London trainees' experiences of Paediatric training during the COVID-19 pandemic: lessons learnt.
Summary from LSOP trainee questionnaires and workshop May 2020

Introduction

During March 2020, as hospitals got busier with Covid-19 work, Paediatric units across London (and the rest of the country) changed their working patterns: Emergency Departments became eerily quiet, routine face to face clinical activity was scaled down, and often paused, and Paediatric doctors in training were redeployed; Community trainees were redeployed to acute work, and hospital trainees were often redeployed to adult areas of work such as adult Covid wards, ED and ITU. In addition to the dramatic change in clinical workloads, certain groups of individuals were advised to "shield", isolate at home, and avoid face to face contact all together, and yet still somehow work in whatever capacity they could. During this period every department across the wider School of Paediatrics, and indeed all specialties, teams started doing things differently: often achieving changes – such as remote access to hospital IT systems - that have long been desired. Remote working for much of the time has become the "new normal", and certainly brings with it some advantages to training, such as attendance at remote teaching, but there have also been many losses – such as the loss of much routine face to face clinical contact training time.

We wanted to capture the experiences of the trainee body, to learn from areas of good practice, and innovations, and also highlight things that didn't work so well, to avoid them in the future. In addition, with a significant number of trainees, and indeed Consultants, needing to shield, and most likely required to do so in the future, we wanted to identify some best practice guidance on training opportunities for remote working, specific to different levels of training in different clinical areas.

In order to achieve this we carried out a preliminary online questionnaire and held a workshop with the London School of Paediatrics STC to reflect on how the pandemic had affected our training experience. We sought to brainstorm strategies for keeping good practice and how we might retrieve aspects of good practice that may have been lost in these unprecedented times, so that we may learn from and benefit from positive changes to our training and clinical working during this period.

We also focussed on aspects which had been challenging in this time and what we should avoid if significant changes to our clinical work were required again as a result of a second wave of the pandemic, including any safeguards to our training which might need to be in place should this happen.

We ran 4 separate workshop streams to explore trainees' experiences with the following themes:

- Training and working clinically
- Working remotely/shielding doctors
- Wellbeing and support
- Nonclinical training – management and education

We had 41 responses to the questionnaire, and 54 participants at the workshop.

Below is a summary of our discussions:

1. Training and working clinically

Clinical working patterns:
Rotas

There has been a great deal of change regarding trainees' rotas which has required huge flexibility; some rotas have even changed week by week. Many of the rota changes have been driven by the junior doctor team, whereas in other places it has been led by consultants over-seeing the rota. Changes to rotas and working patterns were for a variety of reasons; redeployment of staff to work with adult teams, to cover staff sickness or requirements for staff to isolate due to contacts with suspected or confirmed COVID-19 and to cover for staff unable to work on-site i.e. shielding or strict social distancing being required. While a minority of trusts were able to retain their existing rotas, the vast majority of trusts moved to new rotas, adopting shift patterns consisting of 13hrs shifts only, night and day, often to align with the rest of the hospital. In some cases trainees were on completely new rotas within a new trust eg. re-structure of all north central Paediatric services leading to North London Paediatric trainees being moved to Great Ormond Street.

Many rotas had intense working patterns with trainees working every 1-1.5 weekends.
Many trusts have been operating a 'back-up shift' schedule where trainees who are not on site can be called upon as required to fill gaps on site at relatively short notice e.g. due to staff sickness. In addition some trusts have adopted 'resilience shifts' giving extra days off to staff in the early phase of the pandemic to try and give people adequate rest to compensate for heavier rotas later during the pandemic.
In some trusts there has been a designated 'remote working' rota to include those trainees who are working from home/shielding, but also others to reduce unnecessary footfall in clinical areas thus potentially reducing spread of COVID-19. In one trust E-rostering with rotageek has been working very well (at Evelina NICU) and allowed agility and adapatability.
Some Trusts e.g The Evelina have seen higher numbers of cases of PIMS TS and therefore a requirement for rotas to change again is emerging to appropropritely staff and manage the associated increased workload. **In all sites, the flexibility for trainees at this very unusual time has been remarkable.**

Redeployment of Paediatric trainees and movement of Paediatric departments

Redeployment of Paediatric trainees to assist adult medics coping with huge numbers of adult patients with COVID 19 has occurred in almost all Trusts, in tertiary as well as district general hospitals. Some Trusts were affected more than others.
In addition to redeployment of Paediatric trainees, Paediatric departments were significantly affected by the redeployment of doctors in other specialities or stages of their training such as GP trainees and Foundation doctors. This has posed a number of challenges such as learning new

medicine in unfamiliar clinical areas and with new teams and coping with high pressure of huge numbers of very unwell adult patients. However many trainees reported positive aspects such as feeling part of the team and lots of opportunities for teaching, though teaching mostly related to managing unwell adults with COVID rather than Paediatric teaching.

Some Trusts have had their Paediatric departments temporarily closed in order to make additional space for adult COVID patients, for example PICU and PSSU at St Marys, and several district general hospitals in North London. This continues to be hugely disruptive for a number of Paediatric trainees and potentially detrimental to training opportunities. As a result trainees in certain trusts are getting limited exposure to different aspects of Paediatric training eg no ED assessment or management, or no inpatient care. This has resulted in some trainees feeling isolated, and nothing more than a bleep holder at times.

In addition, almost all sites have significantly scaled down routine OPD work, with a reduced workload, and most clinics being done virtually. Whilst some areas, eg Community Paediatrics have shifted to enable trainees to continue to do clinics, in most trusts this has significantly reduced OPD as a training opportunity for trainees. As services return to a new normal, trusts are improving on this – trainees can do virtual clinics, and many IT solutions eg Attend Anywhere, Accurx would enable trainees to join clinics, or even to access consultant supervision. Virtual clinics also allow better potential MDT working across sites. Virtual clinics also work well for those who are shielding.

Teaching

There has been fast and effective transition of Paediatric teaching into virtual teaching sessions– online teaching from LSP and many other sites has had universally fantastic feedback. All sites report much improved attendance; it has been particularly good for those who work part time who often missed teaching previously. Social distancing has been proving a challenge for those actually in the hospital/clinical sites. The LSOP plan to continue the very full teaching programme indefinitely, with many of the LSOP courses now moving into that format. Many trusts are now timetabling the LSOP programme into their daily timetable. Some sites have abandoned local teaching in favour of online central teaching only, and this is a potential loss that needs to be explored. One aspect which needs to be explored is how to monitor virtual/remote attendance.

Central SIM teaching has been paused over the last few months but trusts have been trying to organise small SIMS locally.

A couple of sites have set up regular virtual SLE training sessions with signups for slots eg a daily slot at 2pm via doodle poll, which is done by a remote working consultant. The consultant and trainee then have an ms teams meeting/zoom to chat through an assessment. This has been well received.

-

2. Remote working/working from home (WFH)

Many trainees have been working from home for their own health reasons, because of living with an extremely vulnerable person, or because of pregnancy. In addition, doctors often need to self-isolate because someone in their household has been unwell, although they themselves have been well enough to work. In addition, some trusts actually timetable "working from home" shifts to reduce footfall in hospital and community sites.
The group identified multiple different tasks that working from home team both clinical and more managerial or teaching related. A key factor is whether or not trainees can get remote access to hospital IT systems. In departments where this has been arranged the scope for remote working is completely different.

Positive aspects of remote working

- There is a range of tasks that can be done from home
- Allows for flexibility eg around other commitments
- If clinical tasks done from home– often takes away from admin stress for busy ward/clinical staff
- Great use of technology – Zoom/google meetings to keep connected
- Teaching medical students/junior doctor teaching/case presentations can work well
- more time and independence for own projects, much more time to engage with portfolio,

Challenges of remote working

- Need clear allocation of work, there is a **risk of lacking direction and feeling isolated**
- Someone needs to identify body of work **reasonably done remotely**
- **Issue of establish accountability when off site**
- Difficulties balancing life at home while WFH – difficult to "turn off"
- Missing actual clinical encounters - doesn't replicate clinical work, possibly works best for senior trainees than more junior trainees
- Concern: it may become just service provision or is it reasonable training
- **Adequate IT network essential for clinical work but lots of issues**
    - Failure to connect to portal
    - Trust laptop takes ages to warm up
    - Internet traffic is a problem
    - Takes a lot of time, phone calls, emails to set up
    - Often access to patient records

Solutions and best practice

- **How to establish accountability and ground rules** – regular check in times, check out times, summary of tasks completed/progress
- Clear dialogue and ground rules around what is expected
- Making sure workload is manageable
- Named consultant checking in with trainees WFH
- Challenge of balance of clinical and non-clinical work

- Importance of access to trust devices and making best of IT avail at DGH – badger, access to copies of letters, results program
- IT "workarounds" eg using Dictate IT on phones rather than trust computer

Maximising clinical and other training opportunities

- **Missing patient contact & clinical work – maximising where possible** e.g. through telephone reviews/fitting for chemo
- Video consultations – but challenges of practicality with IT platforms
- V**irtual CBDs to keep up with Work place based assessments**
- Lo**ts of different skills acquired** – reflect on them, **engage with eportfolio**
- Really important to have clear line of educational supervision, regular virtual checks – eg fortnightly, discuss a case and making it WPBAs
- Opportunity to do other things eg Guidelines, attending management meetings, doing teaching, grand rounds, data collection, audit, online learning etc

Case study 1: Remote working as a senior Paediatric registrar in tertiary Paediatric multi-disciplinary team

A Paediatric registrar undertaking a specialist Paediatric job at a tertiary hospital has been able to continue in the post while working remotely from home throughout the COVID-19 pandemic, while the majority of the Paediatric services were moved to another hospital temporarily to make space for adult COVID patients.

Overall they described a positive and valuable experience however they faced a number of challenges which they shared with the group, and the solutions they created. Challenges included finding themselves working remotely in a brand new post having rotated just prior to the Pandemic, working within a brand new team, with many members they had not properly met in person before lockdown ensued. There were also a number of new ways of working which they needed to master quickly.

Efforts were hampered initially because although the hospital had electronic health records enabled which should facilitate remote working, the programme was not compatible with their personal laptop. In addition they found that there weren't always clear lines of communication with medical team and little clear accountability for tasks they were undertaking remotely. They were able to overcome some of these challenges by establishing their own lines of communication daily with the on-site Paediatric specialist nursing team and developing their own channels of accountability each day for tasks completed.

They organised a suitable Trust device to enable access to the electronic health records and have therefore been able to undertake a number of important clinical tasks remotely including providing prescriptions for all medications, and undertaking telephone and video consultations, which also helped continue some clinical contact with patients which they have found very valuable. A concern shared in the group discussion was about the potential vulnerability of prescribing remotely from home and the processes for indemnity and insurance should an error occur

Case Study 2: Whole departmental remote working on the University College London Hospital tertiary neonatal unit.

By mid- March 2020 as the COVID-19 pandemic took hold, a remote working team was quickly established on the tertiary neonatal unit at UCLH so that members of the junior and senior team were able to contribute to clinical and non-clinical tasks from the start.

Members of the team working from home varied from those needing to work remotely throughout the pandemic for their own health reasons, doctors at varying stages of pregnancy to team members who were isolating for shorter periods of time due to contact with suspected or confirmed COVID, or who had been unwell themselves with suspected or confirmed COVID. In addition the vast majority of shifts that would have been assigned for tasks such as admin/audit were switched to remote working days to generally reduce footfall on the neonatal unit. 'Float days' where staff are usually assigned to fill gaps as required on the day were also switched to 'Float from home' and team members instead work from home unless workload demands for these staff to be called upon to attend for clinical shift on the unit.

Two senior registrars working remotely have developed and led the 'Working from home rota' assigning all the working from home team to a different clinical areas each day as follows; support for the ITU and SCBU teams, registrar neonatal telephone clinic, point of contact for midwife and ANNP referrals and queries. In addition the working from home team have been able to engage in valuable training opportunities by working on a number of non-clinical tasks, particularly those trainees who are remotely working on a longer term basis. Such tasks have included on-going 'Working from home' rota co-ordination, writing/updating Trust guidelines, working on their own QI projects/audits while also co-ordinating and assigning QI/audits to other trainees, writing up own research paper and virtual presentation at regional meetings e.g. child death review panel. There has also been more time to engage with their own e-portfolios, evidencing the learning and competencies achieved while working remotely.

Case study 3: Senior Paediatric registrar in role at a specialist hospital

Another senior Paediatric registrar shared their experience of working remotely in a post at a specialist hospital during the pandemic. They described the experience as hugely rewarding and it has enabled excellent opportunities to meet leadership and management competencies. They have worked remotely in a senior advisory role to the multi-disciplinary team with frequent opportunities to step up in seniority being the first port of call, due to a number of the consultants also working remotely. They have had the opportunity to work with a greater level of autonomy and have gained valuable managerial experience from liaising regularly within the multi-disciplinary team and also with multiple other teams. They have also benefitted from having more time and independence to work on some of their own projects and to engage more with e-portfolio, evidencing the learning and competencies achieved which is so often more challenging to do while working intense clinical shifts on site in hospital.

Case study 4: General Paediatric SHO remote working – Virtual SHO (V-SHO), Evelina

Two general Paediatric SHOs have been working from home as V-SHOs during this period and have been an integral part of the team. The roles have developed and become more efficient as time has gone on. Initially communicating through WhatsApp telephone calls, we have now developed secure lines of communication using the Pando app for clinical tasks and communication around them. The V-SHOs can call into huddles of handovers through WhatsApp calls, or MS teams and at the end of handovers tasks are earmarked for the V-SHOs. This might include chasing results, liaising with other teams, organising tests and writing discharge summaries. We have introduced a ward SHO phone for non-urgent tasks e.g rewriting drug charts, and these are diverted to the V-SHOs working from home at the beginning of shifts.

Initial communication difficulties were improved by having a link ward doctor who is responsible as the key liaison – the FY1. The V-SHOs can call into all meetings e.g Xray meetings MDT etc as these are now all virtual. All these tasks are enabled by electronic records – so they can see the notes, electronic prescribing, and electronic discharges. Both the V-SHOs have remote access and work computers through VPN.

3. Nonclinical aspects of working and training

Virtual working and new ways of connecting have enabled many trainees to access meetings and activities that geography previously limited. Many have reported opportunities to get involved in management roles such as rapid rewriting of rotas, and liaising with senior and management teams. As most meetings are now virtual, being the trainee representative in a management meeting can be easier. This is particularly true for trainees working from home or on back up shifts, those working clinically are still limited by clinical workload.

In our workshop discussing the idea of "virtual" paired learning was brought up as a way of learning more from management teams. There is lots of opportunities for developing as a teacher, particularly for those working remotely , for UG students, and more junior trainees.

4. Wellbeing and support

One of the overwhelmingly positive aspects of this period has been the emphasis on wellbeing support and the introduction of wellbeing resources within the workplace. This was often hospital wide, but also within Departments. Examples include introduction of wellbeing boards, wellbeing hubs (physical spaces) and dedicated staff support. Some sites developed virtual sites where all wellbeing support was brought together eg on trust intranet, *trello* boards, or a padlet site. The London School of Paediatrics team developed its own Surviving and Thriving COVID-19 Handbook. Many sites introduced parking for staff, which really made a difference and free food and accommodation. There were also the widespread public offers eg free taxis, free food offers etc.

Lots of normal support structures are obviously lost, and trainees reported the negative impact of losing face to face support, and changed team-working. Wellbeing was obviously affected by the whole sense of the uncertainty of the pandemic, but also the rapidly changing circumstances including changing rotas, cancelled events such as exams, and fear about training progress.

Redeployed doctors found it a particularly challenging time, and it was emphasised that they should get specific support – with both their "old" educational supervisor and clinical supervisors in their new clinical area. Remote socials worked well in some areas. There was a definite feeling that wellbeing should continue to be prioritised, and kept as a central theme in LSOP.

Good examples of wellbeing and support

Kindness locker –an open locker in a staff area, designated for treats, available for the whole healthcare and support team. Individual unit worked out rotas and resource to refill the kindness locker.

Project wingman - a program that utilized volunteer flight attendants who were grounded to set up lounge spaces in different hospitals to provide healthcare workers with a relaxing experience and refreshments while on the job.

Positivity Squad – a WhatsApp Group set up by one of the Positivity champions where positive messages, activities, achievements are shared – anyone interested can join to spread the positive vibes! https://chat.whatsapp.com/Bs3c5tRsYTv2ZqkbC1nwQ3

Formal coaching and psychology support available every day face to face or virtually for healthcare, support staff and individual groups. Manager toolkit for promoting wellbeing and signposting appropriately.

Summary

It has been a challenging time with lots of change and uncertainty but the overwhelming feeling from both the questionnaire responses and workshops was one of being part of a great team: the flexibility and adaptability of departments and teams has been enormous. Some changes have been particularly well received and should stay eg online teaching, opportunities for working remotely; some still need to be worked up more, such as the opportunity for virtual training clinics. Remote access for trainees seems key.

If similar circumstances occur in the future, for example a second peak, trusts and departments should aim to avoid last minute changes to any aspects of working life e.g rotas, placements etc – we should work hard to anticipate and forward plan to give people as much warning as possible, continue to drive changes in rotas e.g e-rostering and trainee leadership

to maximise autonomy of trainees. Trainees suggested that particular attention should be paid to ensure that trainees continue to have access to outpatient clinics at least remotely.

It seems likely that many of these changes in clinical training will be around for some time , if not for ever, and we must continue to share best practice and embed these positive changes, to enable us to get the best training possible.

Mariyum Hyrapetian, Kate Dharmarajah, Marietta Pal-Magdics, Chloe Macaulay
LSOP
June 2020

General principles regarding trainees shielding and working from home

We have developed these guidelines to help manage and structure the work and supervision of trainees who will be based at home during the Covid pandemic. These are unusual circumstances and we appreciate that it goes against all our natural instincts to be "doctoring" from a distance but we hope that through the options below, it can be seen that there is still plenty of valuable clinical and non-clinical training and work which can be done.

A positive that has come out from this time is that we are discovering innovative and more effective ways to deliver both clinical care and training, which do not involve face to face contact. The involvement in developing these from both the supervisors and the trainees is really invaluable.

General principles

- Arrangement for working from home needs to be agreed formally between the trainee and their supervisor/line manager following an Occupational Health process.
- The trainee should aim to work the same number of hours/week that they are normally contracted for. The *actual* working days and time table can be flexible to allow for childcare or other commitments.
- If the trainee cannot fulfil their contracted hours or wishes to change the number of hours that they do, this needs to be discussed and agreed with the Educational supervisor/line manager.
- It is advised that a log is kept of the work done and this will be reviewed at least weekly.
- All should continue to try and maximise training opportunities. Clinical exposure will be, by definition, reduced and different, so learning opportunities will also be different. Trainees may take on some different roles not traditionally done by trainees eg admin/clinic booking or organisation. Trainees should reflect on educational opportunities/learning from these activities and are encouraged to keep a record of learning in their e-portfolios.
- Trainees may be asked to work with a different department from their normal allocated department if there is clinically appropriate work available for them to do.
- Annual leave and sickness should be taken and reported in the same way as for trainees working in hospital.
- Each trainee will be allocated someone to oversee the work being done from home – a "clinical" supervisor. They should "check in" once a week with trainee.
- At handover/safety briefing at the start of each shift it should be highlighted who is working from home and the clinical area they have been allocated so that remote working team is involved proactively in tasks to support on-site workload.

Clinical and nonclinical training and other activities

Clinical

Ward based – works well for more junior trainees:

- Dialling in and joining handover/ward rounds virtually
- Remotely accessing all clinical applications to check results etc, write summaries, drug charts
- Writing Complex discharge Summaries
- Remote phone and bleep handling eg from ward, or outside hospitals if IT allows

- Trainees should continue to access ward based teaching remotely e.g handovers, Complex Patient MDT, X-ray meeting, local teaching sessions, journal club

OPD based – works well for more senior trainees

- Telephone triage of referrals e.g hot line, vetting online referrals– works well for more senior trainees
- Sitting in "Attend Anywhere" clinics as an observer or participant – junior and senior trainees
- Telephone /video clinics - these can be supervised directly, or remotely– junior and senior trainees

Non-clinical – these are just a list of examples, there are many more

1. Teaching
    a. Undergraduate
        i. Become an UG clinical supervisor, delivering weekly online tutorials
        ii. Write and deliver lectures virtually
        iii. Develop UG cases
        iv. Exam question writing
        v. Develop innovative UG content – videos/PP animations
    b. Postgraduate
        i. Delivering regular departmental PG teaching including journal club
        ii. Contributing to LSOP teaching programme
2. Guideline development
    a. Writing and updating Trust guidelines –
    b. Guideline review as part of Guideline group

3. QI/service development
    a. Evaluating current working – audit
    b. Service improvement projects
    c. Trainee representations in different groups
        i. E.g wellbeing group
        ii. Pharmacy
        iii. Safeguarding meetings
        iv. Regional meetings e.g. Child health death review panel
4. Management
    a. Administrative roles e.g booking clinic patients, coordinating clinics and patients, contacting families, remote working rota management
    b. Specific OPD based projects
    c. Other clinical governance tasks – e.g. supporting consultants with governance related tasks, such as responding to complaints where appropriate

5. Research and audit
6. New other opportunities
    a. NHS 111 advisor

Education and training principles

1. Trainees should try and maximise the training opportunities in the role
2. Trainees should keep up with e-portfolio and evidence learning, particularly non-clinical and management competencies. Need to keep up with WPBAs as much as possible.
3. Trainees should keep up with normal ES meetings and document these

4. Trainees should have an additional clinical supervisor in area of remote working if that isn't the same as their allocated area
5. Oversight of activity in your clinical area is essential – will depend on where they are re regularity and from whom – e.g a ward based doctor working remotely will need daily touch in, but someone working in a more OPD specialty e.g Community Paediatrics will need weekly.
6. Must ensure all Trust mandatory training is kept up to date.