Royal College of Anaesthetists

Minimising the impact of rotational training within the anaesthetic training programme

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Introduction

The principles underlying rotational training have recently been brought to the fore. Anaesthetists in training (AiTs) and trainers alike have raised concerns over the impact frequent rotations are having on the educational effectiveness of placements. In addition, the impact of frequent rotations on wellbeing and quality of life for AiTs has been raised as a concern. This review will look at the use of rotations in the light of anaesthetic training in 2024 and the requirements of the 2021 Curriculum.

Why do we have rotational training?

Over the past 30 years many attempts have been made to streamline medical training. In the early 1990s Sir Kenneth Calman looked to restructure specialty training to 'produce a shorter, more structured and organised training pathway'. The Calman proposals also introduced the idea of regional programmes which required doctors in specialty training to rotate within a fixed geographical area as they worked through a specific curriculum. These 'Calman Numbers' were followed in 2005 by a challenging period in medical education triggered by the failed implementation of Modernising Medical Careers (MMC). MMC was a programme which re-classified the traditional grades of medical career before the level of consultant. It also cemented the principle of geographically focused training programmes within a region or nation. This change required the doctor in training to rotate through a variety of hospital settings, including District General Hospitals and Tertiary centres, whilst working through a competency-based curriculum. These training programmes would work towards a Certificate of Completion of Training (CCT) and entry onto the GMC Specialist Register.

Rotational training has now become commonplace in the delivery of medical specialty training. With training time reduced from pre-Calman days there has been a move to more shortened placements and regular rotations to move doctors in training through a number of hospitals to gain a wider range of experience and access to specific specialties to fulfil the requirements of the curriculum.

Rotational training in anaesthesia: the requirements

There is a recognition, in line with the nature of anaesthetic specialty training, that AiTs will need to rotate through a tertiary centre at least once to gain access to all aspects of the 2021 curriculum. This will be a requirement within Stage 2 and likely to be needed again, depending on the specific Special Interest Areas (SIAs) chosen in Stage 3. It is also recognised that experiencing a wide range of clinical environments helps AiTs to develop a more rounded approach to delivering high quality anaesthetic care. Rotation within a training programme offers exposure to a broad range of clinical skills and ways of working. It can offer additional potential benefits including:

1. helping AiTs experience a greater diversity and breadth of exposure to different disciplines
2. developing confidence and competence through a wider clinical experience
3. clarifying potential career pathways through a wider clinical exposure prior to making future plans
4. developing a flexible and dynamic approach to working as a team member through experience in a variety of settings
5. an opportunity to work with patients who represent a wider and more varied population demographic within different localities
6. supporting learning in specialist areas of anaesthetic practice that form part of the Final FRCA exam.

Rotational training: the challenges

Despite the requirements for rotating AiTs, and the potential benefits listed above, rotational training provides challenges for both those within training and those responsible for organising/supporting rotations.

Rotating to a new hospital can be disruptive for AiTs. At a minimum, changing trusts, in particular within a region where there is no Lead Employer, requires an AiT to:

- start a new contract
- engage with a new payroll department
- undertake a fresh batch of mandatory training
- organise parking/ID badges
- engage with new IT systems and be assigned logins/passwords
- meet new colleagues within a department and meet a new set of theatre staff
- review their training needs with a new educational supervisor/College Tutor
- adjust to a new commute.

This list is not exhaustive, and all of these requirements mean transitions to a new trust can be stressful and require adjustments within both work and home life that put pressure on the doctor in training. Given the above it can easily take up to two months to fully adjust to a new place of work and to start getting the most academically, clinically and socially from a new placement.

Rotational training: the impact

If grouped into themes, these challenges have educational, social, structural and wellbeing components:

1 **Educational**

- **a** In line with other professionals, AiTs need to form trusting working relationships with their trainers, as would be expected in any other working environment. This is difficult to achieve during short placements. An understanding between AiTs and their Educational Supervisor (ES) is needed to maximise training opportunities, achieve the required capabilities and maximise the additional opportunities available in each placement particularly when considering the breadth of the HALOs in the 2021 curriculum.
- **b** Frequent rotations limit the opportunities to engage in further endeavours that are crucial for meeting and excelling in all aspects of the curriculum. The restrictions imposed by the requirement to rotate often mean that opportunities to participate in quality improvement projects, teaching, and research are constrained. In some instances, AiTs find themselves returning to their former trusts during their personal time to complete essential projects. This is not conducive to the educational development and growth of AiTs. Stability in the workplace is essential for AiTs to become known across departments, feel part of the team, and make a substantial, positive contribution. Short term rotations also limit opportunities to undergo work towards the Generic Professional Capabilities embedded within the 2021 curriculum. These are all crucial aspects in the development of AiTs, especially for ST4 and consultant applications where it may be part of the person specification.

2 Teamwork and cohesion

- **a** Frequently moving departments impacts on cohesion within teams, as relationships are short and temporary. Shorter rotations make it harder for AiTs to put down roots within a department.
- **b** The frequent rotation of AiTs disrupts departmental cohesion too. In such an environment, AiTs struggle to establish a sense of belonging, which inevitably impacts morale. They feel unsettled whilst working to understand the nuance of each department. It takes time to adapt, and particularly with three- and six-month rotations, AiTs rarely have the chance to settle in before being uprooted once more.
- **c** Teams work best when everyone knows each other. This knowledge and understanding within teams naturally occurs after spending time in a workplace. After spending a while in a department, engagement in social events is more likely to occur, which for many is key in feeling like an equally valued team member.

3 Structural and wellbeing

- **a** Moving frequently has a greater impact in those local education and training boards (LETBs), regions and nations which cover a larger geographical area. This leads to longer commutes made more challenging due to increased costs and a reduced travel allowance. This is particularly difficult for those with caring roles who may have to regularly alter cover for parental or caring arrangements due to changing working patterns through frequent rotation.
- **b** In the past, many doctors in training enjoyed benefits including free or affordable accommodation, free parking, and good rest facilities. Unfortunately, these benefits are increasingly scarce in many trusts, requiring AiTs to travel long distances at a significant personal cost.
- **c** The repetition of administrative activities, eg ID checks, compounds the disruption caused by changing workplace location.

Rotational training: impact of the 2021 Curriculum

The previous Anaesthetics Curriculum, written in 2010, was based on the concept of 'spiral learning'. This meant that basic principles learnt during the training programme were expanded and further revisited as an AiT progressed. This also meant that time spent in specialist area blocks of practice had to be undertaken twice, often necessitating frequent rotations to tertiary units where these training opportunities were available.

The development of the 2021 Anaesthetics Curriculum was an opportunity to learn from developments made to the previous curriculum. These included removing the principle of spiral learning except in areas of special interest to an AiT. Within the 2021 curriculum AiTs are only required to undertake single blocks of neuroanaesthesia, cardiac anaesthesia and ICM during Stage 2, which reduces the need for frequent rotations and may lead to better experience in these areas of specialist practice.

The nature of a broad-based general training, on which the principles of the 2021 curriculum are based, promotes flexibility. They also promote greater opportunities, at the senior levels of training, for independent practice and development of the full range of knowledge, skills, behaviours, and attributes needed to practice as a consultant anaesthetist in the NHS.

In addition to the removal of spiral learning for sub-specialty training the change to a three-year Core Training Programme (Stage 1, four years for ACCS) allows AiTs the opportunity to spend more time in placements in the early stages of the training programme.

Work being done in other organisations

Enhancing Doctors Working Lives Working Group (NHSE)

Since 2016 NHSE has hosted a working group focusing on enhancing junior doctors working lives. In April 2024 they published their latest guidance entitled 'Improving the working lives of doctors in training'. Within the document, improving the working lives of NHS staff is described as a key strategic priority of the NHS. While this commitment extends to improving the working lives of the entire workforce, it is recognised from conversations with doctors in training that the NHS needs to do better for them.

The actions outlined in 'Improving the working lives of doctors in training' are specifically aimed at addressing the concerns of doctors in training and staff who rotate. Within the document there is a recognition that rotations mean that doctors in training can experience low levels of choice and flexibility of when and where they work, high levels of uncertainty and competition about the next steps on the training pathway and duplicative inductions and unacceptable pay errors as they move between employers.

As well as frustration and lost productivity, they recognise that these can result in a reduced sense of belonging, making it harder to retain the future workforce.

Summary of Anaesthetic Training Representatives (ATRG) responses to the RCoA survey into the impact of rotational training

The ATRG members, who represent all four nations, were asked to provide feedback on their experiences of rotational training within anaesthetics across the UK. Their responses are summarised below.

Within Stage 1 and ACCS training, one third said that AiTs knew all rotations at the point of offer acceptance with the rest either unsure or reporting about three months' notice of placements.

Within Stage 2 training, all responders acknowledged that cardiac and neuro blocks would inevitably necessitate short rotations but reported examples of positive practice such as knowing placement dates well in advance, provision of accommodation by the region or Trust, and the practice of using a lead employer as mitigating the disadvantages of this.

Within Stage 3, all responders were positive about the Special Interest Area (SIA) system and reflected that rotations less than one year were less disagreeable as generally AiTs had more choice over the duration and length of their placements.

Overall, responders reported positive practice at all stages of training. These related to knowing placements well in advance, efforts made to abolish rotations of less than six months and regional efforts to minimise the effects of rotating on wellbeing by providing accommodation or, in one case, a financial uplift for the region's most remote placement.

Multiple responses reported the benefits of larger regions (East of England, East Midlands) dividing into smaller 'hubs' to minimise the geographical upheaval associated with rotating. A number of responders explicitly acknowledged and thanked the work they could see their regional Training Programme Directors (TPDs) did in minimising the impact of rotational training and flexibly adapting placements where possible.

Ongoing challenges caused by short rotations included the failure of AiTs to embed within departments which can negatively impact the educational impact and meaningful accomplishments that these individuals could achieve during the rotation; lack of lead employer meaning excessive 'new starter' paperwork and payroll or tax errors that financially disadvantage AiTs; difficulty obtaining parking permits, which are often expensive, exacerbated by short rotations and long commutes necessitating travel by car; travel reimbursements that were either non-existent or heavily out of date with current petrol costs, and variable provision and quality of accommodation provided by hospitals or regions.

Of note, the same number of responders explicitly reported that placement swaps were generally achievable, if requested, in their region as the number who explicitly reported that swaps were generally not allowed.

Case studies of good practice from ATRG feedback

Scotland – East

'A unique deanery with few rotations. All rotations essential to gain core competencies.

Stage 2 and 3 trainees occasionally visit two other hospitals in the deanery, but these are for occasional lists not a formal rotation (as in stage 1). One of these hospitals is staffed with a separate anaesthetic department, the other is staffed from the base hospital. Rotations are less frequent in stages 2 and 3 as most complex surgery is carried out on one site. Very good communication, free accommodation, minimal time away from base. .... I think we're the gold standard.'

South West – Peninsula

'The TPD works really hard to get everyone their first choice and planning on a f2f meeting after ST4 ARCP to discuss career aspirations and plans for stage 3. A lot of thought and care go into it. People kept locally as much as possible. Rotating is good for change.'

East of England

'Core trainees really appreciate having their rotations mapped out at the beginning of the stage. Given the size of the deanery this is really important for life planning! If you go LTFT your rotations change. The TPDs will try and accommodate placements at your original hospitals but this isn't always possible and placements do change.'

North West – Mersey

In Stage 2 training (where trainees can rotate hospitals up to seven times): 'Cardiac, neuro, paeds and obs are all in separate individual hospitals in our region, which means there is a lot of short rotations and moving around to accommodate this. Thankfully we have a lead employer and all the trusts are within a reasonable distance range so you can easily rotate between them living in the same place but it is an issue. I'm not sure how the moving around could be improved given the way the region's hospitals are set out, but maybe having an over-arching educational supervisor for the stage of training and clinical supervisors in each trust would at least give some point of continuity rather than never really knowing your supervisor?

Rotational training: future considerations

In line with the 2021 Curriculum and in recognition of the impact of rotational training the College established a working party to produce guidance to enable Schools of Anaesthesia to minimise the need for placements of less than one year in the future. This will support both AiTs, trainers and Training Programme Directors to get the most out of the anaesthetic training programme.

Potential actions that will need to be undertaken to deliver longer rotations include the recommendations below.

Recommendations

Following on from the review of the background to and impact of rotational training in the context of the new anaesthetic curriculum we have produced a number of recommendations. These are aimed to guide Schools of Anaesthesia, the Royal College of Anaesthetists, departments of anaesthesia and individual anaesthetists as to areas they may consider developing to minimise the frequency and impact of rotations where required. In addition, where relevant, we have included the recommendations from NHSE's publication, 'improving the working lives of doctors in training'. We consider many of these recommendations to be vital in minimising the impact of rotations and they should be urgently implemented.

Schools of Anaesthesia

RECOMMENDATION 1:
Heads of School (HoS) and Training Programme Directors (TPD) should review and look to minimise the number of rotations required to complete each stage of training

Within Stage 1:

- It is possible to gain all of the capabilities required to complete Stage 1 training without needing to rotate (if within a department that provides obstetrics and ITU)
- All aspects of the curriculum are deliverable in a DGH environment
- Consideration could be given to reducing the delivery of the curriculum to a rotation between 2 departments only (eg 2 x 18 months or 1x 24 months and 1 x 12 months).

Within Stage 2:

- Training could be delivered flexibly to minimise the need for rotation within Stage 2
- The need to visit tertiary units for cardiac, neuro and paeds can potentially be aligned with the requirements of the other clinical domains to maximise curriculum coverage.

Within Stage 3:

- Within this stage of training the requirement to rotate will be dependent on the chosen training requirements of the individual AiT
- Rotations are likely to require shorter placements depending on which SIAs the AiT wishes to explore
- It may be possible to align some of the general requirements of the Stage 3 curriculum with working towards an SIA hence reducing the need for rotation.

RECOMMENDATION 2:
Each School of Anaesthesia should review the provision and delivery of educational supervision

Consideration should be given to providing an educational supervisor for the duration of each stage of training to improve continuity of support. One of the significant benefits cited in maximising the length of placements is continuity of educational supervision. This is beneficial for the AiT and trainer alike. The continuity provides the trainer with a better understanding of the AiT's needs, development and progress. It also allows the AiT to make longer term plans and make better progress within the General Professional Capabilities. This has been successfully run in a number of regions where an AiT has an overarching supervisor/mentor for the duration of their training programme (see Appendix 1 for case study)

Consideration should be given to ensuring educational supervision is stage specific. Stability of educational supervision also comes with a requirement for greater knowledge and understanding from the supervisor. If AiTs are to be placed with an ES for longer it is paramount that the AiT can rely on their supervision to be of a high quality. To this end it would be prudent for ES to focus on a particular stage of the curriculum to ensure they have a detailed understanding of what the AiT will need to achieve (eg ES for Stage 1, ES for Stage 2, ES for Stage 3, ES with experience of SIA)

RECOMMENDATION 3:
AiTs should be provided with advanced notice of rotations

Whilst there will always be a need for flexibility within the training programme to the benefit of all AiTs, consideration should be made to inform them of their likely rotations as far in advance as possible.

- In Stage 1 this should be details of the total three years prior to starting CT1.
- In Stages 2 & 3 this should be a minimum of two years' placements in advance of starting ST4 or ST6.

This will enable AiTs to plan ahead but with the understanding that they or their TPD may request a change if mutually agreeable (see Appendix 2 for case study).

RECOMMENDATION 4:
Where possible AiTs should be involved in choosing their rotations

Providing AiTs with an opportunity to be involved in the planning of their own rotations will provide them with a greater sense of control over their training programme. We recognise that a number of Schools already allow AiTs to preference their placements in Stage 1 and all AiTs will be involved in the decisions made around SIAs in Stage 3. Extending this process to all Schools and all stages of training will reduce the impact of rotations, as well as taking into account the AiT's own training needs and interest.

We also encourage Schools to provide support where appropriate for intra-regional rotation swaps where mutually agreed and in line with both AiTs' educational needs.

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RECOMMENDATION 5:
The College should continue to explore appropriate flexibility within the curriculum

- To help with the management of training programmes, and to enable AiTs to benefit from longer placements, we are working with the GMC to develop flexibility between Stages 2 and 3 of the 2021 curriculum.
- It is proposed that flexibility be introduced to enable some aspects of the Stage 3 curriculum to be brought forward into ST5 if that enables an AiT to remain in a post longer, on the understanding that the remaining aspects of the Stage 2 curriculum are completed before the end of ST6. These domains/capabilities would not include those required within the SIA of the curriculum.
- Of note, although flexibility is being proposed in the gaining of capabilities, completion of the Final FRCA would remain a requirement for progression from ST5 to ST6.

RECOMMENDATION 6:
The College to review the support and training available to College Tutors and Educational Supervisors in the delivery and requirements of the 2021 curriculum

We recommend that the College engage in providing training and support for College Tutors and Educational Supervisors to help them develop a detailed understanding of the 2021 curriculum, examinations and ARCP requirements. This would help ensure that all involved in the support of AiTs are clear on the requirements of the curriculum and hence what is available and achievable in each placement.

RECOMMENDATION 7:
The College to continue its engagement with the Enhancing Doctors Working Lives workstream (NHSE WTE)

The College has been supporting NHSE WTE in the ongoing work of the EDWL workstream. We would recommend continued support of this work and we welcome the recent publication of their document 'improving the working lives of doctors in training'. Within the document are many recommendations that will require financial support to employing trusts to deliver. We ask the College to continue to exert pressure on NHSE to deliver on promises outlined in the document.

NHSE, HEIW, NES & NIMDTA

RECOMMENDATION 8:
Those with direct responsibility for overseeing the delivery of anaesthetic training programmes (Deans or equivalent) should ensure appropriate administrative support is provided to their Heads of School and Training Programme Directors

The management, communication and delivery of training programmes requires a significant amount of administrative time. In many areas the recent merger of HEE with NHSE has led to a restructuring of staff at a local level. The feedback from Heads of Schools and Training Programme Directors is that this has added to their own administrative burden and impacted the timeliness of communications with AiTs and the notifications of rotations to departments. We recommend that this support is reviewed as a matter of urgency.

RECOMMENDATION 9:

Implementation of the recommendations from 'improving the working lives of doctors in training' as a matter of priority

Following the publication of the document 'improving the working lives of doctors in training' by NHSE, we ask the education bodies in all four nations to implement the recommendations as a matter of urgency. The ones highlighted below will have a significant impact on minimising the impact of rotational training.

i **Introduction of a Lead Employer Model**

The development of a central employer looking after all AiTs on a rotation has been shown to be beneficial. The avoidance of needing to change employer between placements has reduced the issues with incorrect or delayed salary payments, taxation issues and significantly reduced paperwork.

ii **Reinstate monitoring of compliance with rota requirements**

a information regarding incoming doctors is provided to organisations within the **required 12-week time frame** and with improved accuracy.

iii **Provide intensive support to providers including a review and redesign of payroll processes to reduce payroll errors**

iv **Addressing the unique issues caused by rotations**

To include reviewing on-boarding processes, and other practical steps to help foster a sense of wellbeing and belonging such as reviewing the application processes for lockers or car parking spaces and the availability of facilities.

v **Make it easier for staff to move between organisations on a Memorandum of Understanding (MOU) for providers to accept each other's mandatory training.**

This will remove the requirement for staff to repeat the training in a new organisation.

vi **Reform the existing approach to Statutory and Mandatory training (StatMand)**

To create a new non-professional Statutory and Mandatory training (StatMand) framework by December 2024 and a new professional StatMand framework by the end of June 2025.

vii **Reverse the system for paying course fees**

This will require the NHS, rather than the AiT, to pay any course fees upfront, avoiding the hardship caused by waiting for reimbursement.

Departments of Anaesthesia, Clinical Directors and College Tutors

As part of the work to limit the impact of rotations on AiTs there are opportunities for departments of anaesthesia and their associated clinical directors and College Tutors to make a significant difference. We also wish to recognise the work already done within anaesthetic departments across the four nations to support and develop the next generation of anaesthetists. This work often goes unnoticed, and we are grateful for all the support that is given.

Part of the strain associated with rotating into a new department can be alleviated through planning and preparation by the receiving department. As part of this work to minimise the impact of rotations where required, we encourage departments to review the following recommendations.

RECOMMENDATION 10:
Delivery of induction and Rota management

Doctors in training are particularly impacted by induction and shift allocation due to multiple employer changes, so all employers are required to ensure they:

- provide work schedules at least eight weeks in advance and finalised duty rosters six weeks in advance, as per the current contract
- improve rota management by exploring the opportunities technology offers to move towards greater self-rostering, so doctors have greater control over their lives while meeting the needs of the service
- Where rota changes are required with less than six weeks' notice, the doctors in training impacted should be involved in creating the new rota. In such situations all pre-existing leave arrangements must be accommodated.

RECOMMENDATION 11:
Each department should undertake a review of the availability of rest facilities, post-shift accommodation, access to study leave, access to parking, accuracy of payroll and access to hot and cold food 24/7. It is vital that all staff, including AiTs, should feel safe in their workplace and not be subjected to bullying or harassment of any kind.

The following resources can be utilised to help signpost both leadership teams and AiTs to help reduce the impact of fatigue and damage to wellbeing induced by rotations.

Fighting Fatigue (Association of Anaesthetists, RCoA & FICM)

A suite of resources to help departments and individuals manage their approach to the management of and protection against fatigue.

BMA: Five Priorities for Improving Wellbeing in the Workplace

The BMAs priorities are:

1. On-call designated parking spaces
2. Self-directed learning time to commensurate the training needs of each individual
3. The right to work from home to undertake portfolio and self-directed learning
4. Mess, rest facilities and lockers included in all hospitals including any new hospital builds
5. Access to an out-of-hours menu 24/7 that includes a hot meal and cold snacks for staff.

Their aim, with this campaign is to empower BMA members to act locally to achieve these five priorities through local negotiation. The campaign guide can be accessed on the BMA website.

BMA: Facilities Charter

The BMA has produced guidance for doctors and other clinical staff on how best to manage the risks of fatigue associated with current working patterns.

This includes:

- information about the causes and risks of fatigue
- ways to maximise rest and recovery
- guidance on supporting good quality decision-making
- advice on managing night shift working
- ways your employer and the BMA can help you.

NHS England Sexual Safety Charter

On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system.

Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. It is expected that signatories will implement all ten commitments by July 2024.

Appendix 1
Case Study in Educational Supervision

'As a trainee in West Yorkshire region, and upon starting Stage 2 training, trainees are allocated a 'Programme Educational Supervisor' who is intended to supervise for the entirety of higher training, and provide the overarching support for the trainee, with responsibility for HALO sign offs and ARCP preparation such as signing off the ESSR. The Programme ES is often (though not always) based in the Trust that a trainee commences Stage 2 training in. Trainees are then allocated a 'Local Educational Supervisor' in each Trust they are employed in, who oversees their specific training in that hospital, and provides practical support, in liaison with the Programme ES. There is flexibility for trainees to speak to the TPD if they feel they would like to switch Programme ES, either due to personal preference or if more specific support is required, such as mentoring for a subspecialty interest.

On a personal level and anecdotally from discussion with trainees in the region, it is felt to be a positive move. Having a supervisor for a longer period of time allows development of a more productive working relationship, and means feedback can be more meaningful as the supervisor actually gets to know the trainee. It can be useful if the path through training has been, as it is for many trainees, less than smooth, and I feel it allows for better quality support with issues such as time out of training and LTFT working. It also allows more of a holistic view of the trainee's progress through training and greater ability to identify areas for development.'

Appendix 2
Case Studies in Programme Management

Two hypothetical case studies demonstrating process for notifying AiTs of their rotations in East of England:

Twice yearly, prior to Feb and Aug national recruitment, the Stage 1 and Stage 2/3 TPDs submit rotations to be advertised via ANRO for entry at CT1 and ST4. These itemise hospital placements according to base trust/employer.

Case Study 1 – Stage 1 appointment

Dr A is a FY doctor.

They have ranked the EOE training rotations according to preference.

Following MSRA and successful interview they are deemed appointable on their overall score, ranked and are offered their second choice EOE training rotation by ANRO, which they accept.

The Stage 1 TPDs receive confirmation from ANRO about all successful appointments for Stage 1 and then send an individualised letter to each trainee, via the email address Dr A has used with ANRO, confirming their appointment.

In this letter the hospital placements are confirmed, 24 months Peterborough and 12 months Bedford, and the TPD explains that a condition of the trainee accepting this rotation is that they accept the 3 years planned hospital placements. Adjustments are considered in exceptional circumstances only.

They are asked to let the TPDs know if they intend to apply for LTFT training as rotations will need to be extended accordingly.

Case Study 2 – Stage 2 direct from Stage 1

Dr B is a CT3 doctor.

They have ranked the EOE Higher training rotations according to preference.

Following successful Self Assessment and Interview they are deemed appointable on their overall score and are offered their third choice EOE training rotation by ANRO, which they accept.

This itemises 24 months Stage 2 NNUH, 12 months Stage 3.1 WSH and 12 months Stage 3.2 CUH.

The Stage 2/3 TPDs receive confirmation from ANRO about all successful appointments for Stage 2 and then send an individualised letter to each trainee, via the email address used with ANRO, confirming their appointment.

In this letter the base trust/employing hospital placements are confirmed and additionally the 3/12 cardiac and 3/12 neuro placements are added for information, in this case scenario NNUH will remain the employing trust and Dr B will rotate to cardiac and neuro on honorary contracts. The TPD letter explains that a condition of the trainee accepting this 48-month rotation is that they accept the 4 years planned hospital placements.

They are asked to let TPDs know if they intend to apply for LTFT training or apply for Dual ICM training to allow any necessary adjustments prior to them joining the training programme.

Additionally, trainees are asked to let TPDs know if they want any prior learning to be considered towards Stage 2 training.

It is acknowledged that adjustment to Stage 3 may be required depending on SIAs.

They are invited to join the online ST TPD Stage 2 Welcome to EOE Session on the second Wednesday of their rotation.

Dr B replies by email that they intend to enter full time as an ST4 single CCT and so no adjustments are needed for them. They accept the link to the TPD Welcome session.

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