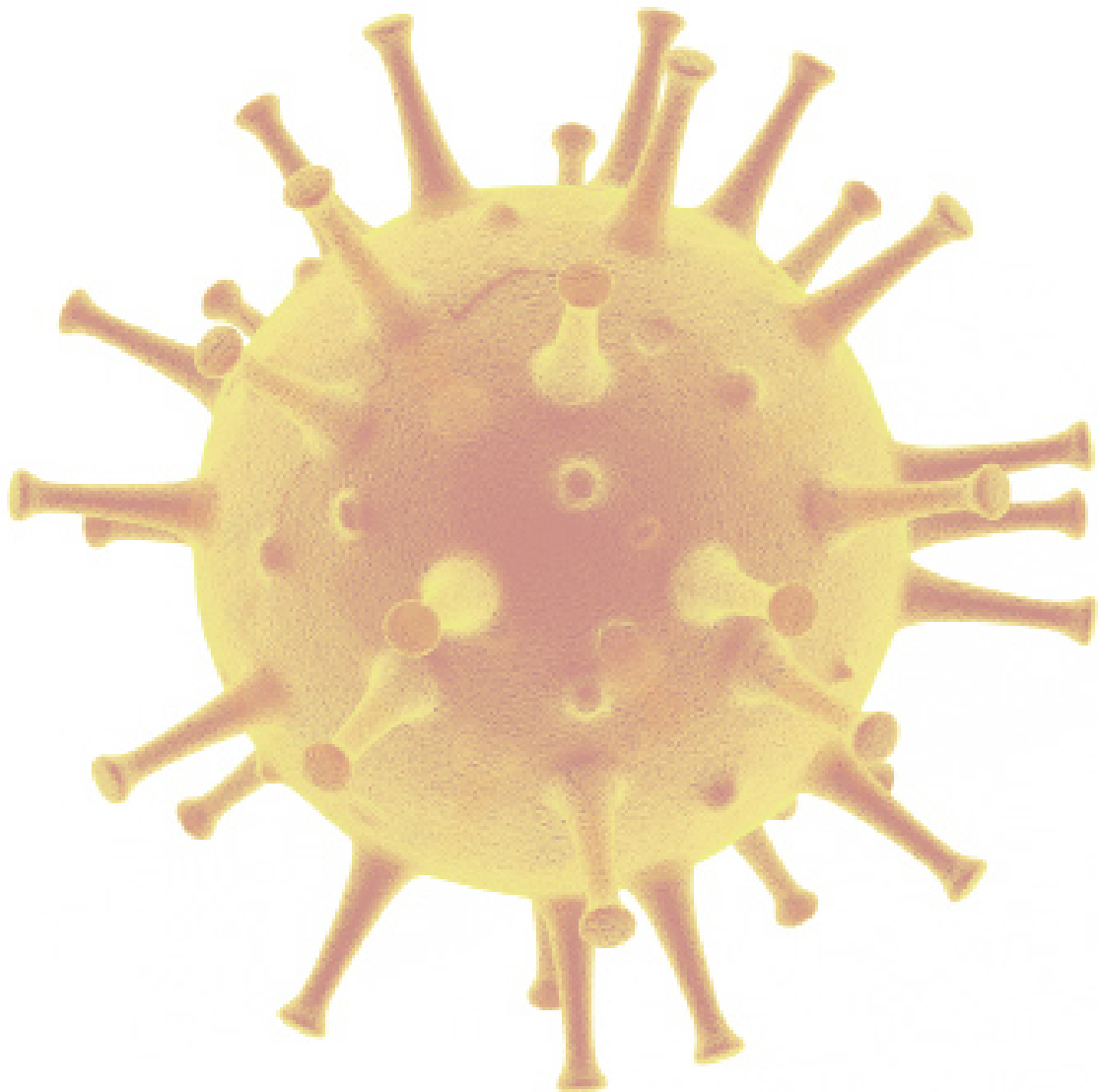


FICM position statement on sustainable senior doctor working patterns during COVID-19 pandemic

2020



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Executive Summary- 5 Key Messages

- 1. The impact on critical care services and staff during the Covid period has been considerable and is still ongoing. Planning for reintroduction of NHS activity must consider how this relates to use of an ICM service which is still stretched nationally.**
- 2. Job plans and working patterns that have been changed to respond to the pandemic must not be assumed to continue to operate unchanged in order to facilitate the reintroduction of increased NHS activity.**
- 3. Active senior input from parent teams into considering escalation decisions prior to critical care referral (as per NICE guidance NG 159) should be retained as it improves patient care and supports the hard pressed ICM workforce.**
- 4. Reconfiguration changes developed as part of the response to Covid 19 should be kept under review in order to respond swiftly to any increase in demand on the workforce whether from Covid or other increased NHS activity.**
- 5. The burden of 24 hour working shouldered by senior ICM doctors and other individuals in a clinical leadership role during the pandemic response should not be continued to facilitate service delivery alone.**

Scope

This statement outlines considerations regarding sustainable working by senior intensive care doctors and Advanced Critical Care Practitioners during the COVID-19 pandemic. The Faculty of Intensive Care Medicine is the professional body responsible for the training, assessment, practice and continuing professional development of Intensive Care Medicine consultants and ACCPs in the UK. This statement contains considerations which will be relevant to other ICM staff groups e.g. nursing staff, clinical pharmacists and allied health professionals.

Reason for development

Intensive Care staff have been asked to undertake exceptional working patterns to support patient care and maintain the NHS response to the Covid pandemic. This statement focuses predominantly on senior ICM doctors for the following reasons:

- Senior ICM doctors have had a significant planning and preparedness role locally, regionally and nationally in responding to the challenges of the pandemic
- Senior ICM doctors as a group have also been required to deliver enhanced clinical activity outside the existing consultant contract.
- Senior ICM doctors will be required to maintain the ICM response to the pandemic at a time when recovery of additional NHS activity 'stood down' during the pandemic will place

additional pressure on them and the ICM service by the removal of additional support provided by other staff groups.

However other ICM staff groups have been asked to make a similar exceptional response. For example, many lead ACCPs and critical care pharmacists have taken on additional administrative/ planning work as part of this response, extending their working hours to facilitate planning and ensure patient safety, medication continuity etc.

This guidance recognises the need to balance the needs of patients and organisations during the current pandemic and develop a sustainable response. This is particularly important now as the NHS considers how it can re-engage with non Covid services and patients to meet the unmet healthcare need that has been developing as a result of the pandemic. Such planning should not occur without reference to the ICM service and team in the organisation.

Introduction

The basic principles of sustainable working are vital to ensure the ICM workforce remains healthy and engaged considering the additional demands being placed on NHS staff.

The CMO Professor Chris Whitty has described this pandemic as a ‘marathon not a sprint’, adding ‘People should be thinking of a minimum of weeks to months and, depending how it goes, it may be longer.’¹ ICM working patterns need to be resilient, and sustainable over many months as the burden of high intensity working and extended shift patterns has fallen significantly on ICM staff and rotas and will continue for the foreseeable future without careful planning and consideration.

Service Reconfiguration

Many hospitals have already been carrying unfilled ICM Consultant posts prior to the pandemic, putting a historical burden on the existing ICM workforce. Support that has been provided from senior doctors in other acute specialties during the pandemic eg anaesthesia, respiratory medicine may well be needed to continue for the foreseeable future to some extent, and so will need to be factored in to any discussions of increasing clinical activity.

Some system changes that have occurred to respond to the pandemic will be likely to be beneficial to patients and the ICM service going forward and should be reviewed and retained wherever possible. For example the importance of admitting teams confirming the likely benefits and burdens of ICM therapies along with patient wishes and expectations for intensive care treatments at the point of admission to hospital as outlined in NICE guidance NG159, is an important consideration for all patients who are at risk of deterioration in hospital irrespective of Covid status. It is vital that the reconfiguration changes generated by the pandemic are not immediately ‘stood down’ based on a perception that they will be needed only to respond to the peak demand of the pandemic.

Working Patterns and Job Planning

If additional demand is created for ICM activity on top of the existing Covid demand, there will be no respite for ICM staff.

¹ 5 March 2020

It is possible that ICM doctors, ACCPs and clinical pharmacists will be asked to work extended shifts within rotas affected by sickness, and where existing establishments are not normally able to support the sort of patterns and intensity that may be required beyond the short term.

This cannot become the 'new normal' for ICM staff. New ways of working and the support that can be provided for patient care from other staff e.g. ACCPs and clinical pharmacists should be considered in business planning as other clinical activity resumes alongside the Covid response. For example, a 7 day a week clinical pharmacy service provides additional clinical and professional support to assist with planning medication therapies, facilitating medication continuity during a period of medication supply pressures and supporting clinical trial delivery, enabling senior ICM doctors to focus on their primary role of directing patient care. The focus should be to improve the overall quality of the recovering service.

Sustainable plans for working must consider:

- 1) Supporting wellbeing and sustainable working. This must include an acceptance that annual leave has to take a high priority whilst ensuring staffing and working patterns are supported. Local arrangements should be made to ensure that annualisation of activity can allow for suitable rest periods, and that ICM senior staff are able to take equitable annual leave where possible, during the course of the pandemic response.
- 2) Job planning should reflect not just the changed clinical activity but the additional administrative burden placed on many ICM doctors. Prolonged periods of time working clinically with an additional administrative burden is not sustainable. Routine resident clinical activity should aim to be completed in 8-10 hour shifts with an absolute maximum of 12 hours (plus time for handover). Converting existing SPA to DCC and then engaging in additional SPA on top is not sustainable.
- 3) Designing working patterns to reflect that historically many ICM consultants may also have provided service in other areas e.g. anaesthesia, renal clinics. This activity may not be delivered by them for some time in order to help 'redress the balance' that increased ICM working for the pandemic has placed on the ICM component of their job plan. The job plan should be considered in its entirety and reflect that fact that increased activity accrued through ICM working may need to be addressed in whole or in part through other clinical components of the job plan which may have different financial reporting lines.
- 4) If resident overnight consultant working is required for the ICM service going forward in the coming weeks or months, then this needs to be remunerated fairly. We would suggest that existing local arrangements should be continued with all high intensity specialities (i.e. those with a requirement to be resident overnight) being treated equally, unless agreement is reached to temporarily modify them. This recognition can be either financial or as time off in lieu (TOIL). The Royal College of Emergency Medicine recommends that PA rates should be at least 2 hours = 1 PA for time spent resident and working routinely after 2200. This is the current level of recognition in departments previously undertaking overnight working, usually in the context of major trauma, or other complex conditions requiring senior clinical leadership and decision making. For new working arrangements to support reintroduced NHS activity alongside the ongoing Covid response, national PA rates for different parts of the day should be the bare minimum.
- 5) It is anticipated that extended and overnight working may be required in some critical care units in order to provide senior and visible clinical leadership as well as service delivery. It is

important however that the burden of 24-hour working should not just be shouldered by ICM senior doctors for service delivery alone. This needs to be a whole system and hospital effort, and there should be equity and consideration given as to how this can be properly supported for the months that follow the initial pandemic surge and reflecting the sustained pressure on the ICM service. Continued ICM resident working should only be undertaken where mutually agreed and should be considered as time limited.

- 6) Recognition that high intensity working is more demanding with age, or where there are other health or disability issues. Changes to working patterns should allow for adequate rest and recuperation and fall within those accepted for other staff groups e.g. minimum 11 hours rest.
- 7) The NHS response to the pandemic was swift and moving into a rapid recovery phase for other services may create additional burdens on intensive care staff. ICM senior doctor job plans that can be scaled up and scaled down as required with support from other staff groups as needed is recommended. For example, trainees redeployed back into training may leave a gap in supporting the critical care service. ICM senior doctors have been instrumental in operational planning associated with the pandemic and will be needed to help plan return of services. SPA activity must be recognised as an important element of patient care and needs to be protected going forward.