MINISTRY OF HEALTH
SINGAPORE

MH 34:24/8

MOH Circular No. 60/2020

27 February 2020

Please refer to Distribution List

UPDATED GUIDANCE ON THE MOVEMENT OF HEALTHCARE WORKERS, PATIENTS AND VISITORS IN HEALTHCARE INSTITUTIONS AT DORSCON ORANGE

The Ministry of Health ("Ministry") had previously issued circulars and advisories to healthcare institutions on preparedness measures at DORSCON Orange, which included guidance on movement restrictions for Healthcare Workers (HCWs), patients and visitors. The Ministry has since received feedback and concerns from the medical community on the impact on the continuity of care for patients as a result of movement restrictions and would like to clarify the rationale for such measures.

RATIONALE

2. Movement restrictions for HCWs, patients and visitors are essential to minimise infection risk and any cross-institutional transmission of COVID-19:

a) Whilst COVID-19 infection may be acquired in the community, the risk of nosocomial spread should still be minimised during DORSCON Orange;

b) Minimising the risk of HCW-HCW transmission also serves to reduce the impact on staffing levels and our system's capacity to deliver essential medical services; and

c) There is a need to protect patients, especially those who are most vulnerable, e.g. those with high acuity, long lengths of stay.

3. The movement restrictions are detailed in the proceeding paragraphs and have been determined based on the risks in the different care settings / sectors, which include the acuity, volume and movement of patients receiving clinical care (see **Annex A** for schematic representation depicting the movement restrictions within and across the different settings). While the Ministry understands that these measures may cause inconveniences to some healthcare institutions and HCWs, and disrupt some existing clinical practices, we hope that you can continue to play a part in our ongoing efforts to contain COVID-19 situation, and effectively minimise the risk of cross-institutional transmission of COVID-19.

4. This Circular therefore supersedes the Ministry's Circular No. 42/2020 on Restricted Movement of Healthcare Staff Between Healthcare Institutions as well as all other circulars and advisories relating to the movement of HCWs (see **Annex B** for previously issued circulars and advisories).

GUIDANCE ON MOVEMENT RESTRICTIONS FOR HCWs

5. All healthcare institutions and HCWs are advised to comply with the movement restrictions in the specific settings outlined below:

Acute and Intermediate Care Setting
(High risk: High patient acuity, moderate to high patient volume and movement)

6. Healthcare institutions providing services in the acute and intermediate care setting include the public and private hospitals, community hospitals, national specialty centres, medical centres[1], and ambulatory surgical centres. As far as possible, HCWs practising in the acute and intermediate care setting should stay within the institution(s) they are allowed to or have chosen to practise in, specifically:

a) Public Hospitals[2] / National Centres / Medical Centres[1] / Community Hospitals – The movement of HCWs providing care is **limited only to the same healthcare campus or between designated acute hospital-community hospital (AH-CH) pairings or designated acute hospital-medical centre pairings[3,4]**. Movement between different campuses or beyond the designated AH-CH or AH-Medical Centre pairings is limited to pre-approved HCWs or medical teams providing emergency and/or time-critical services only. Any further cross-campus/cross-pairing movements and its reasons must be cleared with the CEO/ CMB/Medical Director or equivalent, and surfaced to the Ministry for prior approval.

b) Private Institutions – The movement of HCWs providing inpatient care is limited to **one** place of practice, with the following exceptions:

   i. Doctors providing anaesthesiology services for continuity of the inpatient services. These doctors should limit their inpatient practice to no more than one cluster of private hospitals, as detailed in **Annex C**, and must be supported by the CEO / CMB / Medical Director or equivalent.

   ii. Doctors or medical teams providing emergency and time-critical services (e.g. e-PCI, ECMO, organ transplants, emergency surgical services, neuro-interventional services) or where there is limited number of doctors in the specialised area of care in the private sector (i.e. only Infectious Diseases Physicians, Neurosurgeons and Cardiothoracic Surgeons). For these HCWs, movement beyond the clusters indicated in **Annex C** would be allowed and must be supported by the CEO / CMB / Medical Director or equivalent.

   Other than the movements described in (i) and (ii) above, all other deviations will have to be supported by the CEO / CMB / Medical Director or equivalent, and approved by the Ministry on a named-HCW basis.

[1] Refers to Admiralty Medical Centre and Jurong Medical Centre.
[2] Includes Specialist Outpatient Clinics (SOCs) as they form part of the services provided in the public hospitals.
[3] KTPH-Admiralty Medical Centre, and NTFGH-Jurong Medical Centre.
[4] For Regional Health Systems (RHS) providing RHS-led community services, community services staff who are redeployed for inpatient care should not be concurrently deployed to support home visits.

c) Private Standalone Ambulatory Surgical Centres – Doctors practising at standalone ambulatory surgical centres (ASCs) should limit their practice to **one ASC**. Preferably they should practice in a standalone ASC with emergency admissions to the **one** hospital in which they have admitting rights to during this period of restricted movement.

Primary Care Setting, Private Specialist Clinics and Private Allied Health Clinics
(Moderate risk: Moderate patient acuity, moderate to low patient volume and movement)

7. Healthcare institutions providing outpatient services include the polyclinics and GPs in the primary care sector, as well as private specialist clinics (medical and dental) as well as private allied health clinics. The following movement restrictions apply:

a) Polyclinics – HCWs should limit to **one** primary place of practice (i.e. one polyclinic), and **one other** polyclinic within the same cluster if necessary.

b) GP Clinics – HCWs should limit to **one** primary place of practice (i.e. one GP clinic), and **two other** GP clinics if necessary.

c) Private Specialist Clinics – HCWs should limit their outpatient practice to **up to two** clinics if necessary. Preferably, the private specialist clinic should be located within the same premises as the private institution in which the doctor has chosen to provide inpatient services at (in this instance, private specialists can practise in one private institution, one standalone ASC and up to two private specialist clinics[5]).

d) Private Allied Health Clinics – HCWs should limit their outpatient practice to **up to two** clinics if necessary.

Long-Term Care Setting
(Moderate to low risk: Moderate to low patient acuity, moderate to low patient volume, low patient movement)

8. Healthcare institutions in the long-term care setting include renal dialysis centres, hospices, nursing homes and organisations in the community care setting (excluding home care[6]). The following movement restrictions apply to the long-term care setting:

a) HCWs can practice in **no more than four places of practice** within the long-term care setting, with **no more than two places** being renal dialysis centres or inpatient/day hospices (e.g. HCWs can practise in two RDCs and two Nursing Homes).

b) To support continuity of care in the long-term care setting, HCWs from acute, intermediate and primary care, private specialist clinics and private allied health professionals are allowed to practise in the long-term care setting. No approval is required except for HCWs in the public healthcare institutions, and they must seek the approval from MOH for these arrangements before doing so. This would mean that HCWs can retain their base place of practice in their existing sector and in addition practise up to the cap of four places in the long-term care setting. For example, a GP who has a base practice in a GP clinic can practise in four

[5] The standalone ASC and one private specialist clinic will be located in the private institution in which the HCW has admitting rights.
[6] This guidance does not apply to HCWs who are visiting patients/clients at their own homes.

long-term care places (with no more than two places being renal dialysis centres or inpatient/day hospices).

c) For HCWs who are practicing in the long-term care setting and are affected by the restriction on the number of places of practice as described in paragraphs 8(a) and (b) above, please inform AIC at "gp@aic.sg" by 2 March 2020.

N.B.: The Ministry has allowed HCWs to practise in more places in the long-term care setting compared to the other settings, as this is necessary to ensure continuity of care and proper medical coverage.

Deviations from Movement Policy

9. Where there is need for deviation to the guidance detailed above (including across care settings or between the public and private sectors or to practise in more places than allowed):

a) HCWs should seek approval from CEO / CMB / Medical Director or equivalent of all institutions involved and surface to the Ministry for evaluation on a case-by-case basis. This would be on a named-HCW basis, and the request should include information on the specialty / sub-specialty of practice, the list of institutions that require the service, necessary approvals from CEO / CMB / Medical Director or equivalent of all institutions involved, as well as the justifications to be provided to the Ministry for review.

b) Institutions should exercise discretion and accountability when approving deviations from the stipulated guidelines and ensure proper documentation and record-keeping of all approvals and agreements.

10. Institutions should also put in place cross-institutional operational arrangements, care protocols and mitigation measures to reduce transmission for these exceptional circumstances e.g. to mitigate transmission risks associated with cross-institutional movement beyond the movement restrictions, institutions may consider setting up dedicated Operating Theatres (OTs) or wards to accommodate such circumstances and as part of proper business continuity plans, such that the impact may be ringfenced if there were any cross-institutional transmission of the infection.

11. Wherever feasible, institutions are also strongly encouraged to consider the use of digital tools when appropriate to reduce the need for cross-institutional movement e.g. consider remote monitoring of patients with follow-up appointments, arrange peer learning sessions or set up remote meetings with fellow colleagues through digital conferencing platforms.

GUIDANCE ON MOVEMENT RESTRICTIONS FOR PATIENTS

12. Inpatient movement and transfers between healthcare institutions within and across care settings/ public-private sectors should be minimised as far as possible during DORSCON Orange to reduce the risk of cross-institutional transmission due to the transfer. The following principles should be followed if inter-hospital transfers cannot be avoided:

a) Only cases requiring urgent and essential clinical expertise that is not available in-house and cannot be managed with remote support should be transferred.

This includes ECMO, O&G, neuro-interventional radiology, major/poly trauma care, ePCI, organ transplant etc.

b) Both sending and receiving hospitals should assess and communicate on the possible risk of COVID-19 for patients being transferred.

   i. If the patient's condition and time permits, sending hospitals should assess such patients for active respiratory infection prior to the transfer, including initiation of appropriate diagnostic testing.

   ii. The results of any diagnostic test for COVID-19 should be traced and informed to the receiving hospital for their follow-up as soon as available.

c) There should be mutual agreement from both the sending and receiving hospitals' clinical leadership before the transfer takes place. (This does not apply to cases where patients require urgent care or care that cannot be managed in the sender's facility e.g. from nursing homes to hospital emergency departments).

d) If the infection risk of the patient to be transferred is assessed to be high, both sending and receiving hospitals should ensure the availability of appropriate clinical resources (e.g. isolation beds) and take appropriate personal protection and infection control precautions before, during and after the transfer.

e) Teams must communicate to ensure safe handover of care. Staff from both institutions should minimise face-to-face interaction during the transfer.

13. Any patients seeking medical attention should be strongly advised against attendance at multiple healthcare institutions, unless otherwise clinically-indicated.

14. Patients seeking medical attention in the primary care setting are highly encouraged to stick to one polyclinic or GP clinic of choice. The Public Health Preparedness Clinics (PHPCs)[7] have also been activated since 18 Feb 2020 partially to reduce 'doctor-hopping' in the primary care setting.

GUIDANCE ON MOVEMENT RESTRICTIONS FOR VISITORS & ACCOMPANYING PERSONS

15. For the safety and welfare of all HCWs, patients and visitors, the following movement restrictions apply to:

a) Institutions providing inpatient and day surgical services - Each inpatient in a public or private institution, and each patient at national specialty centre, medical centres or ambulatory surgical centres is allowed **only one visitor/ accompanying person (including caregiver)** at any one time.

b) Institutions providing outpatient services – Each patient seeking medical attention at the polyclinic, GP clinic, private specialist clinic and private allied health clinic should be accompanied by **only one** person.

[7] Public Health Preparedness Clinics (PHPCs) are designated general practitioner clinics that form part of the primary care response to public health emergencies. These clinics have progressively been activated from 18 Feb 2020 to provide subsidised treatment for patients with respiratory illness, as part of our efforts to manage the COVID-19 situation.

c) Institutions providing community care services – Each resident in a residential care facility is allowed **only one visitor** at any one time. Seniors attending centre-based services in the community such as day rehabilitation centre, day hospice and senior care centres or residents visiting community nursing posts should be accompanied by **only one** caregiver at any one time.

16. Exceptions can be made for unique circumstances such as dangerously-ill patients. Institutions are to make the assessment on a case by case basis. In all cases, there should be an appropriate workflow to ensure family members or caregivers are properly screened and infection control measures in place to prevent infection risks. Steps should also be taken to ensure family members or caregivers of dangerously-ill patients have minimal interactions with other inpatients.

COMPLIANCE TO MEASURES

17. In addition to the guidance on movement policies in their setting, all healthcare institutions and HCWs should also ensure strict compliance to the following measures:

a) Maintain strict infection control practices aligned with the National Infection Prevention and Control Guidelines for Acute Healthcare Facilities 2017;

b) All HCWs, patients and visitors to maintain good personal hygiene measures including frequent hand washing with soap and water;

c) All HCWs are reminded to strictly adhere to hand hygiene practices as well as adopt appropriate PPE usage at various clinical settings (please refer to the 7 February 2020 guidance on PPE use);

d) All HCWs to be placed on health surveillance (e.g. taking temperature twice daily) and to monitor their health regularly;

e) All HCWs should comply with prevailing travel advisories and anyone returning from the list of affected countries/regions[8] that are subjected to Leave of Absence, or Stay Home Notice[9] must do so for a period of 14 days upon return to Singapore;

f) All unwell HCWs with symptoms suggestive of an acute respiratory illness (fever, cough, sore throat, breathlessness, sputum production, fatigue/malaise) should not come to work and should stay at home and minimise close contact with others. They should wear a mask and seek medical attention, as necessary. They should also update their employer or institution point-of-contact promptly; and

g) Check the MOH website (www.moh.gov.sg/covid-19) regularly for further updates and Health Advisories.

18. The Ministry will continue to work closely with you to safeguard the safety and welfare of our HCWs, patients and visitors in our healthcare institutions. Together, we can maintain the confidence in our healthcare system in this challenging time.

[8] As at 26 Feb 2020, the list of affected countries/regions are mainland China, Daegu City and Cheongdo County in South Korea.

[9] This is based on the latest circular on the revision of suspect case definition for COVID-19 dated 23 February 2020, and healthcare institutions may need to adjust accordingly based on new circular from the Ministry.

19. For clarifications on the movement restrictions set out in this Circular, please e-mail the points of contact in the respective sectors.

Thank you.

A/PROF KENNETH MAK
DIRECTOR OF MEDICAL SERVICES
MINISTRY OF HEALTH

Distribution List
GCEOs, CEOs, CMBs, COOs, CHROs of Public Hospitals
Directors/Medical Directors/Executive Directors of National Specialty Centres and Medical Centres
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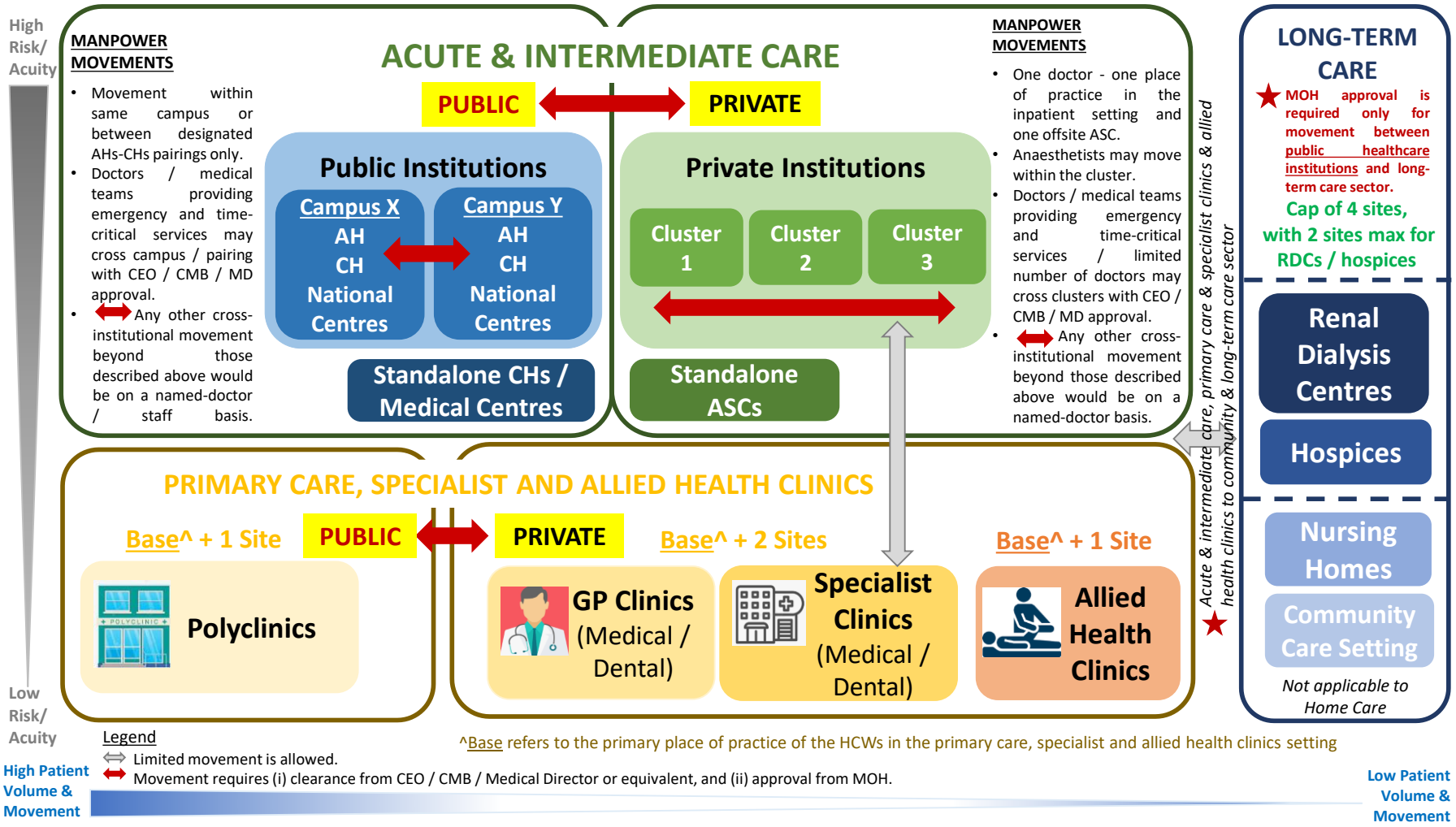
Allied Health Associations and Societies
CEOs and COOs of Polyclinics
CEOs of Private Hospitals
CEOs/Clinic Managers of Private Ambulatory Surgical Centres, Private Specialist Clinics
CEOs/Clinic Managers of General Practitioner Clinics, Renal Dialysis Centres
CEOs of Community Care Organisations
All Registered Medical and Dental Practitioners

Annex A

SCHEMATIC REPRESENTATION DEPICTING MOVEMENT RESTRICTIONS ACROSS DIFFERENT SECTORS AND SETTINGS



Annex B

CIRCULAR, GUIDANCE AND ADVISORIES PREVIOUSLY ISSUED BY THE MINISTRY PERTAINING TO MOVEMENT OF HCWs

S/n	Date Issued	Title of Circular, Guidance and Advisory	Document
1	6 Feb 2020	ADVISORY ON 2019-nCOV READINESS PREPAREDNESS MEASURES FOR THE COMMUNITY CARE SECTOR	ADVISORY ON 2019-nCOV READINE
2	7 Feb 2020	ADVISORY ON 2019-nCOV READINESS PREPAREDNESS MEASURES FOR PUBLIC HEALTHCARE INSTITUTIONS	MOH Guidance for PHIs at DORSCON Or
3	7 Feb 2020	ADVISORY ON 2019-nCOV READINESS PREPAREDNESS MEASURES FOR THE COMMUNITY HOSPITALS	MOH Guidance for CHs at DORSCON Ora
4	7 Feb 2020	ADVISORY ON 20190-nCoV READINESS PREPAREDNESS MEASURES FOR POLYCLINICS	ADVISORY ON 2019-nCOV READINE
5	7 Feb 2020	**MOH Circular No. 42/2020** RESTRICTED MOVEMENT OF HEALTHCARE STAFF BETWEEN HEALTHCARE INSTITUTIONS	MOH Cir No 42_2020_7Feb20_Ma
6	10 Feb 2020	ADVISORY ON 2019-nCOV READINESS PREPAREDNESS MEASURES FOR PRIVATE HOSPITALS	MOH Guidance for Pte Hosp at DORSC(
7	10 Feb 2020	ADVISORY ON 2019-nCOV READINESS PREPAREDNESS MEASURES FOR PRIVATE SPECIALIST CLINICS	MOH Guidance for Pte SOC Clinics at D
8	16 Feb 2020	GUIDANCE ON CROSS-INSTITUTIONAL MANPOWER MOVEMENT IN PRIVATE INSTITUTIONS	20200216_GUIDANC E ON CROSS-INSTITU

* MOH Circular No. 60/2020 provides further guidance and clarification, and supersedes only the portions of those circular, guidance and advisories pertaining to movement of HCWs previously issued by the Ministry.

Annex C

PRIVATE INSTITUTION CLUSTERS

Private Institution Clusters		
Cluster 1	**Cluster 2**	**Cluster 3**
• Mount Elizabeth Hospital • Parkway East Hospital • Farrer Park Hospital	• Mount Elizabeth Novena Hospital • Mount Alvernia Hospital • Raffles Hospital	• Gleneagles Hospital • Thomson Medical Centre • Concord International Hospital

FREQUENTLY ASKED QUESTIONS (FAQs) ON MOH's GUIDANCE ON THE MOVEMENT OF HEALTHCARE WORKERS, PATIENTS AND VISITORS IN HEALTHCARE INSTITUTIONS AT DORSCON ORANGE – GENERAL

1) Are all healthcare workers (HCWs) affected?

Yes. Healthcare workers (HCWs) includes all employees (directly employed or outsourced) who are doctors, nurses, allied healthcare professionals, clinic and dental assistants, clinical/non-clinical researchers, locums, including administrative and ancillary staff working in any healthcare institution with no direct care roles. Should there be a need for discussion, remote discussion platforms such as video-conferencing may be adopted to reduce the need for a physical meeting among HCWs.

Cluster-level management (e.g. Group CEOs, Group CMBs) who need to coordinate outbreak response measures across campuses are exempted from restrictions to cross institutions and/or campuses. However, digital tools should be used where possible to facilitate remote meeting arrangements, so as to keep movements between institutions to a minimal. Appropriate infection control measures should also be taken. On the other hand, institution-level management should continue to comply with the movement policies relevant in their settings.

2) What about urgent patient transfers or the need for HCWs to support essential services in partner institutions?

Arrangements should be made to station staff permanently at partner institutions for the entire duration of alert level Orange to support essential services, so as to minimise any cross institutional staff movement.

For urgent patient transfers for clinical reasons (e.g. transfer of cases for ePCI, trauma), individual institutions are required to make their own risk assessment per para 12 and ensure that strict infection control protocols and precautions are adhered to.

3) Do staff working at different hospitals and living together need to practice strict social distancing at home?

It is not necessary for staff to be strictly segregated from family members or flatmates working in another hospital. Staff can continue to stay in the same room/apartment but take some precautions, such as maintaining good personal hygiene at all times, reduce interaction and minimise contact with staff from another hospital.

4) What is the process of seeking approval for movement <u>across care settings</u>?

Movements across care settings is not allowed, with the following exceptions:

- Movements of HCWs within public healthcare campuses and designated AH-CH / AH-MC pairings
- Doctors practising in the private specialist clinics can provide care in the private institutions and ASCs (grey arrows in **<u>Annex A</u>**).

As stated in paragraph 8b, HCWs from acute, intermediate and primary care, private specialist clinics and private allied health practices are also allowed to practise in the long-term care

setting. No approval is required except for HCWs in the public healthcare institutions, and they must seek the approval from MOH for these arrangements before doing so.

Private sector and VWO sector HCWs (e.g. GPs and therapists) can practice in the LTC sector subject to the caps in the number of places of practice in para 8a. We request that HCWs inform their respective institutions about their places of practices sector for accountability and record keeping.

Any other movement across care settings beyond those described above should be surfaced to the Ministry for evaluation on a case-by-case basis.

5) Can I move between the public and private sector?

Movement between the public and private sector (i.e. between public healthcare institutions and private institutions, between polyclinics and GP clinics/private specialist clinics) outside of the restrictions described in paragraphs is not allowed, unless surfaced to the Ministry for review.

Ministry's and institutional approval must be sought prior to such movement.

6) I am a General Practitioner (GP) practising in a few GP clinics in the primary care setting and I also provide clinical care to patients in the long-term care setting. What is the allowable number of places of practice in each care setting?

GPs can practise in up to five places of practice if you are also serving the long-term care setting. This may include your base GP clinic, and up to two other GP clinics. Examples of allowable permutations for GPs practising in both the primary care setting and the long-term care setting are as follows:

- One base GP clinic, and two renal dialysis centres or hospice.
- One base GP clinic, one other GP clinic, and two renal dialysis centres or hospice.
- One base GP clinic, two other GP clinics, and two renal dialysis centres or hospice.
- One base GP clinic and four nursing homes or organisations in the community care setting.
- One base GP clinic, one other GP clinic, and three nursing homes or organisations in the community care setting.
- One base GP clinic, two other GP clinics, and two nursing homes or organisations in the community care setting.
- One base GP clinic, two other GP clinics, one renal dialysis centres or hospice and one nursing home or organisations in the community care setting.

The GP must keep a record of the healthcare institutions he or she has been practising in, as well as the approval sought from all the institutions he or she will be practising in.

7) I am a locum practising in a few GP clinics and I also provide clinical care to patients in the long-term care setting. What is the allowable number of places of practice in each care setting?

Similarly, locums can practise in up to five places of practice if you are also serving the long-term care setting. This may include up to three GP clinics. Examples of allowable permutations for locums practising in both the primary care setting and the long-term care setting are as follows:

- One GP clinic, and two renal dialysis centres or hospice.
- Two GP clinics, one renal dialysis centre and one hospice.
- Two GP clinics, two renal dialysis centres or hospice and one nursing home.
- Three GP clinics, and two renal dialysis centre or hospice.
- Three GP clinics, one renal dialysis centre or hospice and one nursing home.
- One GP clinic and four nursing homes.

The locum must keep a record of the healthcare institutions he or she has been practising in, as well as the approval sought from all the institutions he or she will be practising in.

8) I am a Specialist practising in specialist clinics and I also provide clinical care to patients in the long-term care setting. What is the allowable number of places of practice in each care setting?

Similarly, specialists can practise in up to five places of practice if you are also serving the long-term care setting. This may include your inpatient place of practice, and up to two specialist clinics. Examples of allowable permutations for specialists are as follows:

- One base private institution, one specialist clinic, and two renal dialysis centres or hospice.
- One base private institution, two specialist clinics, and two renal dialysis centre or hospice.
- One base private institution, two specialist clinics, and one renal dialysis centre or hospice and one nursing home or organisations in the community care setting.
- One base private institution, one specialist clinic, one renal dialysis centres or hospice and two nursing homes or organisations in the community care setting.
- One base private institution, two specialist clinics, and two nursing homes or two organisations in the community care setting.
- One base private institution, one specialist clinic, and three nursing homes or organisations in the community care setting.

The specialist must keep a record of the healthcare institutions he or she has been practising in, as well as the approval sought from all the institutions he or she will be practising.

9) I am a Specialist practising in the private sector and I also provide visiting consultant services in the public hospitals. Am I allowed to continue to provide such services?

Movement between the public and private sector (i.e. between public healthcare institutions and private institutions, between polyclinics and GP clinics/private specialist clinics) is not allowed, unless surfaced to the Ministry for review.

Ministry's and institutional approval must be sought prior to such movement.

10) Are HCWs who are receiving medical treatment at other healthcare institutions subject to these movement restrictions?

Such HCWs may continue to seek treatment as necessary, if clinically required, and should maintain good personal hygiene.

Training in the Public Sector

11) Are healthcare students still posted to the healthcare institutions for training purposes?

At DORSCON Orange, all students' clinical postings to healthcare institutions (including to the community hospitals) will be suspended until further notice.

12) Can Medical Officers (MOs) and Dental Officers (DOs) be rotated as part of their posting cycle?

MOs and DOs will stay within their existing institution until further notice. MOHH will work with the institutions if redeployment of MOs and DOs within the same campus / institution / designated *Acute Hospital-Community Hospital* pairing is required.

13) Will PGY1s be allowed to move between institutions as part of the training?

All PGY1s will complete their training within the same campus. Similar to MOs and DOs, MOHH will work with the institutions if redeployment of PGY1s within the same campus/institution/designated *Acute Hospital-Community Hospital* pairing is required.

14) Will residents and specialist trainees be allowed to move between institutions as part of their residency training?

For residents and specialist trainees, cross cluster and cross institutional rotations will align to the above principles of healthcare staff movement. Residents will stay within their existing institution until further notice. However, rotations between institutions within the same campus or between designated *Acute Hospital-Community Hospital* or *Acute Hospital-AdMC/JMC* pairings for the purposes of training will be allowed. The following exceptions will also be allowed:

- Family Medicine Residents rotations between hospitals and polyclinics (these are not their continuity clinics)
- Family Medicine Residents and other Residents that require postings to KK Women's and Children's Hospital

15) Are the educators from healthcare institutions be allowed to move to other educational institutions?

Educators from healthcare institutions are allowed to travel to educational institutions, especially to conduct exams for graduating students in order not to cause disruption to the wider healthcare system. There should be strict enforcement of infection control measures and segregation of educators from different healthcare campuses.

16) Are HCWs still allowed to attend part-time/evening Clinical Education & Training programmes or other courses?

HCWs may continue to attend courses and trainings, but should take reference to guidance for HMDP and MOE's guidelines. In addition, HCWs from different institutions should minimise interactions, and participants should sit 1 seat apart in classroom/lecture theatre. Where available, HCW may wish to leverage on virtual learning or tele-conference to attend these programmes instead.

17) Will HCWs be allowed to attend interviews at other healthcare institutions (e.g. for recruitment or scholarship purposes)?

Movement between healthcare institutions for physical meetings and interviews should be minimised. Where possible, consider leveraging on technology such as phone and video conferencing for such purposes instead.