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This is guidance to help individuals who are planning paediatric and neonatal staffing, rotas and services. We are aware that different services and regions will have varying requirements. We are now in the second peak of the pandemic and whilst in the first wave not many children became unwell from COVID-19 we know there were many unintended consequences for children. Many services did not have enough time to regain normality before the second peak was upon us and it is vital that we protect our services as well considering the impact of coronavirus amid the usual peak activity over the winter months. This guidance will be updated with further iterations.

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## Introduction

Staffing is a huge challenge and we hope this guidance helps support you in your decision making.

Key principles are:

1. **This is a marathon not a sprint.** We need to do our best to try to sustainably support all grades and forms of staff, in order that they can provide appropriate services for CYP. These are trying times, and we recognise our workforce will go above and beyond.
2. **Flexibility and adaptability** will be needed as the situation evolves.
3. **Put your own oxygen mask on first.** The service needs healthy staff who are not burned out. Look after yourself and your colleagues.

The healthcare workforce continues to be fundamental to the NHS’s response to the ongoing challenges. We have seen much disruption to paediatric services through loss of inpatient capacity and differences in the availability or role of staff (due to redeployment, illness, shielding, etc). Caution must be taken to minimise disruption as much as possible. Redeployment of child health staff to other areas of care and loss of paediatric clinical space must be kept to an absolute minimum, and considered only as a last resort, to avoid detrimental impact to children and young people. Child health services must be supported so that they can be resilient during winter when activity increases.

Maintaining paediatric and neonatal rotas in as many hospitals as possible remain essential. We must also link up across all services used by children and young people to ensure there are no unintended consequences for those who are not being seen as they usually would. Trust and Health Board senior management need to be engaged in system wide thinking to maintain as much of the paediatric services on as many sites as safely as possible, tailored to the local outbreak, geography and pressure in other sectors.

There is detailed guidance available for working with vulnerable children in England, Wales and Northern Ireland and in Scotland, community services, neonatal units, acute and emergency paediatric services and paediatric intensive care.
During the first wave of the pandemic, there was less routine care provided and fewer children accessing urgent care. This meant that some paediatricians were redeployed. In the second wave there is an expectation that routine care will continue as well as managing waiting lists. NHSE are also focusing on maintaining Special educational needs and disability (SEND) services and working with CCG’s to minimise disruption in care from allied health professionals to vulnerable children. It is important to creatively consider skill acquisition when working in other areas and for the second wave maintaining paediatric services is of paramount importance.

However, whilst safeguarding the care of children and young people is our primary responsibility as paediatricians, we also have a responsibility to the wider profession in times of a pandemic. We need to continue to be ready to help our colleagues in adult medical care, critical care and the emergency department but in balance with our paediatric responsibilities. The four UK chief medical officers, the national medical director, the Academy of Medical Royal Colleges and the GMC wrote to all UK doctors (PDF) stressing that it will be appropriate and necessary for clinicians to work beyond their usual disciplinary boundaries and specialisms under these difficult circumstances, and they will support individuals who do so. Equivalent considerations apply for nurses, advanced health practitioners (AHPs) and other registered health professionals.

The impact of COVID-19 on people’s mental health will endure beyond the pandemic. Supporting staff wellbeing is vital and it is important to consider the safety of staff both with relation to protection from COVID-19 and in managing risk with a reduced workforce.

**Rotas**

As availability of staff increases and we return to ‘the new normal’, departments should seek to return to patterns of staffing which are similar to those pre-COVID. The following are points to consider should you have to amend your rotas during the second local/national peak:

- If the activity is reduced consider **reducing the number of staff per shift** but having **more senior availability** in the hospital to support decision making.
  - For example, move from a three tier on-call to a two tier on-call rota with resident consultants. This will also enable some individuals to rest, or free up some of the workforce to support other services.
- If the activity is reduced consider making the **shifts longer** but having **more time between shifts**.
  - Maximum shift length should remain less than 13 hours at present.
  - Can you align your shift pattern with other services within your organisation? Shift length of 9 hours three times per day may be appropriate.
  - A shift pattern could be adopted which is more similar to nursing staff, where all shifts are either long days (eg 08:30 - 21:00) or nights (20:30 - 09:00), allowing time for handover in between.
- If activity is high then reducing shift length may be important as intensity of shift work is equally important in burnout.
- Consider the area of practice as it may well be that longer shift in high risk areas increase the risk of acquiring coronavirus:
High risk: ED, PICU and respiratory  
Lower risk: general paediatrics and neonates

- Consider a **rolling model** with 3 days on and 2 or 3 days off.

- Consider rostering people in **teams with different skill levels**.
  - For example, a “blue team” may consist of one full time ST3 and two less than full time ST7s (who job share/divide their shifts)

- Follow the **minimum requirements of safe staffing** for your hospital and roster that many individuals to work, other staff may be **rested or redeployed**.

- **Weekend and weekdays** may need to be scheduled with the **same amount of staffing**.

- **Engage and consult local staff** when revising the rotas.
  - Work with trainees to identify which days they can or cannot work due to caring responsibilities.
  - Junior doctor rota changes must be done in conjunction with Medical Staffing and the Guardian of Safe Working
  - Set a date for the new rota to be introduced, but also keep staff aware that the situation is evolving and may change.

- **Rotas should comply with the conditions of the updated** Junior Doctor Contract (2019). There are variations in each of the devolved nations, **outlined here by the BMA**
  - Where rotas are non-compliant, this must be transparently communicated and recorded.
  - Co-designing junior doctor rotas with trainees will mitigate this to some extent.
  - See the [NHS Employers and BMA guidance](https://www.bma.org.uk) on the application of contractual protections during the pandemic. The guidance summarises some initial flexibilities and examples of acceptable steps while maintaining much of the intended safeguards.

- All staff should ensure that they **keep track of additional hours** worked to ensure **appropriate remuneration**.

- The [BMA](https://www.bma.org.uk) have issued guidance regarding PA allocation for out of hours and additional work during the pandemic.

- Ensure you have **up to date contact details** for staff and **plans for arranging cover in emergency situations**.
  - WhatsApp or other messaging groups may be helpful for this.

- You may need to pool all specialist patients into one general service, especially as some sub-specialties will have very limited outpatient activity and so more capacity for inpatient work.

- [HEE](https://www.hee.nhs.uk) have issued guidance on managing the training workforce which is applicable to students and trainees. They have committed not to redeploy students from their scheduled placements in order to avoid any further disruption to education. However, with proper measures, students may be able to support service delivery and continuity during a COVID-19 resurge.

- Community paediatricians should not be transferred to acute services unless absolutely
necessary. There will likely be an increase in demand.

- Redeployment of specialist children's nurses is having a knock-on effect on neonatal units and children's services, and they need to be brought back to their respective units.

**Rest**

- Identify hospital accommodation where staff can rest in if they cannot easily get home safely.
  - Can rooms be converted into rest areas?
- NHS-reimbursed hotel accommodation has been agreed centrally.
  - Ask your hospital to liaise with local hotels to support this.
- Signpost trainees towards NHS-reimbursed hotel accommodation (which has been agreed centrally).
  - If this is not already in place, ask your hospital to liaise with local hotels to support this. The offer of accommodation is optional for staff who are:
    - Self-isolating from their household and wish to remain working
    - Too tired to travel home and needing to do frequent shifts
- Each room should have access to separate toilet/washroom facilities in case the staff member is required to self-isolate from others.

**Returning to clinical work**

Staff have returned after long periods of absence during the first wave and are concerned over new disruptions to work, education and training over the winter period, e.g. from shielding, out of programme (OOP):

- Ensure risk assessments take place when trainees or other staff are returning from shielding.
- Many people shielding have concerns over recommencing face to face activity and this needs to be acknowledged with recognition that support may need to be put in place.
- Ensure relevant induction, including training in personal protective equipment (PPE).
- Returning trainees should spend two weeks working shifts where there is appropriate supervision from someone working at consultant level.
- For trainees in England, signpost to local Supported Return to Training resources
- Ensure staff have received simulation training and Basic Life Support/Advanced Paediatric Life Support/Neonatal Life Support as relevant. Electronic resources to support this are provided at the bottom of the page.
- Ensure up to date information on child protection is provided.

**Returning to clinical work after retirement** (retire and return)

- The GMC has provided temporary registration to our recently retired colleagues.
- However, be aware that these individuals have contributed significantly over the years, and they may be in vulnerable groups, and so consider carefully if and what we ask them to do.
Assessing competency to work at a higher level

Consider the core skills that are available within your department or service and whether people can work at a higher level. It is important to ensure these individuals are appropriately supported and inducted.

Moving up to the Tier 2 rota:

- If an individual has completed their MRCPCH part 1 examination and has obtained appropriate ARCP (Annual Review of Competence Progression) outcomes, then they can move to the Tier 2 rota.
- If an individual has not completed their exams or reached their ARCP, then sign off from their most recent clinical supervisor and educational supervisor should be obtained and be competency based.

ST7/8 moving up to consultant-level working:

- If an ST7/8 has obtained appropriate ARCP and START (assessment), they can move to consultant working.
- If an ST7/8 does not have their START assessment feedback, then sign off from their most recent clinical supervisor and educational supervisor should be obtained.
- Appropriate support should be available from other consultants. For example, those self-isolating or recently retired from acute paediatrics could have a ‘home rota’ where they are available to give advice via telephone across different hospitals.

Other professional groups:

- You may well have advanced nurse practitioners, advanced clinical practitioners or physician associates who have developed the skills and experience to work at a more senior level. You will need to consider:
  - What support they need to do this
  - Their own organisational regulation requirements
  - Sign off from the most senior nurse in your organisation and two paediatric consultants.

Staff at higher risk

We have a large number of expectant mothers working in paediatrics as well as other groups of staff at higher risk, such as those from black, Asian and minority ethnic (BAME) backgrounds. There is some evidence from the BMA to suggest that staff from BAME backgrounds have been disproportionately affected by lack of access to personal protective equipment (PPE). Sadly, 94% of the doctors who have died from COVID-19 were from a BAME background. BAME doctors, alongside other high risk individuals, must have access to risk assessments. Despite this, 36% of BAME doctors have not had access to risk assessments. We must ensure our colleagues are appropriately protected and we strongly encourage you to work with your Trusts and Health Boards to ensure BAME doctors, and other high risk groups, have timely access to meaningful risk assessments with an action plan to move forward with.
Staff should feel enabled, safe and protected to deliver the best care possible which includes personnel considerations and protection of staff, changes in timing to accommodate spacing, and infection control measures.

- The **UK government** is advising that shielding restarted for a restricted group of extremely clinically vulnerable individuals for the second lockdown. This may be the pattern over the winter during the second wave.
- **NHS Employers** and the **BMA** have guidance on supporting staff to return to the workplace following shielding, and for those in vulnerable groups.
- **Pregnant women and other vulnerable groups** should abide by social distancing advice (guidance from **Public Health England**, **Public Health Wales** and **NHS Inform Scotland**).
- Royal College of Obstetricians, Royal College of Midwives, RCPCH, Public Health England and Health Protection Scotland have **produced guidance for healthcare professionals on Coronavirus (COVID-19) infection in pregnancy**.
- The **Equality Human Rights Commission** has issued **Coronavirus (COVID-19) guidance for employers: Your duties on pregnancy and maternity** to help ensure pregnant or breastfeeding mothers, or those on maternity leave, are treated fairly.
- The Department of Health of Northern Ireland has **guidance for health care workers with underlying health conditions**.
- There are ways in which people can **work differently** to safeguard their health, such as:
  - Working in the **neonatal intensive care unit** may be lower risk
  - Some hospitals are developing ‘**COVID-free**’ clinical areas.

If staff at higher risk would have to breach advice to be physically present at work, for example because of their commute to work or crowded working environment, they should **work from home**. They should be supported to do work such as:

- Giving **advice to primary care** via a GP connect system or telephone 'hot line'
- Being available to **advise parents**
- Being responsive to **social services or teachers** when there are worries about vulnerable groups
- Doing **virtual clinics** from home, if the technology allows
- **Triaging** new referrals
- Maintaining a **list of tasks** that will need to be completed when the **crisis is over**
- **Auditing** how well the current changes in the system are working, eg telephone clinics - see our guidance on **auditing and data collection**.

**Working in systems and local planning**

As ever, staff and service planning should be done according to local need. Check local incidence and projection of COVID-19 cases to help determine planning, rather than referring to nation-wide or London-based figures.

- See the **NHS paediatric clinical guidance** for managing patients across different systems.
- Create a central organisational plan to help determine whether services should be moved from one hospital to another.
For example, diverting maternity services and paediatrics departments to other sites. This needs to be considered early even if not enacted as all available space may well be needed for adult patients with COVID-19.

- NHS England encourages hospitals within a Sustainable Transformation Partnership (STP) or Integrated Care System (ICS) footprint to consider how they can support each other.
- Set up groups (e.g., on WhatsApp) for each group of professionals to facilitate communication.
  - Consider having a representative from other groups to facilitate communication and transfer of appropriate information – e.g., one consultant representative on the Tier 2 WhatsApp group.
- To aid in your decision making process and strategy, you can register to view data collected across the UK from our ‘Impact of COVID-19 on child health services tool’ here which also includes regional reporting. An overall summary of the results can be accessed via results webpage. A letter discussing the importance of prioritising paediatric staff and space so every child has access to care can be viewed here.

Small, remote and rural services

Pressure points in remote and rural services can be the following:

- Physical space to practice infection control.
- Paediatric spaces being taken for adult patients. Discuss locally with critical care and plan where this will happen across units.
- Staffing, particularly in light of the self-isolation advice.
- Non COVID-19 patients. With the focus on COVID-19 paediatricians may be distracted to enquire about other symptoms.
- Produced documents have little to no mention of paediatrics, children or neonates in them.

Clinical negligence indemnity

Healthcare professionals and others carrying out NHS activities will continue to be covered for clinical negligence incidents if they have to work in different ways or locations.

You can access the joint letter from the Department for Health and Social Care, NHS Resolution, and NHS England and NHS Improvement.

Guidance from NHS Resolution specifies that the indemnity powers provided by the Coronavirus Act 2020 are comparable across the four nations as the Devolved Administrations have taken an equivalent approach to England. In all four nations, staff providing NHS services related to the coronavirus outbreak will have indemnity under the Act, where they are not already covered by an existing indemnity arrangement.

See the NHS Resolution FAQ for further information about the indemnity arrangements applying to the COVID-19 pandemic.

See the NHS Wales Shared Services Partnership for related indemnity arrangements.

See the Department of Health (NI-Direct) FAQ for indemnity arrangements for doctors,
nurses and midwives, allied health professionals, and social workers.

See the [NHS National Services Scotland](https://www.nhsnational.services.scotland) for related indemnity arrangements.

### Death in service/ill health retirement

It is vital that all staff consider their personal circumstances and ensure that they and their family are protected. Please encourage staff to check their respective [pension scheme](https://www.bma.org.uk) for the benefits they have access to should the worse were to happen.

It is worth noting that certain issues may be present for staff who have opted out of the pension scheme, more junior members and medical students that may be brought into work before the completion of their training. For further information please visit the [BMA website](https://www.bma.org.uk).

### Staff wellbeing

In the past few months, the healthcare workforce has demonstrated extraordinary commitment, going above and beyond the usual scope to provide as much support as possible. Although flexibility and adaptation has been needed during these unprecedented times, it is paramount that wellbeing of staff is not neglected. It is of great importance for staff to be working in a manner which is safe and which will not compromise their own health and safety, as well as that of their patients. As we face the backlog of care, and enter the second peak alongside other winter pressures, we must ensure we safeguard the wellbeing of our staff.

Our members have recommended a range of [wellbeing resources](https://www.bma.org.uk).

### Winter pressures

For guidance on winter pressures, please visit the [RCPCH winter planning section](https://www.rchp.ac.uk) where you can also view case studies and our recommendations.

You can also read the 7 October 2020 [joint letter on Winter Planning: Support to Children and Families](https://www.lga.org.uk) from LGA, NHS and Public Health England to Directors of Nursing.

### Best practice and innovative models

If you have examples of innovative models of practice and how this has been adopted in your service, please email workforce@rcpch.ac.uk: we can share these innovation examples on our quality improvement sharing website, [QI Central](https://www.rchp.ac.uk).

### Resources

- RCPCH guidance for paediatric services
- RCPCH guidance for community paediatrics
- RCPCH trainee progression through 2020
- RCPCH guidance on developing capabilities around curriculum
- RCPCH wellbeing resources from members
- RCPCH data collection and surveillance
• RCPCH impact of COVID-19 on child health services tool - results - and register
• Prioritising paediatric staff and space so every child has access to care (Letter to the Editor; BMJ/ADC publication)
• NHS England service evaluation and audit
• NHSE guidance for redeployment of secondary care staff
• NHSE guidance for paediatric critical care
• NHSE guidance on supporting staff to work from home
• NHS Employers and BMA terms and conditions of service and application of contractual protections (PDF)
• QI Central (innovative models of care, including content specific to COVID-19)
• AoMRC Principles for reintroducing healthcare services
• Free Advanced Life Support Group full APLS manual
• Free Paediatric Life Support e-modules
• COVID-19: how redeployment is affecting children’s services
• RCPCH winter planning
• RCPCH winter pressures- our recommendations
• Mental health, learning disabilities and autism: Guidance (NHSE and NHSI)
• BMA Consultants Committee guidance on working during COVID-19
• HEE guidance on managing the training workforce