COVID-19 - guidance for planning paediatric staffing and rotas

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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, and as the situation evolves services may need to adapt. This guidance will be updated with further iterations.

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Table of contents

- Introduction
- Rotas
- Rest
- Assessing competency to work at a higher level or return to clinical work
- Vulnerable workforce
- Working in systems and local planning
- Small, remote and rural services
- Clinical negligence indemnity
- Death in service/ill health retirement
- Staff wellbeing
- Best practice and innovative models
- Resources
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 is fundamental to the NHS’s response to this huge challenge. Paediatricians, alongside other doctors, are being called on to play their part.

Maintaining paediatric and neonatal rotas in as many hospitals as possible is 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 pandemic, there will be less routine care provided and it is expected that fewer children access urgent care. This means that some paediatricians will have capacity to work in other areas, and it will be worth thinking creatively about skill acquisition.

While safeguarding the care of children and young people is our primary responsibility as paediatricians, we also have a responsibility to the wider profession at this time. We need to be ready to help our colleagues in adult medical care, critical care and the emergency department. The four UK chief medical officers, the national medical director, the Academy of Medical Royal Colleges and the GMC have written 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.

Rotas

- 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.
- 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.
- 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)
- Consider a future scenario where many junior doctors are moved to work in adult specialties.
- 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 should be scheduled with the same amount of staffing for now.
- 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.
- All staff should ensure that they keep track of additional hours worked to ensure appropriate remuneration.
- 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.

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.
• 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.

**Assessing competency to work at a higher level or return to clinical work**

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 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.

**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.

**Returning to clinical work after absence**, eg out of programme (OOP):

- 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.
- Ensure staff have received simulation training and Basic Life Support/Advanced Paediatric Life Support/Neonatal Life Support as relevant.
- 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.

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.

Vulnerable workforce

We have a large number of expectant mothers working in paediatrics as well as other vulnerable groups.

• Shielded groups should self-isolate for 12 weeks (guidance from Public Health England, Public Health Wales and NHS Inform Scotland).
• 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 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 vulnerable staff 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 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.

The RCPCH will shortly be publishing data on COVID-19 cases to support such planning.

- See the [NHS paediatric clinical guidance](https://www.nhs.uk/conditions/coronavirus-covid-19/paediatric-clinical-guidance/) for managing patients across different systems.
- Create a central organisational plan to help determine whether services should be moved from 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.

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](https://www.gov.uk/government/publications/coronavirus-nda-clinical-negligence-indemnity).

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.

An update will be posted here once further clarification has been received about the indemnity arrangements for Scotland and Northern Ireland.

## 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 check your respective pension scheme for the benefits you 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.

## Staff wellbeing

In the past few weeks, 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 is 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.

See the NHS Employers and BMA guidance 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.

## 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 so that we can share them!

## 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 (coming soon)
- RCPCH data collection and surveillance
- NHS England service evaluation and audit
- NHSE guidance for redeployment of secondary care staff
- NHSE guidance for paediatric critical care
- 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)