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Redeploying your secondary care medical workforce safely

14 July 2020, version 2 – updates highlighted

This is a live document and will be routinely updated. Please send any comments or local insight to england.covid-secondarycareDOP@nhs.net

Contents

1. Introduction

This guidance supports trusts to safely redeploy their secondary care medical workforce during the prolonged major incident caused by the coronavirus pandemic (COVID-19) and is applicable only in exceptional circumstances.

It sets out the level of supervision staff may need if they are redeployed, to ensure they still work within their competency. It should be read in conjunction with guidance issued by Health Education England: https://www.hee.nhs.uk/coronavirus-information-trainees

NHS England and NHS Improvement have produced multi-professional workforce deployment guidance for COVID-19. Detailed guidelines have also been issued by the Royal Colleges and these documents should be reviewed in conjunction with this document.

Redeployment should be locally determined: Local discretion is needed when deciding which of the measures outlined below should be enacted and the timing of their implementation. There is local variation in staff skill mix, staff availability, services available on site, patient population and impact of coronavirus; so it must be emphasised that the below is prepared as guidance to support local decision-making. Many trusts are already working on detailed plans for redeployment and this document has been informed by their experiences. It is also vital that postgraduate deans are made aware of any trainee redeployment so that they can provide support.

Please click on the following hyperlinks for detailed guidance on:

- advice relevant to all specialties:
  - principles for staff redeployment
  - front door streaming
- specialty-specific advice:
  - emergency medicine:
    - rapid assessment & triage (RAT)
    - patients with an unknown aetiology @ RAT
    - unstable patients arriving in resus
  - critical care

- medicine
- paediatrics
- injuries (orthopaedics, maxillo-facial, plastics, neurosurgery)
- surgery
- obstetrics and gynaecology
- mental health
- diagnostic services (radiology and pathology).

2. Principles for medical staff redeployment

Supervision: All redeployed doctors should be appropriately supervised when delivering clinical care. This should be delivered by senior doctors who routinely work in this service, although it is recognised that through necessity there is likely to be a higher number of junior doctors per supervising senior doctor.

Competency: It is likely that staff within two years of completing foundation training have retained their foundation competencies and are suitable to work across all specialties with the appropriate level of supervision. However, they may not feel confident in this work and will initially need additional support. Consideration should also be given to previous experience and site familiarity.

Deploying returning staff: A wide range of clinicians have responded to a request to return to clinical practice. Some are only available to work remotely and many have had significant time away from clinical duties. A review of individual competencies and circumstances should take place to inform the deployment of these clinicians. Some returning staff who are only available to work remotely, have facilitated ITU communication by acting as a link between families and on-site clinicians. Others have supported the delivery and rapid expansion of remote outpatient services. These clinicians may prove invaluable to reducing waiting lists and supporting the returning workforce as they recover from a period of unprecedented demand. More information can be found here.

Induction: All doctors redeployed to a new clinical area should receive a focused induction. This induction should concentrate on clinical considerations to deliver safe patient care, life support and personal protective equipment (PPE) training. If departments already have standard induction packs aimed at FY1/2 or CT1 level, these could be used for this purpose. Induction should occur as a priority so that staff are prepared for redeployment.

Rosters: Working patterns may need to be redesigned with an increased presence of staff at night and out of hours. **All staff, in all specialties and at all grades may need to contribute to on-site, on-call rotas.** Senior grades may need to cover their junior colleagues as their skills are redeployed. This will likely impact on staff morale and plans to mitigate this should be prioritised.

Staff wellbeing: It is likely that there will be high sickness rates and staff will be stretched beyond their usual working practices. It is also recognised that working outside usual systems is stressful and, sometimes, extreme circumstances will additionally impact on wellbeing and staff morale. Local support mechanisms for doctors should be developed as a priority. Rosters should also be designed with the assumption that a proportion of staff will be unavailable due to sickness. Guidance on staff wellbeing can be found here and here.

It is important to risk assess staff members' vulnerability to COVID-19 prior to their deployment, taking into consideration factors such as their age, gender, BAME background and health. This process should involve shared decision-making and ensure that staff and patient safety is prioritised. The outcome may result in staff members being deployed to sites with low-exposure to COVID-19 or remote working.

Prioritisation: Teams may choose to start their shift by allocating individual roles to ensure key services are covered and sickness is noted. Organisations will have their own local prioritisation processes which should be followed. The following is a suggested order of priority:

- admitting team (based in the emergency department (ED) or similar clinical area)
- inpatient team and emergency surgery/procedure team (joint or separate as appropriate)
- staff delivering ongoing time-critical elective care such as cancer treatment
- staff delivering ongoing elective care such as virtual clinics.

Productivity: All teams should also review their clinical processes and ensure they are streamlined to reduce duplication and optimise patient care (eg one clerking is adequate before senior review).

Service leadership: When relocating services away from EDs, all staff must be aware of who is leading the service. This helps to ensure quality and safety of patient care.

Staff tracking: Organisations need robust measures to ensure **all** doctors are identified and contactable, and their attendance/absence is tracked appropriately, including their contributions to on-call rotas. It is vital that postgraduate deans are informed of any trainee redeployment via a robust reporting mechanism. This will require significant administrative support within each department.

Advanced Clinical Practitioner (ACP) redeployment: ACPs have a wide variety of clinical competencies and a varied background, often with extensive experience within their specialty and sometimes other specialties. ACP redeployment should reflect the individual's experience and competency and should be decided on an individual basis through consultation with the individual ACP. Some ACPs will feel comfortable being deployed outside their usual specialty, however others will not. Equally, some could be deployed at the same level of supervision as they have within their usual specialty, whereas others may need additional supervision.

Physician Associate (PA) redeployment: PAs have a broad range of clinical skills and will vary in terms of their clinical competencies dependent on their prior experiences. PA redeployment should reflect the individual's experience and competency and should be decided on an individual basis through consultation with the individual PA. Some PAs will feel comfortable being deployed outside their usual specialty, however others will not. Equally, some could be deployed at the same level of supervision as they have within their usual specialty, whereas others may need additional supervision.

Further escalation: Further redeployment of clinical staff may be needed and the process for this should consider individual staff circumstances, including their previous experience and, in some cases, their own health and current medical history. The following suggests initial redeployment steps; however, the scale of the incident may require an expansion of redeployment beyond these.

De-escalation: As the initial peak in COVID-19 related presentations subsides, some organisations will begin deploying staff back to their original specialty, for example to support elective services:

- staff will need to be supported during this process, facilitating them to take appropriate rest and annual leave
- organisations will need to maintain redeployment plans in case a second surge necessitates further redeployment
- organisations should ensure that clear records of hours worked and outstanding annual leave are maintained
- postgraduate deans should be kept informed of trainee movements

Front door streaming

To manage a sustained increase in the number of patients attending hospital, many local organisations have reported that they are planning to redesign their services along the following principles:

- Rapid assessment and triage (RAT) at the front door helps ensure the safe management of increased patient numbers arriving at secondary care. This involves the streaming of patients by directing:
  - well COVID-potential patients home to access services via NHS 111 on-line/remote primary care
  - well non-COVID presentations to primary care services/home as appropriate (including all minor illness presentations traditionally seen by UCC and GPCOOPs)
  - COVID-potential patients to ‘hot assessment’ zones
  - non-COVID patients to ‘cold assessment’ zones.
- Patients being seen directly by the specialty, without prior ED assessment (other than rapid assessment and triage). To achieve this:
  - specialties are allocated patients by the RAT team without a verbal referral or handover but with clear documentation (unless patient is clinically unstable or requires urgent review)
  - some specialty teams are based within the ED (or equivalent relocated service) seeing patients directly. This requires allocated members of staff who remain within the ED and are not responding to ward emergencies or performing emergency surgery
  - specialty teams may need to refer to each other as some patients will inevitably be incorrectly streamed. It is assumed that all specialties will work collaboratively, in the patient’s interest, when agreeing the ultimate admitting specialty.

3. Rapid assessment and triage (RAT)

Rapid assessment and triage is usually led by senior clinicians with experience in emergency medicine. This is primarily performed by ED consultants and ST3+ registrars (or equivalent). These individuals should be supported by experienced emergency medicine nurses and health care assistants.

High quality RAT is known to be important as it ensures unstable and time-critical patients are prioritised, specialist input occurs promptly and patients are seen in the most appropriate care setting.

It is also known that RAT can be an intense task and where possible staff should be rotated into this role throughout the shift to facilitate resilience.

Please see Table 1 below for clinicians appropriate to fulfil this role (SAS doctors should be considered at their equivalent grade).

Table 1 Doctors suitable to work in rapid assessment & triage

Scope of practice		RAT
Clinical team leader/supervisor	**No supervision required**	EM consultant
	Remote supervision	EM ST4+
On-site supervision	**Limited supervision**	EM ST3
	Close supervision	
Direct supervision	**Direct supervision**	

4. Patients with an unknown aetiology @ RAT

There is likely to be a cohort of patients who cannot be streamed correctly at RAT without a full history, examination and investigation. These patients are usually assessed by the ED team and then referred to the appropriate specialty or discharged.

It is expected that this cohort will be small and restricted to the diagnostically challenging patients.

Please see Table 2 below for clinicians appropriate to fulfil this role (SAS doctors should be considered at their equivalent grade):

Table 2 Doctors suitable to see patients with an unknown aetiology

Scope of practice		Patients of unknown aetiology @ RAT
Clinical team leader/supervisor	No supervision required	EM consultant
	Remote supervision	EM ST4+
On-site supervision	Limited supervision	ACCS or EM CT1–3
	Close supervision	FY2 with ED experience
Direct supervision	Direct supervision	

5. Unstable patients arriving in resus

Non-COVID presentations

Unstable patients are usually stabilised by the ED with the support of other specialties as required. Once stabilised they can then be referred to the appropriate specialty.

Please see Table 3 below for clinicians appropriate to fulfil this role (SAS doctors should be considered at their equivalent grade).

Table 3 Emergency medicine doctors suitable to work in resus

Scope of practice		Unstable patients arriving in resus
Clinical team leader/supervisor	**No supervision required**	EM consultant
	Remote supervision	EM ST4+
On-site supervision	**Limited supervision**	EM CT3
	Close supervision	ACCS or EM CT1/2
Direct supervision	**Direct supervision**	FY2 with ED experience

Staffing for trauma calls and cardiac arrests should continue to be managed as per previous, pre-COVID practices.

COVID presentations

COVID patients arriving to ED may be managed by the ED, medical (acute, respiratory or general) or critical care team as locally determined, supported by their surgical colleagues.

Please see Table 3 above (ED), medical and critical care tables for clinicians appropriate to fulfil this role.

6. Critical care

Critical care should be a priority for staff redeployment. Due to the unique skill set required in critical care, anaesthetists are the most appropriate staff to redeploy. If given focused tasks, surgical colleagues may be invaluable in supporting critical care staff. If patient numbers become overwhelming, it may be appropriate to redeploy medical and ED staff to support critical care, despite these also being priority areas. This will need to be guided by local circumstance. Further information on critical care staffing can be found here.

This applies for both COVID and non-COVID presentations.

Table 4 provides our recommendations for clinicians who are appropriate to fulfil these roles within the intensive care department (SAS doctors should be considered at their equivalent grade). NB: In this table the term ‘general medical’ refers to respiratory, cardiology, gastroenterology, acute internal medicine, nephrology, neurology, endocrine and diabetes, geriatrics and rheumatology.

Table 4 Doctors suitable to work in critical care

Scope of practice		Adult critical care patients (COVID & non-COVID patients)
Clinical team leader/supervisor	**No supervision required**	ITU consultants Anaesthetic consultants with significant ITU experience
	Remote supervision	Anaesthetic consultant without significant ITU experience EM consultant General medical consultants (with airway skills) Paediatric intensive care consultants with previous adult experience ITU ST4+ Anaesthetic ST3+
On-site supervision	**Limited supervision**	General medical consultants (without airway skills) General medical ST3+ Paediatric intensive care specialist trainees and fellows EM ST3+ Anaesthetic CT2 Cardiothoracic and ENT specialists (consultant and ST3+)
	Close supervision	Anaesthetics CT1 ACCS CT2 Other doctors with previous ITU experience
Direct supervision	**Direct supervision**	Core trainees of any specialty (inc surgical, radiology, GP etc) FY2 doctors

7. Medicine

It is likely that there will be a large increase in medical admissions as a result of the coronavirus pandemic. Many of these will require respiratory support of varying levels and some will also need support from the palliative medicine team.

There will likely be a shortage of general medical skills as these may be needed to support the critical care team.

Non-COVID presentations

Every effort should be made to facilitate ambulatory or virtual acute medical care to reduce inappropriate admissions and attendances. Acute oncology care staffing also needs to be reviewed to facilitate admission avoidance.

Towards the end of a surge in COVID-19 cases, and as routine services resume, consideration needs to be given to safe delivery and staffing of urgent and elective outpatient endoscopy services. This will include risk-assessing staff delivering this service for vulnerability to COVID.

Other medical specialties (eg dermatology, oncology, haematology, allergy, etc) may need to contribute to the acute medical take with targeted support from their general medical colleagues.

Care for medical patients may need to be delivered by a large team of SHOs and FY1s supervised by registrars and consultants.

Please see Table 5a for clinicians appropriate to fulfil these roles (SAS doctors should be considered at their equivalent grade).

COVID presentations

The development of protocols and guidelines for managing and escalating COVID patients could facilitate the delivery of this model of care by providing clear escalation and discharge triggers. Deteriorating patients can then be reviewed by the acute medical and/or critical care team and stabilised on the ward, palliated or admitted to critical care.

The staffing requirements of these patients will be similar to non-COVID presentations.

Clinical oversight and governance for the management of these patients should be provided by respiratory and acute physicians, supported by their medical colleagues.

Please see Table 5a for clinicians appropriate to fulfil these roles (SAS doctors should be considered at their equivalent grade)

Table 5a Doctors suitable to work in medical specialties

Scope of practice		Medical presentations (including COVID patients)
Clinical team leader/supervisor	**No supervision required**	Any medical consultant with recent experience managing acute presentations
	Remote supervision	Any medical ST3+
On-site supervision	**Limited supervision**	Core medical trainees ACCS trainees GP trainees
	Close supervision	Core trainees of any other specialty FY2
Direct supervision	**Direct supervision**	FY1

Palliative medicine

There is an increase in demand for palliative care skills both in secondary care and in the community. The requirements are for additional support with:

- management of more acute and severe symptoms related to COVID-19
- conversations with patients and those important to them – emotionally demanding and often in less familiar circumstances than usual (eg need to communicate sensitively using technology rather than face to face)
- staff anxiety and distress in coping with more deaths in a short space of time.

Palliative medicine clinicians should be protected from redeployment but should be prepared to be deployed across the different care settings as required within the locality – hospital, hospice, care homes, home-based care, etc. Palliative care teams may need additional augmentation from other clinical teams depending on local

circumstances. Please see Table 5b below for clinicians appropriate to fulfil these roles:

Table 5b Doctors suitable to work in palliative medicine

Scope of practice		Patients who require palliative or end of life care (COVID and non-COVID patients)
Clinical team leader/supervisor	**No supervision required**	Adult or paediatric palliative medicine consultant, associate specialist or equivalent senior doctor
	Remote supervision	Consultant or associate specialist with relevant medical expertise (e.g. oncology, elderly care) Specialty doctors – palliative medicine or relevant specialty (e.g. oncology, elderly care)
On-site supervision	**Limited supervision**	Medical ST3+ and GP trainees
	Close supervision	Core trainees of any specialty FY2
Direct supervision	**Direct supervision**	FY1

8. Paediatrics

This section should be read alongside: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Specialty-guide_paediatrics-and-coronavirus_V1_17-March.pdf

Paediatric services need to continue to deliver high quality children's services throughout the COVID pandemic. If required, community paediatric doctors with recent acute experience should be redeployed to support acute paediatric services and paediatric EDs, although essential community services that keep children safe and well at home should continue.

If staffing is sufficient, trusts may be able to redeploy their FYs and GPSTs allocated to paediatrics to other services. Similarly, they could also consider redeploying paediatric trainees with recent adult experience.

Please see Table 6 below for clinicians appropriate to fulfil these roles (SAS doctors should be considered at their equivalent grade).

Managing paediatric critical care

With respect to paediatric critical care services, if there is sufficient staff capacity paediatric units may consider either increasing the age for admission to PICU or these staff could be redeployed to adult critical care as locally appropriate.

Please see Table 6 for clinicians appropriate to fulfil these roles (SAS doctors should be considered at their equivalent grade):

Table 6 Doctors suitable to work in paediatrics

Scope of practice		Paediatric presentations (including COVID patients)	Paediatric critical care presentations (including COVID patients)
Clinical team leader/supervisor	**No supervision required**	Any acute paediatric consultant	PICM consultants
	Remote supervision	Community paediatric consultant with recent acute experience Paediatric ST3/4+	PICM specialist trainees/ fellows of appropriate skill level
On-site supervision	**Limited supervision**	Community paediatric consultant without recent acute experience Paediatric ST1–3 GP trainees	General paediatric and PICM trainees ST4–8 at appropriate skill level
	Close supervision	Core trainees of any other specialty FY2	General paediatric ST1–8 at appropriate skill level
Direct supervision	**Direct supervision**	FY1	Core trainees of any specialty (inc surgical, radiology, GP, etc) FY2

9. Injuries (orthopaedics, maxillo-facial, plastics, neurosurgery)

To free up space within the ED, it is likely that most trusts will be looking to relocate their injuries service to locations such as their fracture clinic.

This service would be expected to be overseen by an experienced ED practitioner to ensure holistic care is provided (eg safeguarding). They will work closely with the orthopaedic team, maxillo-facial team, plastics team and the existing ENP team (if unable to be redeployed to cover majors illness presentations) to deliver the service.

Head injuries, back pain and cauda equina presentations could be managed directly by either the orthopaedic team, or the neurosurgical team depending on site availability.

The suggested skills to manage these patients are outlined in Table 7 (SAS doctors should be considered at their equivalent grade).

Table 7 Doctors suitable to work in injuries

Scope of practice		Trauma and injuries – triaged to appropriate specialty below:				
		Any limb or soft tissue injury	Max- fax	Plastics/ burns	Head injury/ back pain	Other minor injury
Clinical team leader/supervisor	No supervision required	Ortho consultant	Max-fax consultant	Plastics consultant	Neurosurgical or orthopaedic consultant	ED consultant (remotely)
	Remote supervision	Ortho ST3+	Max fax ST3+	Plastics ST3+	Neurosurgical or orthopaedic ST3+	ENP workforce as current
On-site supervision	Limited supervision		Dentists with max-fax experience			
	Close supervision		Any dentist			
Direct supervision	Direct supervision					

10. Surgery

Due to the cancellation of elective work, it is possible we will have increased availability of this workforce group. As a result, local units may consider redeploying their core trainees (ie CT1/2 or ST1/2) to work at core level in priority areas. The surgical registrars and consultants can then remain to deliver their services, and deal with appropriate patients in ED.

If there is remaining capacity, then higher specialty trainees and consultants may also need to be redeployed to other clinical areas.

Most anaesthetists, and all anaesthetic higher specialty trainees, are likely to be redeployed to critical care. However, the trust should maintain a limited anaesthetic rota to support the delivery of emergency surgery, including out-of-hours provision.

Please see Table 8 below for clinicians appropriate to fulfil these roles (SAS doctors should be considered at their equivalent grade).

Table 8 Doctors suitable to work in surgical specialties

Scope of practice		General surgical presentations	Ophthalmology	ENT	Cardiothoracic surgery	Emergency anaesthesia
Clinical team leader/ supervisor	**No supervision required**	General surgery, urology, vascular consultant	Ophthalmology consultant	ENT consultant	Cardiothoracic consultant	Anaesthetic consultant
	Remote supervision	General surgery, urology, vascular ST3+	Ophthalmology ST3+	ENT ST3+	Cardiothoracic ST3+	
On-site supervision	**Limited supervision**					
	Close supervision					
Direct supervision	**Direct supervision**					

11. Obstetrics and gynaecology

Stable pregnant women or gynaecology patients, who cannot be streamed to community midwifery or primary care, could be streamed to either a maternity assessment unit or a gynaecology assessment unit ± early pregnancy unit. These should be in 'cold' zones, ideally away from the ED and staffed by O&G specialists.

The demand for intrapartum care is not expected to change in terms of numbers but will increase in terms of complexity. The demand for emergency gynaecology care is not expected to change. Medical staffing of obstetrics and gynaecology services is already under pressure and strategies to maintain viable staffing levels have been published by the RCOG: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/rcog-staffing-options-for-obstetrics-and-gynaecology-services-during-covid-19-pandemic/

If staffing is adequate, trusts may be able to redeploy non-specialty grades allocated to O&G to other services. Similarly, if staffing is insufficient, it may be necessary to redeploy non-specialty grades with previous O&G experience into the service. These will need to be local decisions based on local insight.

Consultants are likely to need to work on the on-site, on-call rota (second tier rota) to cover sickness and delivery of emergency care once elective care is cancelled. This may also facilitate redeployment of non-specialty grades to other areas.

12. Mental health

Mental health demand is likely to increase due to:

- social distancing measures impacting the wider population
- increased likelihood of mental health exacerbations triggered by the coronavirus pandemic
- increased demand on primary care
- challenges managing secure units safely with high staff sickness rates
- COVID transmission to patients under psychiatric care (including those detained under the Mental Health Act). These patients may require medical management by appropriately trained staff.

This patient population, including patient groups with learning disabilities, autism or both, is also particularly at risk from the coronavirus pandemic due to the risk of diagnostic overshadowing and their vulnerability to respiratory disease.

As a result, we do not envisage redeploying staff from these services. However, based on local factors, organisations can consider redeployment of non-specialty grades from or to this service.

13. Diagnostic services (radiology and pathology)

Radiology

Due to the cancellation of some elective services, this service may be able to be delivered by ST3+ registrars and consultants, although the demand on patients with COVID-19 disease may absorb the reduction in elective care requirements. Local units may consider redeploying their radiology ST1 and 2 trainees and non-training grades to support priority services. Some local units have also increased remote reporting. This has facilitated the incorporation of returning radiologists and radiographers who are only able to support services remotely.

Pathology

Pathology covers 17 different specialties. Microbiology and virology services, especially in testing, infection and infection control, have seen unprecedented demand, and we do not envisage redeploying any staff away from these services, indeed laboratory staff have been redeployed to these areas.

Some histopathology trainees have been redeployed to clinical areas, and they will need induction and support on return.

Advice from the Royal College of Pathologists on the redeployment of these specialists is here.