Solutions for the medical staffing of acute units

Background

The RCPCH recognises that there is a crisis of staffing in many NHS units at the moment.

The driving force is an inability to fill gaps in training programmes. That comes from a genuine shortage of doctors who can be appointed, particularly at the middle grade level. Although all appointable ST3 doctors were offered posts during harmonisation, one third of FTSTA posts remained unfilled.

The situation involves several factors.

The numbers of posts to be filled have increased due to the expansion of posts in 2003-2005 as a result of the Hutton NTNs to meet the Working Time Directive.

On the other hand, the pool of middle grade doctors is decreasing due to a reduction in experienced doctors from overseas. This is due to the 2006 Immigration rules discontinuing permit free training, coupled with more trainees taking out-of-programme options for either personal or professional reasons.

The overall result of this crisis is that in order to provide a safe acute service, consultants have had to fill gaps in middle grade rotas and the remaining trainees have been asked to undertake additional shifts - which in turn has threatened their own training.

This paper summarises the recent joint report from RCPCH and RCOG “Children's and Maternity Services in 2009: Working Time Solutions” (www.rcpch.ac.uk/Research/Workforce/Working-Time-Directive-Projects/WTD2009RCOG) and looks at a number of proposals that may help deal with this crisis.

This briefing should be considered in parallel with the paper entitled ‘Proposals for Dealing with the Crisis in Filling Short-term Vacancies in Training Programmes’ by Dr Mary McGraw (http://www.rcpch.ac.uk/Training).

A) Optimising fill rates and increasing training grades

Paediatric units wishing to optimise the fill rates in current training posts, or planning to use increased training grades as part of their WTD compliance solution, should consider the following:

1. In all likelihood there will be insufficient middle grade (tier 2) doctors to fill the number of posts needed for WTD compliance.

2. The minimum cell size for staff in paediatric units is eight in both tier 1 (junior grade) and tier 2 (middle grade), to satisfy the educational requirements of trainees who are working 56 hours a week.

3. 9-11 cell rotas are the ideal for WTD 2009 48 hour compliance and training.
4. Adequate numbers within the cell are essential to guarantee adequate training. This is particularly important for subspecialty training where the majority happens within the working day, rather than out of hours.

5. All centres with neonatal level 3 units must have separate rotas for neonates. Generally there will be more than one option, or combinations of options, available for optimising trainees, and each will have different costs, constraints and implications. For more details on this, see the parallel paper ‘Proposals for Dealing with the Crisis in Filling Short-term Vacancies in Training Programmes’ (http://www.rcpch.ac.uk/Training).

B) Rota redesign

Paediatric units planning to use rota redesign as part of their WTD compliance solution should consider the following:

1. There is a database of existing WTD compliant rotas available on the National Workforce Projects online portal: http://www.healthcareworkforce.nhs.uk/working_time_directive/rotas%2c_handover_and_escalation_tools/wtd_compliant_rotas.html

2. Rota redesign should involve wide consultation to ensure that redesigned rotas are workable, are safe for patients and doctors, and provide sufficient training time.

3. Seven consecutive night duties should not be used because of the impact on patient and doctor safety of increasing fatigue and sleep deprivation. One night at a time is best for patient safety but worst for doctor work-life balance. An optimal compromise would be four consecutive nights.

4. Although it is WTD compliant to work for 13 consecutive hours, this should include a period of time required for handover.

5. Handover time must be included in the rota duty times. The recommended handover time is 30 minutes, and a consultant should be involved in the handover.

6. Rota re-banding from band 2A to 1A will release funding, as will re-banding from 2A or 2B to 1B, but re-banding from 2B to 1A will not as they are the same banding supplement.

C) Role substitution

Role substitution is defined as: ‘extending the roles of nurses and midwives to free up doctor time’. This may also involve the creation of support worker roles.

Paediatric units planning to use role substitution or role enhancement and extension as part of their WTD compliance solution should consider the following:

1. Newborn baby checks by midwives may reduce the workload of junior grade (tier 1) doctors in paediatrics and help WTD compliance.
2. If ANNPs are in place it may be possible to reduce tiers of cover for neonatal units.

3. Training for these roles should be of high quality, reproducible and take into account the local work environment of the unit.

4. These roles work better when there are stable groups of senior staff to support them.

5. Units should put in place succession planning for these roles so that staff that leave can be replaced quickly.

6. Career progression and a variety of work should be considered in, for example, ANNP job plans.

7. The impact of these roles on groups of staff that are already challenged by shortages could have a severe impact in other areas of work in the unit. These areas should be assessed in advance and the impact minimised.

8. Good planning and implementation are key factors in the success of these roles in helping to achieve WTD compliance.

9. Units should make themselves aware of the lessons learnt by units who have used these roles successfully, and those that have tried to do so and failed.

10. Partial roles substitution for short periods of time can enable trainees to attend teaching/learning opportunities.

**D) Pathway substitution**

Paediatric units planning to use pathway substitution as part of their WTD compliance solution should consider the following:

1. Redesigning clinical services (pathways) can reduce the Out of Hours (OOH) workload, making it less intense, and can reduce admissions and call-ins. This could benefit work/life balance for all staff, including trainee doctors.

2. Proactive management of long-term conditions has the potential to reduce acute demands hospital services.

**E) Cross-cover**

**E(i) General paediatrics and obstetrics and gynaecology**

Paediatric units planning to use cross-cover at junior grade (tier 1) level with obstetrics and gynaecology as part of their WTD compliance solution, should consider the following:

1. Cross-cover between obstetrics and gynaecology and paediatrics should only be used at junior grade level (tier 1), and restricted to smaller units with a level 1 neonatal unit.
2. There is a potential conflict for the junior grade (tier 1) doctors if they are required to look after two patients at once. Both units must demonstrate that the cross-cover arrangement is safe and workable.

3. The use of cross-cover rotas inevitably changes the workload for the middle grade doctors (tier 2) in both specialties, and has the potential to compromise patient safety in both units. Both specialty units must demonstrate that the arrangement is safe for patients, and safe and workable for the middle grade (tier 2) doctors.

4. Where junior grade (tier 1) doctors are taken from obstetrics and gynaecology, to increase the number of junior grade (tier 1) doctors on the paediatrics OOH rota, it would be better if those doctors had experienced training in paediatrics first in their rotation.

5. The statement by the Royal College of Paediatrics and Child Health (1 June 2004) on cross-cover between obstetrics and gynaecology and paediatrics is still valid (to read the statement visit, www.rcpch.ac.uk/Research/Workforce/Working-Time-Directive-Projects).

**E(ii) General paediatrics and neonatal paediatrics**

Units that are planning to combine separate general paediatric and neonatal junior grade (tier 1) rotas into one cross-cover rota to cover both areas should consider the following:

1. The unit must address and resolve successfully the critical issue of patient safety for neonates where this type of cross-cover solution is being planned.

2. BAPM standards should be adhered to.

**F) Reconfiguration**

Paediatric units planning to use reconfiguration (see *Modelling the Future* at www.rcpch.ac.uk/Health-Services/ServiceReconfiguration/Modelling-the-Future) as part of their WTD compliance solution should consider the following:

1. There should be wide consultation across specialties for a reconfiguration of services in order to identify impacts and issues on other specialties and areas outside of the unit.

2. Specialist services may need to reconfigure to enable the 10-11 cell specialist rota at middle grade level to exist.

**G) Consultant of the Week (CoW)**

Paediatric units using consultant of the week as part of their WTD compliance solution should consider the following.

1. The units that had implemented consultant of the week have reported that it had contributed towards WTD compliance, and cited benefits such as improved patient safety, better continuity of care, better training and supervision and improved consultant support for trainees.
2. A consultant of the week appears to be generally helpful in terms of WTD compliance for smaller units. However, any impact on patient safety of the combination of CoW and on call arrangements leading to tiredness and fatigue later in the week of duty, should be recognised and resolved.

H) Consultant evening sessions

Paediatric units planning to use consultant evening sessions as part of their WTD compliance solution should consider the following:

1. Consultant presence in the evening can improve the triage and efficiency of the unit overall, and could have benefits in patient safety and training.

2. Consultants’ evening sessions need to be part of their negotiated contract.

I) Consultant resident on-call

Paediatric units planning to use consultant resident on-call as part of their WTD compliance solution should consider the following:

1. Having a consultant resident on-call can reduce the workload overall within the unit in OOH periods and could have benefits in patient safety and training. However care must be taken that this does not limit the experience of trainees.

2. If consultants are resident on-call day and night with no middle grade (tier 2), this may prove to be expensive. However, the cost may be offset by benefits in other areas of the service such as patient safety, throughput and training.

3. For the majority of units this option will require consultant expansion.

4. Career planning needs to be considered with the option of progressing into less arduous on-call alternatives in later careers.

5. Support staff, for example advanced nurse practitioners, “physicians assistants” and other options may be needed in busier places.