can-postgraduate-training-organisations-apply-their-duties

Looking after Doctors Looking after Patients:
https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

For those with longer term conditions, the return to training may be difficult and advice should be sought from the educational supervisor and/or training programme director to determine how to proceed. Trainees should ensure that they maintain contact with their educational supervisor and/or training programme director to ensure that support is always available and so that a personal development plan can be developed that reflects where clinical and non-clinical capabilities may be developed. It is also important that these are recorded in the e-portfolio to reflect how the trainee is progressing. The well being of trainees who are isolated because of the pandemic should be monitored carefully and it is important that the ES recognises the need to monitor the well being of the trainee with referral to the supportive mechanisms within local office of HEE (SuppRTT system) or deanery structure in the other nations as appropriate. No trainee should be pressurised into making decisions about their future training without significant time to consider where they themselves perceive their future career should be.
As the pandemic has progressed there are likely to be two main avenues that may be followed by the trainee that wants to return to clinical practice:

1. In discussion with the ES/TPD and occupational health the trainee expresses a wish to return to training in their main specialty. This may require agreement from the primary employer when the risk to the individual is considered.

   The return to training could be facilitated by:

   a) the trainee transiently undertaking training in a safer environment within a non-patient facing specialty under the auspices of an out of programme for pause experience. This can last for up to one year. The financial implications for the trainee would need to be considered but, in many situations, the continued clinical work should make sure that any adverse effect is minimised. During this the trainee will continue to gain capabilities that may be used to count towards their primary training programme. Once the intensity of the pandemic has resolved the trainee could return to their primary specialty.

   b) the trainee indicating that they acknowledge potential risks, and, with the agreement of the employer and occupational health, they return to training using available personal protection equipment to minimise risk.

c) Whenever the trainee does return there should be a review of their wellbeing and training progress with their ES with development of a specific plan to develop capabilities that are required to progress towards CCT. This approach should determine where the trainee should be placed to prioritise capability acquisition and minimise any requirement for an extension to training.

2. If the trainee has been not able to undertake the relevant clinical activities relevant to their specialty for over a year, then further discussion with the ES and possibly the TPD should be pursued. This is not to attempt to force any particular decision from the trainee but should attempt to pursue all avenues that are open to the trainee to maintain their position in training; opportunities for discussion within the deanery or local office, and with occupational health where this is appropriate, should be facilitated.

3. A trainee recognise that the training pathway chosen is no longer viable in the longer term for them individually. In discussion with their ES/TPD, they should investigate other training pathways either within the physician specialties or in another specialty of their choosing that is likely to have minimal direct patient interactions. It is possible that for this group of doctors, or indeed others who have had a significant illness (COVID or non COVID related) that prohibits them from proceeding further with a patient facing specialty, that a training programme in an alternative specialty could be identified within their locality that could fulfil their desire to continue training. It is likely that the trainee would have to apply for entry to the new specialty but with the capabilities gained may expect to progress more quickly in areas where there is commonality between the new and old specialty. When entering the new specialty, the trainee should have their previous training and experience considered in a gap analysis assessment so that capabilities already acquired can be considered and training in the new programme can be accelerated appropriately.

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