Academy of Medical Royal Colleges

AoMRC

Trainee Doctors' Group

March / 2020

# Plans regarding trainee redeployment during the COVID-19 pandemic

A position statement from the Academy Trainee Doctors' Group

## Executive Summary

- Wherever possible, trainees should be working within their existing specialty/skill set in an acute setting
- When working in any setting outside documented competencies or recognised roles, appropriate standardised training must be delivered and supervision clarified, before any patient care is given
- Not all skills/competencies are transferable or upskillable. All trainees, of all levels, should not be 'pooled', rather utilised in a phased (Consolidate, Mobilise, Repurpose & Redeploy) and stratified manner, recognising different skill sets, experience and utility for the NHS
- Welfare and wellness issues must be anticipated, planned for and mitigated where possible. Caring for our colleagues is as important as caring for our patients.

## Introduction

Trainees recognise the need to be supportive, adaptive and reactive in the difficult and evolving environment of the COVID-19 pandemic.

It is essential that the individual skills and specialisms of trainees are recognised and utilised appropriately at this very challenging time. In usual circumstances trainees are expected to be working 'at the top of their licence' but in this unprecedented situation we recognise this isn't feasible - instead trainees are being asked to work in a way that utilises as many of their skills as possible. This may be outside their area of comfort but should remain within their competency and appropriate supervision should be provided. Additionally access to training and resources to support this should be optimised. An example of this is access to therapeutics' 'Summary of Product Characteristics (SPC)' via the 'emc' platform in addition to the British National Formulary (BNF).

During this period there have been a number of letters circulated from the GMC, the four nations' statutory education bodies and the Medical Schools Council discussing the importance of ensuring adequate training and supervision for trainees and the need for trainees to work within their competencies.

NHS England has multifaceted guidelines outlining the management of different patient groups during this time.

Health Protection Scotland has its own advice online for some groups of professionals as does the Welsh Government. Northern Ireland's HSC Public Health Agency also has an online presence for Covid-19 information.

This statement outlines considerations when determining the best use of the trainee doctor workforce. While COVID-19 will place unprecedented demand upon the NHS and necessitate a major change in working, the UK population will continue to have acute, unrelated issues which we must continue to do our best to manage.

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## Trainee workforce heterogeneity

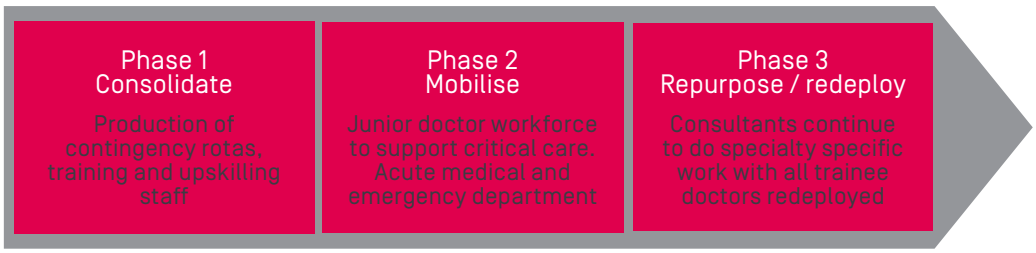
Trainees are not homogenous and skill sets diversify and specialise rapidly following the foundation programme. Doctors who have recently qualified from medical school (recent graduates, Foundation etc.) have a broad skill set and context-specific knowledge of their workplace, enabling them to work across any specialty or healthcare team if provided with adequate supervision. This naturally changes as trainees specialise through their training programme. While all core and higher specialty trainees can work at a lower level of the training path they have been through (including working as foundation doctors in another specialty), they are unlikely to be able to work at a level above this and any movement to take on the work of lower grades must recognise the efficiency loss to the system generated by this movement. Attempts therefore should be made to utilise knowledge, expertise and skills as much as possible when considering movement of staff. While specialty-specific work will continue to be undertaken and led predominantly by the consultant and, for as long as possible, senior trainee workforce, there can be a stratified and phased approach to junior doctor mobilisation around this.

Final year medical students may be asked to join the medical workforce. They will be working in a complex, emotionally charged, and demanding environment unlike anything most doctors have ever experienced before. Their specific roles will be dependent on legislation and registration changes. At pre-registration they have significant skills that can enhance the medical workforce and can help with simple procedures, scribing, phlebotomy, patient observations and other similar activities.

## Phased utilisation and deployment

Given the workforce issues identified above we propose the following principles for redistribution of staff and alternative ways of working. These can be adapted depending on the hospital setting and the resources available. It is expected that progression through the different phases of deployment will occur at differing rates depending on local pressures.

Figure 1. Phases of redeployment




Phase 1. Consolidate with an awareness that trainees may have to move into a different setting (this should occur in both primary and secondary care). Planning of future steps including implementation of contingency rotas, training and upskilling staff as necessary are undertaken early, before trusts and health boards are inundated.

Consideration must be given at this stage to trainees in supernumerary roles (with the exception of GP trainees in a primary care setting) , a number of whom are based outside of the acute hospitals/ trusts. While we assume that these staff will need to move into affected areas of acute trusts the timing of this is vital and will vary based upon local requirements. Move them too early and they are taken out of their training environment, move them too late and they don't have time to learn to work well in a new environment before significant requirements are placed on them. Given the cancellation of rotations in April many of these trainees are towards the end of their placement. We suggest movement sooner rather than later to allow time for trainees to acclimatise and upskill as needed.

Wherever possible changes to how patients are allocated or who assesses them are undertaken: To help utilise trainee skills more efficiently, consideration of ways those services less directly hit by COVID-19 can take work off other specialties is essential. This may mean, for example, allocating patients differently (to specialties), freeing up those services most affected. For non COVID suspected patients these should be assessed by the most senior decision maker available in order to expedite care and facilitate discharge if possible. These changes directly reduce workload on those specialties being freed up but also utilise skills better.

Phase 2. Mobilise the junior doctor workforce to support critical care, acute medical and emergency department services, with skeleton, predominantly senior, staff remaining in specialties less affected by the pandemic, to provide ongoing continuity and emergency care.

This phase may be split into separate parts: initially staff remaining primarily under their parent specialty but assisting by performing and following up jobs for medical outliers on their wards. Overall responsibility for the care and treatment remains under the supervision of the specialty consultants.

Subsequently more direct movement of staff may become necessary. It is likely teams will be restructed because of this. When moving trainees away from one specialty this must be in line with national guidance. Initial staff movements should start at junior levels and gradually progress upwards. Some specialties have useful natural links (cardiothoracics/cardiology, GI surgery/ gastroenterology etc.). Consideration of where staff may be best utilised is essential and must be individualised as much as possible. While many may only be able to work at a relatively junior level in medicine or critical care without prior experience they may well have acquired skills suitable for working at slightly higher levels in the emergency department especially with assessing a particular case mix. It may be appropriate for more senior trainees to also undertake leadership or supervisory roles in these contexts.

Phase 3. Repurpose and redeploy trainees while the consultant body moves in to maintain the specialty specific work. Consultants will continue to do specialty specific work for as long as possible. Consultants will also be at risk of burnout, so there may be a role for locally identified senior trainees to act up in some cases. Additionally in areas of practice where emergency services rely heavily on the work of senior trainees this should be factored into plans for redeployment. While previously never considered, the Italian experience suggests this is a real possibility,

> *"there are no more surgeons, urologists, orthopaedists, we are only doctors who suddenly become part of a single team to face this tsunami..."*

Dr Daniele Macchini, Bergamo, Italy. 9 March 2020

## Trainee Stratification

We suggest that, rather than considering trainees en bloc or based solely on current specialty, that it would be far better to identify suitable roles to move trainees into that are based on their actual skills.

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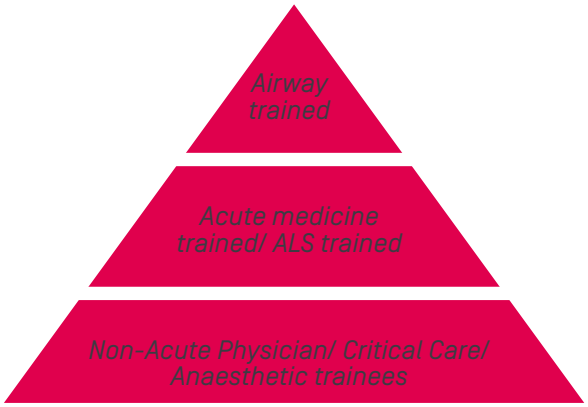
Figure 2. Skill based stratification




Airway Trained. These trainees are likely to come from ICU, anaesthetics, those with past critical care/airway skills and ED. Three cohorts to be considered:

— The work in the formal ICU beds

— The outreach work in areas which have been converted into ITU

— The outreach work to review patients in other areas requiring consideration of escalation of care.

Importantly those paediatric trainees competent in neonatal airway may not be able to be repurposed to adults — this will need to be decided on an individual competency basis.

ALS/ Acute Medicine Trained. Acute assessment and admission of patients including work on isolation wards with patients at high risk of respiratory collapse and cardiac arrest (this includes paediatric and obstetric cardio-respiratory arrest).

Non-Acute Physician/Critical Care/Anaesthetic trainees. Those trainees who do not work within the acute medical/critical care setting in their normal training programmes are best utilised within the ward setting to facilitate care and discharge, to allow flow in the hospital to be maintained and bed utilisation/conversion to COVID-19 bed spaces to occur as efficiently as possible. Skill matching is suggested throughout NHS England guidance – an example is Surgical/Orthopaedic/Ophthalmic specialties to be utilised in ED managing minor injuries/ambulatory patients, to free up ED doctors for majors and resus requiring their particular skills and facilitating treatment and discharge direct from the ED. Extended or supplementary induction and training may be required for those trainees coming from specialties or rotations where acute/secondary care medical emergencies are not a focus. There are also multiple telephone/virtual-based roles where trainees could be of assistance.

The recent statements in regards to a pragmatic and flexible approach to progression and the robust utilisation of the ARCP process mean that there is no role for the 'pausing' of training. Within a competency based system, time does not equal training, and even within the "craft" specialties, there will be opportunities during this crisis to demonstrate competencies and professional capabilities, including, albeit at lower volumes, technical ones.

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## Primary Care

All current GP trainees working in primary care should remain in the primary care setting. If there are trainees with additional skill sets who wish to work outside the primary care setting then this should be considered on an individual basis, as per the stratification system above. Increased out of hours work may be needed to support increasing demand, if appropriate (however arrangements for financial recompense need to be in place).

## Burnout

The risk of burnout due to fatigue, increased intensity of work, fear, anxiety and moral injury must be acknowledged and is very high. A rotational plan whereby doctors move between a high intensity and mid intensity workload may reduce this and is most likely to allow the workforce to continue to provide a high level of care for the longest possible period. Additionally, where possible, emphasis should be placed on more efficient working practices to enable optimal gain from redeployment.

Implementing this, including the use of different groups of trainees (e.g. OOPs, academics, those on research blocks etc.) should be considered in this context. At the present time it is not suggested that these trainees should return immediately to clinical training but preparation for them to do so including induction, indemnity, reskilling, HR processes being completed etc. are all essential. There must also be due care and attention paid to Less Than Full Time (LTFT) trainees so as not to disproportionately disadvantage them with any plans made.

## Other Considerations

It is well understood that all doctors – not just trainees – should be listened to if they feel out of their depth and unable to provide an acceptable level of care. Junior doctors are still the 'canary in the coal mine' and will often be able to highlight impending issues before they become a risk to patients and staff alike. The GMC, the Academy and the four nations' CMOs have released statements of support for the medical workforce in these unprecedented times acknowledging the challenges the profession is currently facing and a pledge that this will be accounted for which will be very pertinent during redeployment.

Support for doctors during this time is essential to enable us to meet the demand of this epidemic for as long as it takes. Consideration should be given to the institution of a 'buddying' system at local level to enhance the support for doctors working in environments outside their normal spectrum of activity.

We will continue to review the situation daily and work alongside the educational bodies to provide the best possible care for the UK, while being mindful of the ongoing impact this crisis has on trainees' health and careers.

This guidance should be read in conjunction with the NHS Document Redeploying your secondary care medical workforce safely

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The Academy Trainee Doctors' Group Executive

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Following agreement from and on behalf of the trainee representatives of,

Association of Surgeons in Training
British Orthopaedic Trainees' Association
Faculty of Dental Surgery
Faculty of Intensive Care Medicine
Faculty of Medical Leadership and Management
Faculty of Occupational Medicine
Faculty of Pharmaceutical Medicine
Faculty of Public Health
Faculty of Sexual and Reproductive Health
Faculty of Sport and Exercise Medicine
Foundation Programme
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians and Surgeons of Glasgow
Royal College of Physicians of Edinburgh
Royal College of Physicians of London
Royal College of Psychiatrists
Royal College of Radiologists (Clinical Oncology)
Royal College of Radiologists (Clinical Radiology)
Royal College of Surgeons of Edinburgh
Royal College of Surgeons of England
Scottish Academy Trainee Doctors' Group