On the edge...

BMA Scotland guidance for consultants in Scotland under pressure in the face of medical staff shortages

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Introduction

The BMA Scottish consultants committee is aware that services increasingly face multiple challenges for long term continuity and sustainability. Rising recruitment and retention issues together with absence from work (for entirely understandable reasons including sickness, maternity leave etc.) can lead to a service approaching crisis and significantly impact on consultant workload. This guidance focuses on consultant gaps in the workforce, but the pressure can be caused by gaps in the medical workforce and health professionals at all levels. This can lead to an already stressed service tipping over into crisis.

The impact of individual consultants ‘coping’ for too long can have a detrimental effect not just on their own mental and physical health, but also on other team members, as well as on the service provided.

This guidance covers five areas.

1. **Defining what a crisis is**
2. **When crisis strikes – strategies to cope**
3. **Getting out of crisis and staying out**
4. **Avoiding the problem – building in system resilience**
5. **Sources of information and support**

1. **Defining what a crisis is**

Defining ‘what is a crisis’ within a service or department involves different perspectives. A pragmatic definition would be where a service whose normal mechanisms and resources have become overwhelmed and is unable to manage on an ongoing basis, presenting a risk to patients and/or staff and requiring urgent and immediate attention. At this point, immediate decisions and actions become necessary to stop the further disintegration of the service.

2. **When crisis strikes – strategies to cope**

Crises by definition are unplanned, and unexpected changes can never be completely mitigated in advance. However, dealing with the situation positively and supportively can make a world of a difference to everyone involved. In some situations an individual’s move/retirement/absence may be perceived to contribute to the crisis. It should be remembered that increased workload as well as reduced capacity conspire to create the crisis and it is never appropriate for an individual in this situation to feel a sense of blame for their legitimate reason to withdraw from the workplace.

Here are some practical steps to support staff in a crisis:

a) **Consider the realistic likely length of the service gap**

Gaps for no more than a few weeks may be covered by an irregular leave policy detailing short-term internal locum cover arrangements depending upon rota frequency (where agreed) – check with the LNC or HR department if there is such a policy. Consultants should not be expected to provide cover without agreement and should be appropriately and promptly remunerated (see Section d below).
Gaps beyond the scope of any irregular leave policy (or any gaps if there is no policy) are the responsibility of the NHS Board management and not the clinicians who provide the service. Clinicians may be approached by their board to help in such a situation but each clinician has a responsibility to consider such a request carefully in light of their own health and the impact of stretching themselves ever thinner on service safety and sustainability.

b) Cover for urgent and emergency care
Cover for urgent and emergency care must take precedence, therefore the on call rota (or out of hours shift) cover should be considered first. Capacity to cover elective work should only be considered once urgent and emergency care is safely covered.

Where there is an ongoing question over capacity to cover emergency or urgent care, this must be escalated through line management to senior management in writing by the consultants in that service and the officers of the consultant subcommittee (or equivalent) should be informed.

c) Elective care
Where there is an ongoing question over capacity to cover elective care, this care must be scaled back to match capacity. Failure of line management to respond to these concerns should be escalated to more senior management in writing. Junior or SAS doctors should never be put in the position of covering clinics or inpatients without appropriate levels of consultant supervision.

d) Agreeing a rate of pay
It is often the case that doctors will offer to provide cover for a prolonged period, though financial remuneration for this work is subject to agreement of an enhanced rate, possibly with additional time back. Where a rate is agreed with a clinician or group of clinicians it should be specified in writing before commencing the work. These rates should be unattractive to management so there is no risk they become a semi-permanent arrangement by default. If a rate cannot be agreed, the health board retains the responsibility for arranging cover.

Where an internal cover arrangement has no end in sight or the long term solution is uncertain, clinicians are advised to be cautious about any indefinite commitment to unsustainable cover arrangements. A service plunging into further crisis through exhaustion of those remaining is not desirable for anyone. Regular review dates with senior management should be explicitly built in to any interim plan (see below).

e) Leave arrangements
When a service is under pressure, doctors may volunteer to, or NHS Boards request that, a doctor postpones or amends arranged leave, or that services temporarily review their leave taking arrangements. Advice should be sought from the BMA in such circumstances, and the following provisos should be applied:

- While this could apply to annual, study, parental or sabbatical leave, it should not apply to sick, maternity, paternity, adoption or shared parental leave.
• Amendment to leave which has already been granted should only ever be used as a very temporary measure, due to unanticipated, urgent and otherwise unresolvable service pressures and is subject to strict criteria. It cannot be required unreasonably.

• When a doctor agrees to postpone arranged leave, the NHS board must reimburse the doctor for any non-refundable associated expenses (these should be agreed in advance) and should enable the doctor concerned to go on the leave/course at the next opportunity which is convenient for the doctor.

• Doctors cannot function for prolonged periods without the opportunity to take appropriate leave. If a crisis is prolonged beyond a few weeks or deepens in scope, then scaling back non-emergency activity should be considered early to support remaining staff. If it is not possible to support urgent or emergency services while facilitating appropriate leave taking, then the service crisis should be escalated as described above by the consultants involved.

f) Using SPA time to cover clinical sessions
In short term scenarios, some doctors may agree to substitute their SPA time to cover a clinical session. This is not appropriate as anything other than a very short-term solution, as this will impact on the consultant’s ability to provide a safe service. Any SPA time used to cover clinical sessions is postponed, not forfeited, and should be compensated by cancelling equivalent periods of later elective activity at mutually agreed times with management to facilitate this. It is not a way to achieve more elective capacity in a service.

g) Reviewing arrangements
Whatever arrangements are instituted they should be subject to regular review on an ongoing basis. This should be monthly as a minimum until the situation has been satisfactorily resolved and resilience work undertaken.

h) Interim job plan review
An interim job plan review should take place in anything other than a very short term gap to review the arrangements for individuals.

i) Staff Support between departments
As NHS boards are a single system, the NHS board management should review how it deploys staff across departments to ensure that one unit does not collapse while others thrive. This should be part of the resilience plan, but is also an important decision at a time when parts of the service are under unacceptable pressure. Any decisions need to recognise that:
   i) training programmes of junior doctors must not be compromised
   ii) work should always be within an individual’s skills and competencies
   iii) all such work should be by mutual agreement.
j) **Enhanced administrative support to the team**

When in a crisis, the NHS board should offer enhanced support to the team that remain. Administrative support, for example, should be strengthened. There should be no additional strain to a system in crisis. A senior medical manager should be designated to support the team regularly and the Medical Director approached if it is not forthcoming.

The risk to the health of a team in crisis is significantly heightened. Identifying a potential ‘domino’ effect early on is important, and staff should not be encouraged to struggle without complaint when there is any risk that personal health may suffer as a result.

The NHS Board should make a high priority of any service which is in crisis without a solution in place. Clinicians who are in such a service should expect this level of support and if it is lacking, should feel empowered to escalate their concerns through their ‘voicing concern’ policy, and ultimately, if necessary, as a protected ‘whistle blower’.

Consultants are sometimes ‘their own worst enemy’, as their professionalism and role as leaders within the service mean they will often manage to keep a service running only by exerting unacceptable pressure on themselves. The employer has an obligation to protect senior staff in these situations, and has a duty of care in supporting consultants who carry unacceptably heavy extra clinical workload and responsibilities. Occupational Health also are an important resource to support the remaining staff under pressure as well as any doctor who is absent as a result of the situation.

3. **Getting out of a crisis and staying out**

When in the middle of it, a crisis can seem overwhelming and getting out of it impossible, but many of the steps to getting out of crisis are similar to those designed to avoid a crisis.

a) **Planning for reduced capacity**

When a gap is going to occur or has occurred the service must make early and where possible pre-emptive arrangements for:

- Locum cover (agreed internal or external) or
- Scaled down elective activity for that period and
- Alternative ongoing care (Ward and Out-patient follow up) arrangements for extant patients.

Failure of management to make a plan should not result in the burden of clinical work being redistributed in a default pattern on those that remain in the service. Managing an expected but unmet need rests with the health board. It is therefore in the best interests of patients to anticipate these situations as early as possible and make appropriate plans.

The Scottish Government should remove specific targets in a crisis situation and the Health Board should be approached by consultants in the service (involving the consultant subcommittee) to seek this.
b) Demand/Capacity planning – ‘Team service planning’
Ongoing efforts must be made to match need with provision. Each service area should collate data on need and trends and determine the business plan for meeting that demand. The management will need to escalate to board level shortfalls in provision (unmet need). Consultants should be actively involved in this team service planning, contributing their own data, expertise and skills to inform planning and in due course to feed information on service requirements to individual job planning with each consultant.

c) Inbuilt extra capacity
Safe medical practice requires a margin of inbuilt extra capacity. Generally speaking the fewer the number of consultants in a service, the wider margin is required to maintain safe cover. Where clinicians perceive there is an unreasonable risk to patient (and/or staff) safety due to adverse load/capacity margins they should raise these concerns at the earliest opportunity in writing through their own service management and if necessary clinical governance mechanisms, including the consultant subcommittee (or equivalent) of the Area Medical Committee.

d) Alternative service planning in a crisis
Each area of service or specialty should develop a written ‘crisis’ plan where alternative strategies are laid out for unanticipated challenges to resources. These plans should be realistic and owned by the service rather than imposed from above. Examples might include
- reducing elective clinical capacity temporarily and cancelling clinics, setting out who will action these measures; transferring workload to neighbouring boards with identified capacity;
- reducing emergency capacity – identifying the point at which the service cannot be offered safely and describing an alternate plan in this situation.

e) Networking solutions
In some areas, Managed Clinical Networks deliver capacity that would not otherwise be possible in smaller boards. These should be factored into both getting out of crisis mode and resilience planning for the future.

4. Avoiding the problem in the first place – building in system resilience
Consultants in a service in crisis are likely to find the challenges of forward planning and resilience overwhelming and not in their control. However preventing a service heading towards crisis must be the starting point, and it’s vital that each NHS Board has an ongoing programme to develop service resilience across the full spectrum of services provided. The investment required by NHS Boards to secure system resilience inevitably has to compete with the immense pressure of having to deliver immediate services, but engaging in forward planning is the only way to effectively deliver secure, affordable high quality services.

Responsibility for ensuring service resilience lies with (medical) management, however all consultant staff have a vital role in advising, participating in service plan development and implementing decisions. Giving doctors the opportunity to express their needs and concerns
at an early stage is critical for creating shared ownership of alternative service planning in a time of crisis.

Succession planning is vital, and each service area or department should take time, at least annually, to consider the age demographics and plans of incumbent consultants. Those approaching retirement can help the rest of their colleagues by, if possible, giving informal notice of their long term plans well in advance of their formal notice period.

When a retirement date has been agreed the NHS Board should commence vacancy procedures immediately or even better aim to have succession planning in place through a period of handover/overlap. Waiting until a vacancy occurs to begin recruitment is poor practice but all too common. Consultants have to give 3 months’ notice, so NHS boards can start giving consideration to recruitment procedures at an early stage. Formal recruitment can only begin following receipt of written resignation.

There are difficulties with rising numbers of unfilled consultant posts across Scotland. NHS Boards must invest properly in adverts that will reach the widest possible range of potential applicants, avoiding false economy in the recruitment of their most senior staff. UK-wide advertisement of posts should be standard practice as was the case previously. If difficulties are anticipated in filling specific posts solutions should consider utilising the full range of enhancements, for example ensuring that the post is competitive in the job market in terms of job planning, SPA allocations, and the consideration of recruitment and retention premia which were designed for this very purpose. NHS Boards should have formal mechanisms for predicting and resolving recruitment and retention hotspots. LNCs can also be a useful resource to advise health boards in such circumstances.

Subspecialist areas with single practitioner (or double practitioner) provision are particularly vulnerable. Recruitment to such areas needs careful succession planning, sometimes years in advance. The role for proleptic appointment should be considered. The service manager should be made aware of any risks to service provision and plans developed to mitigate them as soon as they become apparent. Failure to engage with these plans at departmental management level requires escalation to more senior management. Ultimately the NHS Board should be kept aware of skills (and therefore services) that are under threat.

5. Sources of information and support:

Important sources of advice for colleagues facing a service in crisis may include:

- For issues of clinical provision and safety
  - The committee/group meeting of consultants responsible for that service
  - The consultant subcommittee of the Area Medical Committee
  - The organisation’s ‘voicing concern policy’ (or equivalent) will contain information about escalating clinical service and safety concerns
  - Medical defence organisations may also offer advice to their members
  - The General Medical Council and in particular its publication *the duties of a doctor*

- For issues relating to terms and conditions of service
  - the BMA helpline for members: 0300 123 1233
The local negotiating committees in Scotland can be contacted through the following emails:

- **NHS Ayrshire & Arran** [LNC-NHSA@bma.org.uk](mailto:LNC-NHSA@bma.org.uk)
- **NHS Borders** [LNC-NHSBorders@bma.org.uk](mailto:LNC-NHSBorders@bma.org.uk)
- **NHS Dumfries & Galloway** [LNC-NHSDG@bma.org.uk](mailto:LNC-NHSDG@bma.org.uk)
- **NHS Fife** [LNC-NHSFife@bma.org.uk](mailto:LNC-NHSFife@bma.org.uk)
- **NHS Forth Valley** [LNC-NHSFV@bma.org.uk](mailto:LNC-NHSFV@bma.org.uk)
- **NHS Grampian** [LNC-NHSGrampian@bma.org.uk](mailto:LNC-NHSGrampian@bma.org.uk)
- **NHS Greater Glasgow & Clyde** [LNC-NHSGGC@bma.org.uk](mailto:LNC-NHSGGC@bma.org.uk)
- **NHS Highland** [LNC-NHSHighland@bma.org.uk](mailto:LNC-NHSHighland@bma.org.uk)
- **NHS Lanarkshire** [LNC-NHSLAN@bma.org.uk](mailto:LNC-NHSLAN@bma.org.uk)
- **NHS Lothian** [LNC-NHSLothian@bma.org.uk](mailto:LNC-NHSLothian@bma.org.uk)
- **NHS Orkney** [LNC-NHSOrkney@bma.org.uk](mailto:LNC-NHSOrkney@bma.org.uk)
- **NHS Shetland** [LNC-NHSShetland@bma.org.uk](mailto:LNC-NHSShetland@bma.org.uk)
- **NHS Tayside** [LNC-NHSTayside@bma.org.uk](mailto:LNC-NHSTayside@bma.org.uk)
- **NHS Western Isles** [LNC-WestIsles@bma.org.uk](mailto:LNC-WestIsles@bma.org.uk)
- **National Waiting Times centre (Golden Jubilee)** [LNC-NWTC@bma.org.uk](mailto:LNC-NWTC@bma.org.uk)
- **The State Hospital** [LNC-TSH@bma.org.uk](mailto:LNC-TSH@bma.org.uk)