The Intensive Care Society

Support for NHS Staff working in Exceptional Circumstances Guidance for NHS employers and other relevant organisations

Produced by the Intensive Care Society
July 2009

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Executive Summary

The purpose of this document is to clarify the potential implications for NHS staff during a pandemic or other major disaster event where existing resources are significantly exceeded. The consequent plans to maximise capacity in order to provide the best achievable care for as many patients as possible will be predominantly dependent on staff availability. Information obtained from major national and international events strongly suggests that advanced preparation of systems for maintaining staff confidence and morale will help to maximise the efficiency of all the relevant planning systems created to deal with such circumstances.

It is hoped that provision of this information to NHS employer organisations may therefore help to maintain staffing participation in order to preserve and reinforce essential systems for caring for as many patients as possible. It is also hoped that the contained information may also be beneficial to the relevant professional organisations such as the Royal Colleges and Specialist Societies who may be called upon to provide supportive information for their members, who may find they have to perform procedures or provide care that is outside of their normal area of expertise.

The formal support of these principles by the General Medical Council, the Nursing and Midwifery Council and the Department of Health would also help to ensure that the NHS organisations are able to provide the best achievable care for as many patients as possible in very difficult circumstances.

The documentation should be recognised to be in draft format, the intention being that its content and structure may be amended as necessary in order to meet the specific requirements of any organisations for the benefits of their staff or members.

Support for NHS Staff working in Exceptional Circumstances

Introduction

The planning process for Pandemic Influenza in the United Kingdom has highlighted a number of concerns relating to the difficult problems that NHS staff are likely to encounter in this event. Similar problems may also occur in other circumstances where the need for hospital beds significantly exceeds existing capacity, with recognition that there are likely to be substantial differences between rapid 'big bang' and slower onset 'rising tide' disaster scenarios. The consequent effects on other areas such as staff sickness, access to travel, child care etc. are difficult to predict, but there is a consensus view that the maintenance of existing NHS services – and in necessary circumstances attempting to increase capacity – will be heavily dependent on being able to maintain staff confidence. Failure to achieve this will affect the willingness and ability of staff to attend their workplace[1] with consequent implications for patients, relatives and other staff members.

Although the DH guidance for Human Resources[2] addresses some of the concerns being frequently raised by NHS staff members, it is regarded as a priority that there should be more detailed focus on the main areas likely to influence staff confidence and morale. The accompanying documents provide recommendations on how these should be addressed by NHS and other relevant organisations.

Potential threats to staff confidence

A range of potential problems have been identified either by previous experience in events such as the SARS outbreak,[3, 4] the recent London bombings[5] or as consequence of feedback received on consultation documents released in pandemic and disaster planning work. These can be broadly classified as:

1. Infection-related

    a) Risks of work-acquired infection as a result of caring for patients
    b) Concerns about transmission of infection to family members
    c) Risks of community-acquired infection in potentially crowded public transport

2. Work activity

    a) Inability to deliver normal standards of care because of limited resources / excess demand
    b) Necessity to decline patient admissions (or limit escalation of care)
    c) Withdrawal of care interventions that would be continued in normal circumstances
    d) Excessive workload / prolonged working hours
    e) Potential disagreements with colleagues over treatment-restriction decisions
    f) Pressure to work / provide interventions etc. outside of normal domain
    g) Cancellation of elective care procedures

3. Personal / psychological

    a) Anxiety about personal / family risks

b) Distress relating to
   - patient treatment restrictions
   - treatment withdrawal decisions
   - avoidable deaths

c) Death of family members / friends colleagues
d) Potential errors / failings from working outside areas of normal expertise
e) Antisocial / antagonistic relatives' interactions
f) Fatigue-related anxiety
g) Lack of confidence in management infrastructures / support

4. Personal / professional criticism / litigation relating to:

   a) Treatment limitation /.withdrawal decisions
   b) Normal standards for patient outcomes / complication rates potentially compromised as a consequence of care being provided by staff outside of their normal expertise
   c) Death or serious complications occurring as a result of excessive workload / inability to supervise to normal expectations

There are no single or simple solutions to this wide range of potential problems, but they are more likely to be adequately addressed if advanced planning is coordinated by all of the relevant potential contributors. For this reason, in addition to seeking the full support of NHS organisations for the Recommendations for Staff Support it is also desirable that professional organisations such as the representative Royal Colleges (medical speciality and nursing) or Specialist Societies, the General Medical Council and the Nursing and Midwifery Council will be prepared to provide full support for staff who have acted in the best interests of patients.

Recommendations for Staff Support

The main areas in which support for staff will be essential are outlined, and recommendations on how to provide this are summarised. Many of these areas have been highlighted by the H1N1 outbreak. Although the circumstances will differ in any 'big bang' disaster many of the same principles will apply, and consequently it is probable that appropriate advanced planning for these areas may also provide significant benefits for any subsequent (or concurrent) 'big bang' event.

1. Infection related

a. Work-acquired infection

Although concerns about staff safety in the current pandemic have been influenced by the SARS outbreak, there needs to be awareness of the major difference between SARS (which was a condition with a high mortality risk but one in which prevention of international disease progression was possible by vigilance in infection control) from the pandemic – in which disease progression is inevitable but where predicted mortality rates are relatively low.

This does not however reduce the importance of minimising the risks of disease transmission from infected patients. Failure to do this, and to provide reassurance to staff, is likely to significantly undermine confidence and may reduce staff availability. NHS organisations therefore have an obligation to:

- Provide staff training in high-quality infection control measures for all staff members who are potentially at risk (including support technicians, health care support workers, secretarial and domestic assistants etc.)
- Ensure availability of personal protection equipment etc, guidelines for which are included in the Pandemic Influenza Infection Control and the Critical Care Infection Control guidance documents available on the DH website.

The situation could differ considerably if a different form of transmissible infection, or if, in a second peak, H1N1v were to evolve to create a significantly higher mortality rate. In such circumstances even greater vigilance on staff safety / protection will be required.

b. Transmission to family members

Feedback from centres that have dealt with significant numbers of H1N1v infected patients confirms that staff attendance has been generally good (despite some having acquired influenza from treated patients) because of awareness of the relatively mild form of illness encountered by the majority. However, if mortality rates were to increase staff may have significant concerns about the risk to their family / partners / relatives – particularly if they are known to be significantly vulnerable as a consequence of their age or pre-existing co-morbidities. Staff willingness to continue attending work may be improved if work-based accommodation is made available, preventing the need to return home until there is reasonable confidence that the illness has not been acquired. NHS organisations should therefore consider:

- Performing a survey of staff preferences
- Arranging for local accommodation close to the working area

c. Risks of community-acquired infection in public transport etc.

Anyone with experience of travel in crowded trains or buses will be aware of how many episodes of coughing / sneezing are encountered. Although the DH has made strong public recommendations for use of tissues etc. to minimise the risks of droplet spread and hence disease transmission, the response rates are very variable. Staff may therefore have relevant concerns not only about their own risks, but also on the implications for patient care if staff availability is significantly reduced.

NHS organisations should therefore:

- Discuss and agree with staff representatives the best means of minimising these risks (e.g. local accommodation facilities, sharing transport with colleagues who live in proximity)
- Consider providing a specific staff transport system during the event in order to maintain staffing levels.
- Arrange a system for transferring home any staff members who are developing signs of potential infection.

2. Work activity

a. Inability to deliver normal standards of care because of limited resources / excess demand.

If the number of severely compromised patients starts to escalate staff members will find it difficult to restrict patient care or to limit admissions because of insufficient resources to meet demand. NHS organisations therefore have a responsibility to provide advance training to raise awareness of these potential scenarios to minimise the risk Staff training should include;

- Information relating to the likely duration of the event
- Reassurance (if appropriate) about when a return to normal working practice may be anticipated.

Although this may have limited benefit for the care of acutely ill patients whose risks of recovery may be influenced by lack of resources, for patients with more prolonged conditions (e.g. awaiting transplantation or elective surgery) it is likely to be beneficial if reassurance about future care can be given. Advance contingency planning in accordance with published guidance for expanding capacity will also potentially improve the ability to cope with excess demand, and the engagement of staff in this process may help to reduce the discomfort caused. Failure to maximise the use of the resources available is likely to cause demoralisation, particularly if colleagues, relatives or friends suffer as a result.

b. Necessity to decline admissions / limit treatment escalations.

Similar principles apply relating to the decline of admission of patients who might be expected to benefit from specific therapies in normal working circumstances. Nationally agreed guidance on criteria for helping with these challenging decisions may partially reduce the sense of guilt or discomfort about them. The sharing of decisions with trusted and appropriately trained colleagues will also be important

Explanation to patients and next of kin will be particularly challenging. It is therefore important that on a national level there is advanced clarity about the implications of the event and the reasons why normal expectations may not be achievable. Important principles that need to be addressed include:

- Documentation of the reasons for limiting care will be essential
- Staff who have to take the responsibility for limiting admissions or treatment escalation will need formal confirmation that they will not be vulnerable to professional criticism or suspension for acting within the agreed local / national guidance.

Although the possibility of subsequent legal allegations cannot be excluded staff should be made aware that there has been some discussion with the Litigation Authority about these concerns. The summarised views provided in the HR guidance provide reasonable reassurance that staff will be supported by existing indemnity insurance arrangements and that courts are likely to take sensible views on decisions that have to be made in disaster scenarios or a major pandemic. Nevertheless, there is likely to still be considerable scepticism abut the view expressed by the Authority that they do not believe there would be a substantially greater risk of successful legal challenges to the NHS in scenarios that may arise during an influenza pandemic, and consequently any developments that could provide more robust reassurance could be very valuable in helping to support staff availability.

c. Withdrawal of care interventions that would be continued in normal circumstances.

This is one of the most controversial implications of the national guidance that staff may have to implement, and is likely to cause significant discomfort to all involved. Staff are also likely to encounter a full range of patient / relative responses which will include severe distress, anger and even violence. There will therefore need to be:

- Shared decision-making in accordance with national and/or local guidelines (for both personal and medico-legal reasons)
- Full documentation of the reasons for the decisions taken.

Some may take the view that such decisions – despite being recommended by national or local strategies – are inappropriate, and may refuse to implement them. As there will be resultant implications for other patients (who may have more chance of benefit but who may be denied access to escalated treatment) detailed documentation of the reasons for the chosen process will be essential.

d. Excessive workload / prolonged working hours.

Recommendations in national guidance for coping with increased demand include the transition to longer shift patterns. These changes may be further exacerbated by the number of patients for whom care is provided during shifts, the severity of their conditions, and the increased complexity of handovers etc. In order to minimise the cumulative effect on staff morale consideration should be given to:

- Re-organising staffing rotas so that cumulative periods of prolonged shifts are followed by equivalent respite periods, allowing an appropriate period in isolation to ensure lack of disease acquisition prior to returning to the home environment to minimise the risks of transmission to family.
- Ensuring that staff who have been subjected to abnormal strain are given reasonable recovery time and, if required, access to support once the crisis has passed.

e. Potential disagreements with colleagues over treatment-restriction decisions.

The controversial implications of restricting treatment are likely to generate staff disagreements despite being in accordance with the national or local strategies for surge management. Although the responsibility for these decisions will ultimately fall to senior staff members, it is nevertheless important that the views of all involved are respected and that any reservations raised are considered in detail and discussed openly. If, despite these efforts, there is lack of consensus or accepted agreement it may be important to;

- Arrange for independent review by members of the local Senior Medical Assessment Team (Appendix 4) to assist in the resolution process.
- Ensure comprehensive documentation in anticipation of retrospective complaints / litigation.
- Consider advanced planning on how to minimise the risks of litigation when decisions are made in accordance with agreed national / local policies.
- Prepare an agreed process for the re-allocation of staff who are profoundly against such decisions from patient care. (This should be very much a last resort, and should only be considered if all other attempts to address their concerns and reach agreement have been fully explored - including independent assessment and if necessary recruitment of a staff advocate if considered beneficial).

Any staff members who are unable to accept the treatment limitation decisions and who may be unable to continue working within their normal domain as consequence should be offered the option or assisting in other clinical areas. It is also important that there should be no adverse impact on their subsequent career as a result of having been unwilling to accept decisions which are likely to result in potentially avoidable patient deaths.

f. Pressure to work / provide interventions etc. outside of normal domain.

In extreme circumstances there is a high probability that staff may find themselves under pressure to undertake care or interventions outside of their normal areas of skills /expertise. This pressure may be generated either by their employer or as a result of conscious awareness that without their help patients may be at risk of suffering or death that could be preventable. The most challenging of these responsibilities is likely to be a necessity to care for sick children, but other examples may include staff from other clinical areas who are

recruited to help expand critical care facilities, and who may have to care for seriously ill ventilated patients, or requests for assistance from consultant and trainee anaesthetists who are not normally involved in intensive care (but who are likely to be the most appropriate to provide the core skills required). As cancellation of elective surgery, other procedures and outpatient appointments may be inevitable in the peak of a pandemic or in a 'big bang' event it may also be reasonable to seek engagement of clinicians from other specialist areas whose normal work responsibilities may be reduced but who may be willing to help in the management of acutely ill patients (e.g. surgeons, rheumatologists, dermatologists etc.).

In order to make the most efficient use of such resources NHS organisations have a clear responsibility to prepare formalised reassurance plans in advance. These should include;

- An agreed policy on how staff working outside of their normal domain should endeavour to seek advice or assistance from appropriately trained colleagues wherever possible
- An understanding that despite the difficulties that may be encountered there is still a responsibility to try to minimise risks and avoid serious errors of judgement or decision-making.

g. Cancellation of elective procedures because of excess numbers of patients requiring hospital care.

- This will have an impact on patients and the staff who normally provide these procedures, but any adverse implications may be reduced by good communication and assurance that the procedures will be re-scheduled as efficiently as possible in the recovery phase.
- The potential dissatisfaction of staff who would normally provide this care may be minimised if they can be allocated the responsibility for explanations and positive reassurance.
- Included in the explanatory information should be the fact that temporary cancellation may reduce the risk of acquiring the pandemic virus, and avoid the risk of being unable to access higher levels of supportive care if the procedure were to result in unanticipated complications.

3. Personal / psychological

a. Anxiety about personal / family risks.

It is inevitable that all staff will have concerns about the risks to family members, particularly if they have young children, relatives who are vulnerable because of existing co-morbidities, or if there is reason to believe that any members of family (or close friends) are showing signs of a developing illness. While there are no simple means of reducing such anxiety, it is important that employers and clinical leads are sympathetic to these concerns and that there is advance preparation for;

- Supportive infrastructures, including help in the provision of isolation accommodation facilities
- Transport assistance if needed

- Availability of antiviral medications (for staff and family members)
- Permission of compassionate special leave if required.

b. Distress relating to patient treatment restrictions, treatment withdrawal decisions, and avoidable deaths.

   It is inevitable that the cumulative effect of these will have a profound effect on many staff members, given that the vast majority of those who are responsible for the care of sick patients have made their career decisions based on the desire to help patients recover from serious illness and prevent avoidable deaths. Experience gained from the SARS outbreaks and from other major disaster incidents strongly suggests that the best ways of minimising the negative effect on staff morale are by;

   - Creating frequent teamwork dialogue, enabling concerns to be raised openly and without risk of criticism
   - Reassuring staff that their levels of distress or sadness are entirely understandable and appropriate.

c. The death of family members / friends or colleagues.

   The implications of such deaths will be considerable, particularly if lack of resources or treatment limitation has contributed to deaths that may have been avoidable in normal circumstances. The impact on staff members may be even greater if the individual concerned received care in their own clinical area. It must be anticipated that friends of the affected staff members may also be devastated by such an outcome. There are clearly no simple means for dealing with such problems, but it is important that;

   - Affected staff are given as much support as possible, and (if appropriate) reassured that all reasonable efforts had been made to avoid the outcome from occurring.
   - Full respect and support is provided for the religious preferences of the deceased individual and their family / friends, with particular vigilance to ensuring that any specific requirements for funerals or after-death care preferences are fulfilled.
   - Preparation is considered for compassionate leave allowance, with appropriate infrastructures for ensuring support and bereavement counselling.

d. Potential errors / failings from working outside areas of normal expertise.

   The fact that staff may find themselves undertaking care for patients outside of their normal areas of expertise means that some errors or other failings are virtually inevitable even if all reasonable attempts are made to minimise these risks. It is therefore important that;

   - Staff involved in any adverse events are able to report them without facing intimidation or additional distress.
   - As far as reasonably possible automatic suspension should be avoided unless there are good grounds to believe that there were significant failings in professional responsibilities or other reasons for loss of trust of the individual concerned.
   - Assistance / direct communication facilities are available to support them and, if appropriate, facilitate their return to work in a suitable clinical area within a reasonable timeframe.

e. Antisocial / antagonistic relatives' interactions.

It is highly likely that staff are likely to face difficult circumstances with patients and relatives as a consequence of lack of resources or limited treatment options. Although good communication and honest explanations must be seen as a priority, it is well known that even in normal working circumstances responses from angry relatives can lead to verbal and even physical abuse of staff members. It is therefore essential that;

- Robust security systems are available to provide support for staff.
- In circumstances where such responses may be anticipated in advance arrangements should be made to have security staff present prior to discussions taking place.
- In extreme circumstances consideration is given to denying potentially aggressive relatives access to the clinical areas.

Police support may also be required, particularly if there is perceived to be a risk of physical violence or use of arms to influence decision making.

f. Fatigue-related anxiety.

It must be anticipated that some members of staff who are committed to elongated shift working and who may also have problems obtaining good rest because of difficulties at home or in workplace accommodation will experience increase risks of anxiety or distress-related problems. It is therefore important that team managers and employers should be vigilant about ensuring that staff members are;

- Not allowed to become excessively fatigued
- Any who are at risk are provided with appropriate counselling and support.

g. Lack of confidence in management infrastructures / support.

The responses of staff during a pandemic or other major disaster scenario are likely to be influenced by their effectiveness in normal circumstances.

- Staff who have the benefit of working in organisations which have developed good working relationships and where there is respect and confidence in management infrastructures are more likely to feel confident that they will be adequately supported when they face difficult challenges.
- As the building of confidence and the development of good team-working structures are very much time-dependent it is important that these are seen as priorities for normal working practice.
- Attempts to amend less than ideal working relationships at the last minute are less likely to be successful and the implications may be significant.
- A survey[6] undertaken to assess staff willingness / availability has identified that one of the most influential options for supporting staff may be the ability to provide access to an appropriate vaccine when available. Although the study did not include provision of antiviral treatment for staff who become symptomatic at work, this is also likely to be of benefit.
- Whether to offer antiviral prophylaxis for staff who may have been exposed to risks of

viral transmission must depend on the potential risk / benefits, but should be agreed in local policy decisions.

4. Personal / professional criticism / litigation relating to:

a. Treatment limitation /.withdrawal decisions

The potential implications of professional criticisms or litigation on staff availability will be significant. It is consequently essential that;

- There will be adequate reassurance to staff that all reasonable and agreed decisions will be supported, and fully defended if necessary, by their employer.
- For medico-legal protection national or local policies signed by Trust senior management or executives will be necessary

Appendices A and B provide draft templates for staff protection against such criticisms.

b. Normal standards for patient outcomes / complication rates potentially compromised as a consequence of care being provided by staff outside of their normal expertise.

- NHS organisations must therefore provide full moral and physical support for staff willing to undertake such responsibilities (see above)
- In order to justify such support it may be necessary to have signed evidence of the circumstances in which staff members have undertaken additional challenging responsibilities; a draft version of such is included in Appendix C.
- NHS organisations will also need to agree in advance that they will accept responsibility for any potential litigation claims made against staff for adverse outcomes despite clear evidence that they had done the best they could under difficult circumstances.

c. Death or serious complications occurring as a result of excessive workload / inability to supervise to normal expectations

Despite all recommended strategies to expand critical care capacity and provide reasonable levels of care for as many patients as possible, it is still likely that deaths or serious complications may occur as a consequence of either restricted resources (staffing or equipment) or the development of complications / events that are not identified sufficiently promptly to minimise their consequences. As it is likely that a wide range of crucial supportive services will also be under strain, there needs to be recognition that many other activities regarded as normal practice may be difficult if not impossible. These may include:

- Reluctance to provide inter-hospital transfers and repatriations because of the risks of spreading infection
- Restrictions on patient transfers for specialist care because of lack of spare capacity. This may also have an impact on patient transfers for conditions unrelated to the event such as neurological or cardiac complications.
- Limitations of ambulance transport and the availability of appropriately trained personnel to supervise patient transfers.

d. Professional criticism or litigation may then be faced in retrospect, with either individuals or NHS organisations being held accountable. It is therefore important that prior preparation occurs for such circumstances, and that staff are given appropriate reassurance that they will not be held personally responsible for any resulting deaths or serious adverse incidents arising from lack of resource availability.

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Appendix A

Staff Support Confirmation from NHS Organisations

Dear Colleagues

The purpose of this letter is to provide formal confirmation of support for staff members involved in patient care during an influenza pandemic or other major disaster scenario. It is an important principle that staff should not be vulnerable to retrospective blame or criticisms for having done the best that they can in very challenging circumstances.

It is acknowledged in advance that staff members may have to make difficult decisions about patient treatments or be involved in the resulting care pathways which may differ from normal working circumstances. It is important that any decisions that may result in restricting or withdrawal of treatments should be in accordance with agreed national / local guidance, and wherever possible shared and agreed with all staff involved with full documentation of the reasons for decisions made.

It is also recognised that in order to act in the best interests of patients staff may have to provide care or interventions that are outside of their normal areas of expertise and in which they may have little or no formal training. Such responsibilities should only be undertaken if no better options are available, and all reasonable efforts should be made to seek advice / assistance from other staff members who may have more experience or former training in the relevant areas. However, if no better alternative exists the essential requirement is that staff who are prepared to take such responsibilities use all of their existing skills and expertise to provide the best care that they can for the patients involved. Access to additional advice from distant specialist centres and / or internet based facilities such as Up-to-date.com should also be considered.

Providing that these standards are met and can be confirmed / supported by appropriate documentation (and ideally the witness observations of colleagues) it is important that staff members are reassured that they will be fully supported in any subsequent developments – whether these relate to personal distress, loss of confidence, professional criticisms or even retrospective litigation.

Chief Executive Officer Medical Director

Appendix B

Staff Support Confirmation from Colleges and Specialist Societies

It is an important principle that staff members involved in patient care during an influenza pandemic or other major disaster scenario should not be vulnerable to retrospective blame or criticisms for having done the best that they can in very challenging circumstances.

It is acknowledged in advance that staff members may have to make difficult decisions about patient treatments or be involved in the resulting care pathways which may differ from normal working circumstances. Any decisions that may result in restricting or withdrawal of treatments should be in accordance with agreed national / local guidance, and wherever possible shared and agreed with all staff involved with full documentation of the reasons for decisions made.

It is also recognised that in order to act in the best interests of patients staff may have to provide care or interventions that are outside of their normal areas of expertise and in which they may have little or no formal training. Such responsibilities should only be undertaken if no better options are available, and all reasonable efforts should be made to seek advice / assistance from other staff members who may have more experience or former training in the relevant areas. However, if no better alternative exists the essential requirement is that staff who are prepared to take such responsibilities use all of their existing skills and expertise to provide the best care that they can for the patients involved. Access to additional advice from distant specialist centres and / or internet based facilities such as Up-to-date.com should also be considered.

Providing that these standards are met and can be confirmed / supported by appropriate documentation (and ideally the witness observations of colleagues) it is important that staff members are reassured that they will have the support of this organisation in any subsequent developments – whether these relate to personal distress, loss of confidence, professional criticisms or even retrospective litigation.

President Vice-Presidents

Appendix C

Confirmation of extraordinary circumstances for staff members

The purpose of this document is to confirm that recent exceptional circumstances created a necessity for staff to undertake unusual responsibilities and make difficult decisions in order to provide the best achievable care for as many patients as possible.

Having discussed the situation with the staff members involved and inspected the relevant documentation the following important points can be officially confirmed.

1. All potential options were explored and the necessary decisions were shared and approved by colleagues / appropriate managers.
2. Full documentation was provided of the circumstances and of the decisions that had to be made.
3. Where appropriate and achievable full explanations were given to patients and / or next of kin / family members.
4. Staff who undertook responsibilities for care outside of their normal area of expertise did so as there were no better options available to provide care for the patients involved. All reasonable attempts were made to obtain advice / support from more experienced colleagues.
5. Where decisions were made on either treatment limitation or withdrawal these were in accordance with either national or locally agreed policies and were shared with appropriately experienced colleagues.
6. Normal treatment pathways or specialist referrals could not be followed because of lack of resources. All reasonable alternative options were explored.

It is therefore confirmed that the staff did the best that they could for the benefits of patients in these very difficult circumstances, and consequently should be fully supported for doing all that they could to maintain services for patients most likely to benefit. Further details will be provided if necessary.

Signatures

Clinical Director

Divisional Manager

Medical Director

Chief Executive

Appendix D

Senior Staff Assessment Team

In circumstances where difficult triaging decisions may have to be made it is important that systems are developed in NHS organisations to assist clinicians responsible for providing patient care. In addition to the complex dilemmas about not initiating mechanical ventilation or escalating to multiple organ support, there may also be major disagreements with colleagues, other staff, or family members about treatment restrictions or end-of-life care decisions.

It is therefore recommended that for any such cases there should be access to a group of experienced clinicians who are prepared to become directly involved in assessment of the patient and to either support the intended decision or to take responsibility for any amendments that are felt to be more appropriate.

Although the longstanding concept of '3 Wise Men' is a reasonable principle on which to base the creation of a Senior Staff Assessment Team, the implications of the potential workload that could be created by many such cases, and the possibility that staff members may not be fully available either during a pandemic or other event, suggests that there should be a larger group of appropriate individuals from whom subgroups of 3 can be called upon for assistance. It is therefore recommended that there is advanced planning to establish such groups, with the total number being based on the size of the hospital and its relevant specialties. It is also recommended that consideration is given to preparing specific subgroups based on good professional working relationships between the participating individuals.

Obviously members of the Senior Staff Assessment Team should not be limited to being male – and it may also be appropriate to include experienced specialist nurses in the Team. There will need to be strong reassurance provided to members that they will be fully supported by their employer, and it may therefore be worth considering including a member of the Trust Executive team in the triaging process in order provide managerial confirmation that all reasonable options have been pursued to prevent the need for triaging. Similar support should ideally be provided by the appropriate Colleges / Specialist Organisations / GMC for the decisions made if those who are prepared to take responsibility for triaging decisions are subject to retrospective criticism or litigation.