

To: SHA Chief Executives
SHA Workforce Leads
SHA Medical Directors
Postgraduate Medical Deans
Trust Chief Executives
Trust Medical Directors
Academy of Medical Royal Colleges
BMA Junior Doctors committee
PMETB
NHS (Employers)

Gateway Reference No 12674

29 September 2009

Dear Colleague

Re: Rotation of Doctors in training during Pandemic Influenza

I attach a paper prepared by Prof David Sowden, the Pandemic Flu educational advisor to the DH. It sets out the arrangements for rotations of trainees at national, deanery and trust level in the event of serious pandemic flu.

The safety of patients is paramount, and PMETB supports trainees contributing appropriately to health service delivery in these exceptional circumstances, and appreciates that this may, for a limited period, take precedence over training.

This document supports local decisions being taken where possible, with the exception of the main national rotations. It emphasises the importance of communication with local postgraduate deans, medical directors of SHAs and medical directors of Trusts. Any decisions must also be discussed with the local junior doctors groups and other clinicians affected by the arrangements.

Further work is being done on the educational impact of such decisions and the NHS will need to ensure there is no lasting detriment for those trainees affected.

This paper has been discussed with representatives of key groups who will be affected, including the Junior Doctors Committee. I would be grateful if you could share this advice with colleagues for whom this information is relevant.

Yours sincerely



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Director of Medical Education (England)



Ian Dalton
National Director of NHS Flu Resilience

Rotation of Doctors in training during Pandemic Influenza

Introduction and underlying principles

Doctors in training have a critical role in ensuring that comprehensive, critical healthcare services and patient safety are maintained during a time of national emergency. How they are deployed represents part of the necessary national and local contingency planning for pandemic flu.

As the Postgraduate Medical Education and Training Board (PMETB) has recently written: “PMETB supports trainees contributing appropriately to health service delivery in these exceptional circumstances, and appreciates that this may, for a limited period, take precedence over training” (*PMETB principle in relation to trainees and training during times of national emergency*) .

Similarly, the GMC has emphasised in its guidance *Pandemic Influenza, Good Medical Practice; Responsibilities of doctors in a national pandemic* that doctors must continue to “make the care of your patient your first concern” and that doctors will need “to work flexibly to provide assistance to the public where and how it is most needed”. It has also emphasised that doctors may be asked “to work outside your usual area of practice” and hence by implication outwith their present training placement.

The caveat to these statements is that trainees must still operate within their competences and under appropriate supervision from more senior staff.

This paper is primarily concerned with the rotation of postgraduate doctors in training. However, pandemic flu may also affect the nature of service provision within Trusts, which, irrespective of any changes to rotations, may impact on the availability of training and relevant learning opportunities. For example, cancellation of routine surgical procedures will have a significant impact on surgical training, which may have consequences similar to or in excess of those associated with an adjustment to a particular rotational movement.

Similarly, trainees may need to be redeployed within Trusts to clinical areas of greatest need. Work is being done with PMETB and the Postgraduate Deans to address how such situations should be managed within postgraduate medical training at a local level.

Any decisions about the deployment of doctors in training or adjustments to their training environment as a result of pandemic flu planning must be discussed with the local Post Graduate (PG) Dean before adjustments are implemented. The current deployment and nature of learning opportunities for doctors in training in England are covered by Learning and Development Agreements (LDAs) between SHAs and Trusts and by similar arrangements in

the devolved administrations. Failure to negotiate changes to the learning environment for trainee doctors will normally constitute a material breach of an LDA or similar agreement.

The mechanics of the process for managing adjustments to training rotations needs to be able to be applied on a 4 country basis, but in most cases the decision to make an adjustment can be reached locally. As a result, whilst each country will need to establish its own local arrangements for the halting and restarting of training rotations for doctors it is important that all 4 countries observe the common principles contained in this paper.

The remainder of this paper is written using English nomenclature but can be easily adjusted for wider 4 country implementation. This approach has been taken to avoid making the paper overly long and complicated.

Training rotation arrangements for doctors in training

Doctors in postgraduate training undergo 4 main types of rotation:

1. National

The primary time for the national rotation is August and the set day was Wednesday 5th August 2009. (It is currently always the first Wednesday in August.)

On this day approximately 7000 Foundation programme year one (F1) trainee doctors entered NHS employment, across the whole UK in placements they were assigned following graduation from Medical School.

A large proportion of current Foundation programme year 2 (F2) trainees, again about 7000 UK wide, moved into specialty training (ST and CT) posts. This involved movement across the UK.

A smaller movement of core trainees into higher specialty training also took place.

DECISION REACHED: The national rotation (UK wide) was allowed to proceed as planned on August 5th 2009.

2. Within (intra) Deanery

This type of rotation is the most common.

In Foundation programme (FP) training, trainees often rotate to another Trust for the second year (F2) of such training. Most such trainees will have completed this rotation as part of the national rotation. However, some F2 trainees rotate between Trusts or between Trusts and general practice at 4 monthly intervals as part of their planned training programme.

After FP training, trainees may rotate within their initial years (ST 1, 2 and occasionally 3) of specialty training (in some specialties referred to as core training - CT) to another site (usually another Trust or hospital) within the deanery. Such rotations generally occur 4 or 6 monthly.

For the more senior specialty trainees (ST 3 or 4 and above), this rotation is usually annual and there are set times for this to occur. For some specialties, this will be in August but others may have chosen different months to minimise the service disruption. Other trainees will rotate from one site to another with 4 monthly or 6 monthly intervals (or occasionally even more frequently). There can also be rotations between primary and secondary care (particularly for those in GP training). Some trainees currently work on one site but provide cover, especially out of hours (OOH), in a number of others. Examples include radiology trainees, psychiatry trainees and those in community paediatrics.

Restricting such OOH multisite cover might leave some clinical areas at risk of inadequate cover and would certainly place increased burdens on other, usually, consultant staff.

DECISION REACHED: decisions on the intra-deanery rotation of doctors will be taken locally. It must be reached through a process of close liaison between the local pandemic flu lead and, where relevant, other SHA staff (or the equivalent in the devolved administrations), the local PG Dean and the Medical Directors and Directors of Postgraduate Medical Education (DMEs) of the Trust(s) concerned.

This local process will normally be the most appropriate response as disease activity and patient admissions peak and vary across the country. However, it is likely to cause longer term problems for medical training which will need to be resolved and further work is being done on this.

The process by which any such local decisions are reached must be carefully recorded as part of an established accountability framework, and must include the reasons for and the process of negotiating changes to the normally planned rotations.

It is expected that in all cases where adjustments to the deployment of junior doctors are proposed, best HR practice will be followed, and these proposals outlined for and discussed with the doctors affected as part of the negotiation process. As always, effective communication is the key to achieving understanding and co-operation. Careful consideration needs to be given as to how best achieve these objectives, but may include contact with local junior doctors groups in Trusts and/or the regional BMA junior doctors committee.

3. Within site

Many trainees, particularly in the earlier stages of training (for example, in core and GP training), rotate within one hospital site to a number of different departments on a 2,3,4 or six monthly basis. Many of these rotations also include periods of community placements in general practice or other settings. To preserve continuity of expertise and to reduce the need for local induction, it might be decided to stop this type of rotation. If rotations were stopped, some trainees will have less experience than others.

DECISION REACHED: The decision on halting such rotational movements will be taken locally but the consequences would be similar to the option described with respect to intra-Deanery rotations above. Such decisions must involve discussions between the local pandemic flu lead and, where relevant, other SHA staff (or the equivalent in the devolved administrations), the local PG Dean and the management of the Trust(s) concerned. In general, it is recommended that the following individuals are involved in the local decision making process:

- SHA Medical Director
- PG Dean
- Trust Medical Directors
- Trust Directors of Postgraduate Medical Education (DMEs / Clinical Tutors)

These individuals will need to co-operate with others involved in pandemic flu planning at an SHA and Trust based level and arrangements may vary between the Regions.

The process by which any such local decisions are reached must be carefully recorded as part of an established accountability framework. In particular, the reasons for and the process of negotiating the changes must be recorded.

It is expected that in all cases where within site adjustments to the rotation of junior doctors are proposed, best HR practice will be followed, and these proposals outlined for and discussed with the doctors affected as part of the negotiation process.

4. Inter- Deanery

These types of movement or rotation occur for 3 reasons:

- Inter- Deanery transfers (IDTs) at the request of an individual trainee, usually due to a change in personal circumstances. These moves represent a permanent move to a new Deanery.
- Out of programme (OOP) arrangements. These include OOP experience (OOPE), OOP training (OOPT) and sub-specialty training where approval is given for the trainee to move to another training site (usually, but not exclusively, in another Deanery).
- Inter-Deanery rotations in certain specialties, for example, paediatric surgery, cardio-thoracic surgery.

DECISION REACHED: with respect to IDTs and OOP arrangements (first 2 bullet points above), decisions must be reached locally in the trainee's current employing Trust in consultation with

the PG Dean (who will probably involve the relevant Head of specialty training school for the specialty in question).

In general, it is anticipated that IDTs would only be halted as a last option. The numbers involved are small and the personal impact on the individual doctor of halting an IDT disproportionately large, as in most cases such moves entail arrangements for new housing and related measures depending on personal circumstance, such as new schools for the children.

In the case of both IDTs and OOPs, the decision may have a direct impact on the area/Trust expecting the arrival of the trainee. Whilst the area to which the trainee is planning to move should be involved in the discussions, the final decision on how best to proceed should rest with the source organisation i.e. where the trainee is currently employed.

The process by which any such local decisions are reached must be carefully recorded as part of an established accountability framework. In particular, the reasons for and the process of negotiating the changes must be recorded.

DECISION REACHED: with respect to certain specialties (final bullet point above), inter-Deanery rotations cannot be halted in one area without consequences in another. The potential local need to halt such a rotation should be notified to the local PG Dean who will notify the nominated national Lead Dean for that specialty. The Lead Dean will discuss the circumstances with the specialty (usually the national Specialty Advisory Committee, SAC) concerned and agree a plan of action. Trusts must not independently stop such rotations without going through this process.

IDTs should only be halted when all other measures have been considered and where there remains a significant risk to patient safety relating to the planned doctors move.

The process by which any such decisions are reached must be carefully recorded as part of an established accountability framework. In particular, the reasons for and the process of negotiating the changes must be recorded.

It is expected that in all cases where such adjustments to the training arrangements of junior doctors are proposed, best HR practice will be followed, and these proposals outlined for and discussed with the doctors affected as part of the negotiation process. This is viewed as being especially important with respect to any planned alteration to IDTs.

Re-establishing training rotations

Where a rotational movement is halted, there will need to be a corresponding and carefully documented process for deciding to re-start rotations. Further work is being done to cover the issues that will need to be considered as part of that process.

However, the guiding principle is to ensure that rotational movements, and hence the education of doctors in training, are disrupted as little as possible. All changes must take critical account of their compatibility with high quality and safe patient care. Where rotations are halted, this should be for the minimum period. The greater the disruption to rotational movements, the more likely major problems will arise with educational progression. Such problems will generally be related to the need to catch up on lost education, the resolution of which will have many implications. As a result the NHS will need to introduce a policy of no detriment for those trainees affected and as far as is possible this must recognise personal circumstances.

The process of reviewing and analysing the longer term impact of any or all of the changes described will need to be planned for as it becomes clearer how long an emergency situation might last. Options will need to be sought on how best to resolve the problems created by a delayed rotational movements and other causes of delayed educational progression caused by the pandemic. Such an option appraisal would include consideration of resource implications for the wider NHS and individual Trusts (including potential implications for funding) as a result of any measures designed to address the issues identified.

To minimise the impact on training and related costs, the following steps should be taken:

- a) When a decision is taken to halt a rotational movement, locally or nationally, there must be a documented agreement on how, by whom and when such decisions will be reviewed. At a minimum, such decisions should be reviewed weekly, and the reasons for continuing the stoppage must be documented.
- b) As soon as plans are agreed to halt rotational movements, planning for restarting the rotations should be commenced, and there should be a communications strategy that keeps all informed about the ongoing situation and arrangements for review and restarting (see d) below). Such a communication strategy should take account of prior experience gained during the implementation of MMC and ensure that several different routes of communication are used. For example via national (MMC and MEE) and local (Deanery) websites, direct communication using local cascades with Deaneries and FP,GP and specialty Schools and via the consultant body who supervise the trainee doctors.
- c) Careful consideration needs to be given to the timing of the re-start. In general, re-starting rotations at anything other than the beginning of a month (usually the first Tuesday or Wednesday) is likely to cause longer term problems with the organisation of training and risks disrupting service arrangements in Trusts. However, this needs to be a local decision that involves the PG Dean and takes account of local circumstances.
- d) It will take time to plan, engage and communicate the arrangements for re-starting the rotation to all relevant parties (Trusts, Directorates, Training Programmes, Specialty Schools and trainees). It would be sensible to consider a minimum period of at least 5 working days to cover engagement and communication.

e) For inter-Deanery rotational stoppages, re-starting rotations arrangements should mirror those outlined above for halting the movements (see section 4 above).

Processes to manage the educational implications of this situation fairly and equitably, if a decision is reached to interrupt a rotational movement (or where normal clinical activity is significantly constrained), are being discussed with the PG Deans, PMETB and junior doctor representatives.

Final version. September 2009

Prof D Sowden, Pandemic Flu educational advisor, DH

