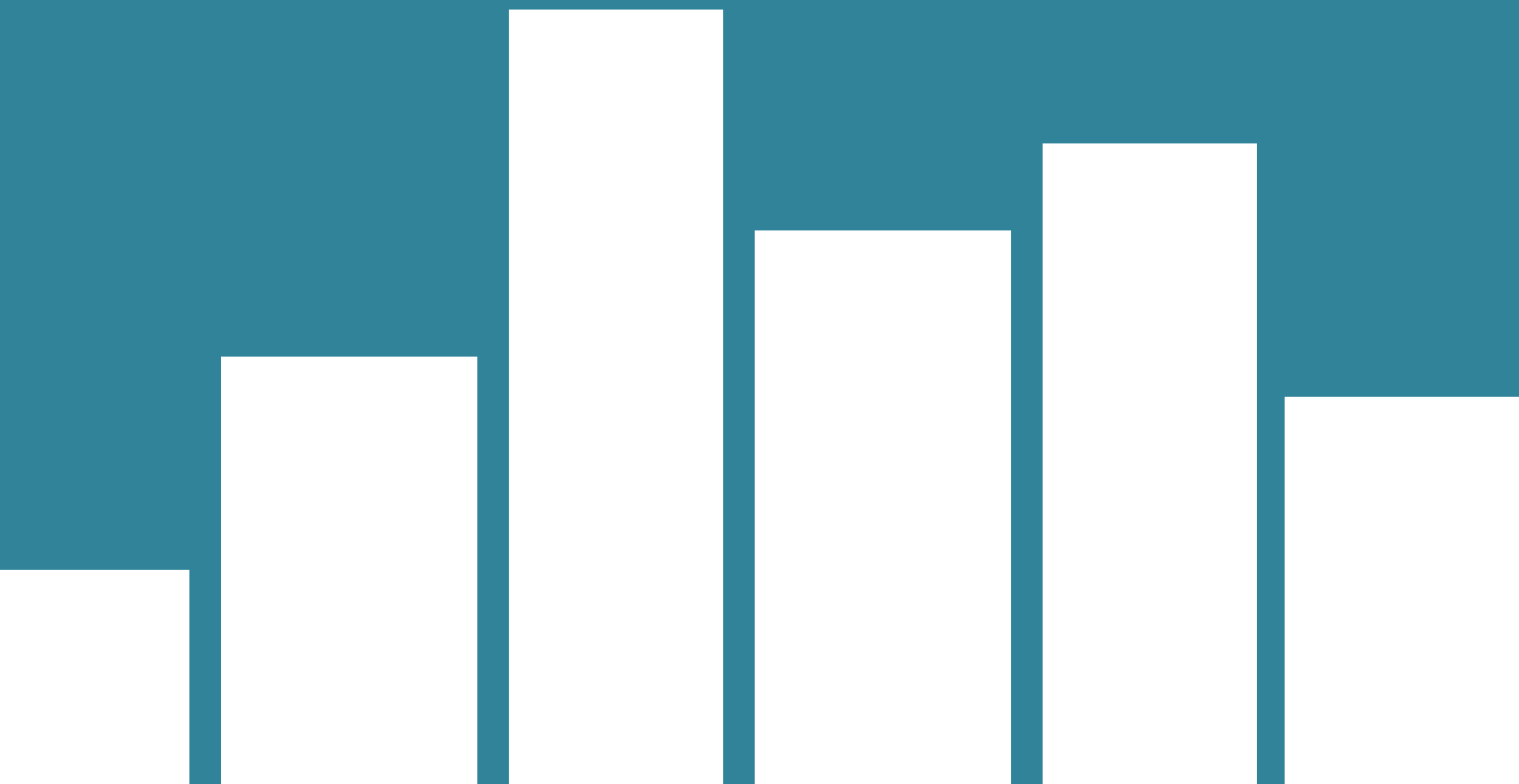
The Faculty of Intensive Care Medicine

CRITICAL STAFFING #2

A best practice framework for **WELLBEING AND SUSTAINABLE WORKING IN CRITICAL CARE**

June 2021



What is the Critical Staffing series and who are they for?

The Critical Staffing series brings together recognised and practical 'Best Practice Frameworks' on staffing. The frameworks have been produced to guide commissioners, hospital management and Critical Care teams on how to ensure they have developed safe, effective and sustainable staffing in Critical Care. It is also a reference for individuals from across the multidisciplinary workforce as to what they might expect from their directorate and employer.

The response of Critical Care services and staff to the public health threat of Covid has necessitated unprecedented changes to staff working. The effects on staff's mental and physical health and their emotional wellbeing are increasingly apparent. Critical Care services need to be engaged in mitigating the longer-term impact of necessary emergency responses. From the Faculty report *'Voices from the Frontline'* (November 2020), it is clear what the stressors were, and how some people and departments met them; we hope this document provides a route out of the situation many may find themselves in, as well as colleagues and multidisciplinary team members. There is a specific section in this report aimed at post Covid recovery. The principles are the same pre-Covid as post Covid but the pandemic has dramatically highlighted the need to look after staff wellbeing. Staff that are not well cared for and looked after, are more likely to leave; poorly responsive departments to individual's needs will struggle with recruitment as well as retention.

What is Critical Staffing #2 covering?

Critical Staffing #2: A best practice framework for wellbeing and sustainable working in Critical Care brings together best practice ways to provide a better employee experience with particular reference to the intensive care medical workforce.

The overall aim is to improve job satisfaction, work-based wellbeing, sustainability, retention and performance. It offers advice on how to make your Critical Care unit, and the wider hospital an attractive place to work; somewhere staff can thrive, whilst also taking into context the increasing demands on capacity, ageing workforce, changing demographics and expectations of the workforce.

A great deal has been written on wellbeing, much of it focused on individual level responses and solutions. We have tried to provide key areas where you might like to concentrate your practical efforts to begin with.

CONTENTS

INTRODUCTION: WHY THIS IS AN ESSENTIAL WORK PLAN FOR EVERY UNIT

"Critical Care's most precious resource is its staff."

There is an ever-increasing demand for Critical Care as societal and professionals' expectations increase referrals, as patient frailty increases length of Critical Care stay, and where Critical Care's successes in achieving survival in ever more patient groups are recognised. Even before the SARS CoV 2 pandemic, Critical Care demands were expected to rise by 4% per annum (ICNARC data).

Covid-19 has put Critical Care services and its staff in the centre of the NHS response. With escalating demand and scrutiny comes increasing pressure, worsened by constraints to our staffed UK bed capacity. If our jobs appear unremitting, unrewarding, and unsustainable to the potential Critical Care workforce of the future, then in a competitive workforce environment we will fail to recruit in sufficient numbers.

Before the Covid pandemic, one third of NHS staff reported having felt unwell due to work related stress[i]. If we do not sustain our staff's wellbeing, and do not provide the necessary opportunities for individuals to develop to their maximum potential, then we will not retain staff.

We need to promote a positive work-based experience, and prevent the development of work related psychological injury or illness. This requires the allocation of resources to protect all our staff in a highly pressurised environment, and thereby continue to provide the multidisciplinary service. There are considerable departmental risks in failing to address these issues: increased sickness, unhappy staff, inability to staff necessary capacity, increase in bank, agency and locum costs, complaints etc.

The *Guidelines for the Provision of Intensive Care Services 2* (GPICS v2) lays out expected standards, and recommendations in Chapter 3.9 'Staff Support' (pg. 102-104). This document expands on GPICS v2 to provide additional help to individuals and units, informed by evidence of the impact of responding to waves of the SARS CoV 2 pandemic.

We recommend 3 key overarching principles for all Critical Care units:

1. **Encourage accessible leadership**
   Good leadership is an essential resource to mitigate the demands of work. Leaders should ensure they prepare staff with the information they need to manage expectations, and are proactive, visible members of the team 'on the shop floor'.

2. **Engage your workforce at every opportunity**
   Engagement is the opposite to burnout. Staff who are on board and feel a sense of belonging will drive the whole workplace forward.

3. **Do not be tokenistic in wellbeing resources**
   Design wellbeing into work patterns and recognise what staff are going through working during Covid. For example, a better designed work schedule and rota will provide more gains than a once-a-year wellbeing day, or placing posters on the unit.

Executive Protocols

What is an executive protocol?

An executive protocol frames the standards, recommendations, prevention techniques and interventions into a succinct checklist so you can check that you are managing the risks with due diligence. Protocols can be used at managerial level, and also for individual employees in the Critical Care team to identify their own risks. If the answer to the questions below is "No" then steps need to be taken to address the deficit and implement necessary changes.

PROTOCOL FOR DIRECTORS, MANAGERS AND COMMISSIONERS OF CRITICAL CARE	
Consideration	Management/Mitigation
Are you adhering to the UK Health and Safety Executive standards on planning for primary preventions? (UK HSE)	**Yes/No**
Does your unit have a policy in place to support staff engagement and retention? (GPICS v2)	**Yes/No**
Do you have clearly identified induction and escalation policies for all staff groups? (GPICS v2)	**Yes/No**
Do you have a process to keep staff informed about changes that affect them? (best practice)	**Yes/No**
Do you have a process to allow staff to suggest ideas and consider putting them into practice regarding team wellbeing and support? (best practice)	**Yes/No**

PROTOCOL FOR CRITICAL CARE TEAM MEMBERS	
Consideration	Your approach to this
Do you know if your unit is adhering to the UK Health and Safety Executive standards on planning for primary preventions? (UK HSE)	**Yes/No**
Are you aware of your unit's policy to support staff engagement and retention? (GPICS v2)	**Yes/No**
Did you have a clear induction or escalation plan? Do your unit colleagues? (GPICS v2)	**Yes/No**
Are you kept abreast of changes that will impact you? If not, is there a process in place for doing so that is not being utilised? (best practice)	**Yes/No**
Are you given opportunities to suggest ideas that may improve staff support and wellbeing? If not, is there a process in place for doing so that is not being utilised? (best practice)	**Yes/No**

EXISTING STANDARDS AND BEST PRACTICE RECOMMENDATIONS

1. STANDARDS: ACROSS HEALTHCARE

The UK Health and Safety Executive considers it an organisational responsibility to modify factors that impact on work-related stress. Factors resulting in stress in the workplace are; demands, lack of control, inadequate support, poor relationships, poorly defined roles and change[ii]. Standards have been identified as those with a directly identified patient safety linkage, and recommendations are those that support the delivery of one of the five Institute for Healthcare Improvement (IHI) recommendations[iii].

1. Physical and psychological safety
2. A meaning and purpose to the individual's role
3. A degree of choice and autonomy regarding the conduct of the work
4. An environment that provides camaraderie
5. An environment that promotes teamwork, fairness and equity

Interventions can be considered as primary (preventative of problems and enhancing experience), secondary (interventions to stop issues as they arise) or tertiary (interventions to resolve issues that have arisen). The Health and Safety Executive strongly advises a focus on primary prevention.

2. STANDARDS: SPECIFIC TO CRITICAL CARE

In addition, experts within Critical Care have provided consensus standards for intensive care units via GPICS 2, as summarised in the table below.

GPICS 2 STANDARDS	EXAMPLES INFORMED BY COVID EXPERIENCES
All units must have policies in place to support staff engagement and retention	• The production of a regular directorate newsletter that includes all MDT member groups with their input. • Exit interviews should be conducted by the directorate manager and clinical lead with all permanent staff members who leave to pick out key areas to improve staff retention. • Facilitate exchange between staff groups and celebrate staff contributions across the Critical Care team, including any redeployed staff.
Induction and escalation policies must be clearly identified for all staff groups	• An induction pack for all new starters in the directorate with specific MDT sections that are regularly updated by the MDT.
100% of new staff must receive a job-specific induction to the unit	• The unit induction should include how the managerial structures work in the department – a 'who to go to for what' approach.
Workplace equity within staff groups must be transparent (e.g. rostering, annual leave policies, job plans). Staff must be aware of the policies.	• Fair, open and transparent career progression for both internal and external applicants for any posts in the directorate.

Staff well-being is an organisational priority. Units must monitor, and regularly review metrics of staff wellbeing as quality indicators (e.g. sickness rates).	• Annual staff satisfaction survey to all members of the MDT. • Sickness rates should be reviewed at least annually. Is there something that can be addressed to reduce sickness rates and improve the return to work? • Is there an appropriate policy in place for staff and family testing in cases of Covid? Are staff aware of the policy?
All staff must have opportunities for personal development reviews including annual appraisals	• Annual job planning for consultants and Personal Appraisal and Development Review (PADRs) provide the opportunity for the individual, but also Directorate management to improve staff engagement
All staff working in Critical Care must be able to access the Freedom to Speak Up Guardian.	• This should be clearly advertised, and staff should be informed of the Guardian at induction • http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_Executive-summary.pdf
Staff must be provided with adequate resources consistent with other GPICS standards to deliver their job role, e.g. adequate staffing ratios, access to facilities for nutrition and hydration, adequate equipment.	• Ensure up front competency training is provided for all staff groups, including newly qualified staff. • Recognise the burden of training others, emotional as well as time. • *Gemba Rounds*. The directorate management team do a monthly "ward round" of staff to talk with them on the unit about their work experiences, rest facilities, equipment issues etc.
Staff rostering must comply with Health and Safety Executive recommendations for sleep and rest.	• Promote shift pattern management and management of fatigue • Make use of AAGBI fatigue resources • Night shift staff need access to food and rest facilities • https://www.ficm.ac.uk/Fatigue
Units must provide adequate workplace facilities for staff breaks, which are separated from areas for relatives.	• The facilities also need to be well maintained and clean for all staff with housekeeping services 7 days a week. • Working practices and breaks need to consider the impact of maintaining social distancing.

3. PRIMARY PREVENTION IDEAS: AN INDIVIDUAL'S WELLBEING

In addition, we recommend the following as ideas to adapt and modify for your local unit.

3.1 Engagement

Engagement is considered to be the opposite end of the spectrum to burnout. Individuals need to feel they are valued within the team. Think about how you include, and engage with individuals in your team. Possible areas for attention are:

- The induction for all new staff members should also explain how the department is managerially structured, and how its processes are supposed to function. This should help enable people to highlight to relevant leads where processes are not working effectively.
- How and where the individual sits within the wider organisation is important, and how they are listened to is necessary for good governance, and staff engagement. Providing a single centralised source of up to date information, and an ability to access information about unit staffing demands when not working, can reduce anxiety and improve engagement.
- Keeping staff informed and involved in all changes, and specifically those that will likely affect them. If they are not already occurring, consider introducing a daily huddle/briefing meeting to highlight and provide immediate action plans for pressing issues e.g. staffing, near misses etc.
- Offering opportunities to put individual's ideas into practice to develop and innovate the team.
- A clear mechanism to communicate with all staff members.

3.2 Fairness

Clear, open and transparent structures for how all individuals can apply, and be allocated funding for education or attendance at meetings are needed. Individuals who do not feel they are being treated fairly will likely leave, or become disgruntled. The same goes for career progression – individuals must feel they stand a fair chance for progression; not progression by favouritism, nepotism etc.

3.3. Education and Research

The assessment of an individual's educational needs, and addressing them can be difficult but will be of benefit over time to staff recruitment and retention. A proactive education team will benefit the whole team dynamic.

An active research programme and team, combined with the opportunity for interested individuals to engage in unit research, can help provide career progression for individuals as well as unit recognition within the hospital and wider.

Provide self-directed learning opportunities as well as 'face to face' training to maximise the opportunity and flexibility.

3.4 Change management for the individual

This could be a return to work policy, or for example provision of support for the transition from Trainee to Consultant. Change is often very stressful. A new staff member's Induction and Welcome pack can be brought together by the directorate to help the transition. There are also courses e.g. Consultant Intensivist Transition Course (CIT) for medical staff. Mentoring/coaching should be offered to all new members of the department. FICM has also recently launched FICM Thrive to provide mentoring to consultants.

3.5 Individual's job planning

Job planning and appraisals need to be addressed annually. This includes the cultivation of talent and opening up of new opportunities. Individual's job plans need to be flexible, and also take into account an individual's changing needs over their career, including with reference to on-call and night-work as an individual ages, or experiences of other limiting factors. Refer to Critical Staffing #1, for more information on effective job planning.

3.6 Support for staff with caring responsibilities

Critical Staffing #3 will provide further detail on support for staff who return to work after a career break. Support for, and policies related to individuals with caring responsibilities should be clearly signposted.

3.7 Rest facilities and social areas

Ensuring the good provision of rest and sleep facilities for staff helps to highlight the value placed on them by the department, and by the wider organisation. This should be central to any unit design/redesign. Clean, comfortable and well looked-after social areas are vitally important to foster the team, and individual. Covid-19 has highlighted the need for adequately large, well-ventilated staff areas to allow breaks together. The positive aspects of working in Critical Care need to outweigh the unavoidable stresses involved in caring for the critically ill and their families.
Well-rested staff are safer for patients, and safer road users.

3.8 Breaks and nourishment

Well-nourished staff have higher morale and make safer decisions. Units should provide kitchen facilities with the ability to heat food, prepare light meals, and make hot drinks. Rest/break facilities where possible, should allow for uninterrupted breaks. The hospital should provide access to hot food at night, weekends and bank holidays.

3.9 The emotional impact of work and trauma response

Staff benefit from learning how to manage the demands of their role, and recognise their own stress signature. A common stressor in Critical Care is witnessing traumatic incidents or ongoing patient stories that leave staff at risk from direct and vicarious traumatisation. Covid has placed additional burdens on staff who have been required to break bad news and manage end of life care remotely, over the telephone or via video-calls.

Training all staff in recognising symptoms of post-traumatic stress disorder is useful, and making use of peer assessment models such as TRiM (Trauma Risk Management)[iv] is advisable. The Intensive Care Society are currently planning a Peer Support Framework[v].

Developing systems to have conversations about work, and process experiences at work at individual and group level are helpful. Consider regular check-ins at the start of the shift and at the end, particularly in more testing shifts where staff may provide a 'hot debrief'. The principles of psychological first aid[vi] are a possible framework to consider. Systematic 'cold debriefs' are not recommended[vii], however evidence suggests where there is a focus on conversation and recovery, having discussions around the impact of the work are both welcomed and helpful to staff. Frameworks such as Schwartz Rounds and similar are useful[viii].

4. PRIMARY PREVENTION IDEAS: DEPARTMENT CULTURE AND WELLBEING

4.1 Leadership

Relationships with managers and having the right leadership approach is the strongest predictor of workplace wellbeing[ix]. Leaders should have access to training, coaching/mentorship and 360 degree leadership evaluation such as the NHS Healthcare Leadership Model[x].

The visibility of leaders and management teams is key, particularly during Covid. Outside of Covid areas, try *'Gemba Rounds'* as a way of walking around the unit once a month to ask staff, "What's going on for you in your working day?"

4.2 Engagement

Regular consultant meetings and senior MDT staff meetings are essential. Regular attendance should be strongly encouraged and ideally job planned as either in supporting professional activity time (SPA), or rostered. The attendance of a consultant meeting by a trainee spokesperson allows their voice, and a different perspective to be heard.

4.3 Strategy

Ensure staff are aware of the department's strategic direction, and make use of tools such as Collective Leadership tools[xi] to help staff feel part of any change. Engagement and strategy are co-dependent.

"Leaders need to ensure that all staff adopt leadership roles in their work and take individual and collective responsibility for delivering safe, effective, high-quality and compassionate care for patients and service users. Achieving this requires careful planning, persistent commitment and a constant focus on nurturing leadership and culture".
Developing collective leadership for healthcare. The Kings Fund (2014).

Individual areas of leadership e.g. education, governance, quality and safety, morbidity and mortality, research etc. need to coalesce, and be recognised by the whole unit.

4.4 Group job planning

A clear understanding of what the department's needs and the subsequent allocation of those individual roles in individual's job plans. Future planning and succession for allocated roles is important for smooth transitions, fairness and transparency.

4.5 Recruitment and retention rates

Directorate management should regularly review recruitment and retention rates to attempt to understand where the potential problems are. Local issues specific to your directorate may be crucial to retention and might need to be specifically addressed.

4.6 Clinical handovers

The importance of good timekeeping for the whole MDT, with a structure to capture risks, address them, and feedback to the department. Using an adapted WHO surgical checklist for introductions

before the ward round starts can be useful. Utilise 'frameworks' for communication such as the IHI SBAR approach[xii]. Safe travel after work should be raised.

4.7 Mortality & Morbidity meetings

Specifically offering time for individuals to reflect and process the potentially traumatic nature of clinical work has been linked to improved individual and team's clinical and emotional experience. Building this into structures such as Mortality & Morbidity meetings (M&Ms), or where departments have access to clinical psychology, and also offering Reflective Rounds. Engaging with other departments in joint M&Ms can improve inter-departmental culture and relationships.

4.8 Education of the MDT

Simulation can improve human factors and multidisciplinary (MDT) team building. This does not need to be high fidelity but the impact of holding remote meetings on MDT education and ability to contribute can be significant.

Use protected learning days as a way of bringing the team together to learn, improve and build better relationships. Try inviting other teams to engage with your quality and safety, as well as M&M meetings to improve relationships, culture and understanding between departments.

4.9 Policies, differential attainment and inclusivity

Critical Care teams are increasingly diverse, with individuals undertaking different roles and different models of flexible working. Team members will come from a large range of cultures, geographies and generations. It is therefore essential to consider all these factors and those of any protected characteristics in the creation of any department policies that impact staff. Alienation will negatively affect wellbeing. It is important that there are equal opportunities for appointment and advancement within the department across different genders, sexual orientations, races, religion, and disabilities.

Critical Staffing #1, in the sections on good rota design, goes into further detail on making Critical Care a specialty that is possible to practice until retirement.

5. SECONDARY INTERVENTIONS THAT CAN BE PROVIDED ARE NEEDED

5.1 Managing bullying and rudeness and creating a just culture

Proactively deal with bullying and rudeness early. Access resources from the Civility Saves Lives campaigns[xiii]. In competitive, low resourced environments, there is a risk that people will shift from thriving to just surviving. Some people naturally struggle to engage where there is open participation or collaboration and will retreat into psychologically safe ways of behaving.

Financial resources are tight in the NHS, but you can improve people's resources of support, control and fairness to encourage more collaborative 'thriving' systems. However, repeated bullying behaviour should be tackled, making use of local workforce systems. Bringing evidence from psychological safety into structures (such as the Undermining Toolkit from the Royal College of Obstetricians and Gynaecologists[xiv]).

It may be work allocating an internal 'Freedom to Speak Up Guardian'. Taking the approach of a Just Culture to create learning rather than punitive cultures[xv], and supplement this with use of systems such as Learning from Excellence[xvi].

5.2 Access to support systems

The availability and awareness of Support Systems should be clear to all within the department. Most NHS Trusts/Health Boards have access to mediation, and Occupational Health for wellbeing and workforce issues. Leaders should stay aware and keep up to date with their local resources. Where and when necessary, members of staff can then self-refer or be referred for support.

Finally, access to psychological therapies is important and can be accessed from a number of different sources. The directorate management team should clearly understand what is available in their Trust/Hospital/Health Board:

- Primary and secondary NHS mental health services are available via the GP.
- Some NHS Trusts have access to counselling, or psychological therapies via their Occupational Health service.
- Some Critical Care departments have chosen to directly fund access to a Clinical Psychologist to offer more rapid access to individual interventions, but also to support the department in providing primary interventions, organisational health monitoring, awareness training, and team building.
- The Deanery provides access to psychological therapies via the Professional Support Unit.

6. WORKFORCE RECOVERY POST COVID

The principles of workforce recovery are no different from those pre or post-Covid. The pandemic and resulting severe stresses on the multidisciplinary team have however highlighted the importance of looking after the whole team's wellbeing. This care needs to come from within Critical Care directorates, but also by recognition and practical support from senior hospital managerial structures including estates.

NHS England, NHS Improvement and NHS London held a series of very well attended remote access workshops in February 2021. Effectively these were five London Critical Care Operational Delivery Networks (ODNs), aligned with their integrated care systems, and Critical Care hubs.

The Integrated Care Systems Critical Care hubs all have a clinical lead, reporting officer, nurse representation (divisional nurse, nurse lead for Critical Care). This initiative was then open to all Critical Care multidisciplinary care staff across London's Critical Care services. The principles this group designed are however equally applicable across England, Scotland, Wales and Northern Ireland. The workshops were led by Dr Julia Wendon and Professor Andy Rhodes. A set of principles were agreed by an iterative process conducted through chaired workshops.

Key Principles:

- Staff who feel well supported and well informed have lower levels of anxiety
- Provide clear communication of the resources available and ensure the information your staff need is all readily accessible in one place
- Support should be provided for **individuals** and for **teams**
- Initial support should focus on **Rest, Recovery** and **Recuperation** time
- Develop peer to peer support systems as a first line resource for responding to traumatic events.

Operational Principles:

- Ensure all staff groups are involved in consultation and enabled to work through the solutions that best apply to your service and team
- Use influence and leverage to ensure the right principles are prioritised
- Demonstrate visible senior leadership and engagement in recovery before restoration of services.

Design Principles:

1. **Staffing ratios** – maintain a minimum of national surge staffing levels before redeployment with an aim to return to GPICS v2 standards.
2. **Annual leave** – all staff should be supported to take the annual leave that supports their individual need.
3. **Recovery and restore time** – all staff should be rostered to a minimum level of non-clinical recovery time in the short and long term.
4. **Psychological support and resilience** – include psychologically aware conversation in 'one to one' return to practice conversations after a period of time away.
5. **Estates** – long term estates changes that improve wellbeing e.g. designated quiet space, sleeping pods.
6. **Awareness** – of local, NHS and other organisation wellbeing offers e.g. ICS offer.
7. **Psychological interventions** – ensure sufficient capacity for referral and self-referral for assessment and/or treatment.
8. **Career Development** – review roster design and flexibility, team based structures and working practices.
9. **Equity** – ensure all are able to access opportunities.
10. **Reward** – ensure staff are rewarded fairly and appropriately for additional work done.

Barriers to Accessing Wellbeing Support:

1. **Awareness.** Consider how you raise awareness of the support on offer. Email 'spamming' is not beneficial and can lead to 'decision paralysis'.
2. **Time.** Give staff time away from the clinical environment to access the support on offer
3. **Confidentiality.** Nurture trust so staff feel their needs will be explored sensitively and confidentially.
4. **Fatigue.** Staff may currently be feeling fatigued or overwhelmed to properly consider what support they need.
5. **Denial.** Staff may not wish to acknowledge they need help.
6. **IT.** Consider what Apps and electronic resources you promote. Staff may access them from their phones or from home or on breaks.
7. **Overload.** Offering too much may be overwhelming and again lead to 'decision paralysis' as staff cannot judge what is right for them.
8. **Coercion.** Do not assume staff need or wish to access wellbeing support through work, they may have other alternative sources of support e.g. family.

LINKS TO USEFUL RESOURCES

FICM Wellbeing Centre
https://www.ficm.ac.uk/careers-recruitment-workforce/wellbeing-centre

GMC guidance: Caring for doctors, caring for patients
https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

Academy of Medical Royal Colleges 'Support for doctors' resource
http://www.aomrc.org.uk/supportfordoctors/

Intensive Care Society Wellbeing Hub
www.ics.ac.uk

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[x] https://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/
[xi] https://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care
[xii] http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx
[xiii] www.civilitysaveslives.com
[xiv] https://www.rcog.org.uk/underminingtoolkit
[xv] https://improvement.nhs.uk/resources/just-culture-guide/
[xvi] https://learningfromexcellence.com/

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