

Experiences, challenges and lessons learnt in medical staff redeployment during response to COVID-19

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ABSTRACT

Background The response to the COVID-19 pandemic required redeployment of large numbers of staff to avoid acute services being overwhelmed. This unprecedented, previously unplanned redeployment occurred in a rapidly changing environment. This paper describes the process of redeployment at a teaching hospital and assessment of this by the redeployed doctors and redeployment team.

Objective Identify key lessons from the redeployment process to inform resilience and future planning for further COVID-19 peaks.

Methods Redeployment team experiences and challenges were documented in real time and formal structured feedback obtained. All redeployed doctors were asked for quantitative and qualitative feedback regarding their experiences in two distinct acute areas with different approaches to staffing.

Results 63 redeployed staff and five members of the redeployment team completed feedback questionnaires. Most redeployed doctors (76%) were satisfied and had adequate support and training. Redeployment was associated with self-reported stress and anxiety in 95% with 59% describing this as moderate or greater. This was reduced by adequate communication, supervision and a sense of belonging to a firm with access to simple information making a significant difference. Awareness of and satisfaction with well-being support services was also high (71%).

The redeployment team identified having a well-mixed team who met daily, an online portal and engagement with leads as the key factors for being successful.

Conclusion Redeployment in response to COVID-19 was associated with reported stress and anxiety in most redeployed doctors. Communication, local induction and feeling valued and being part of a team helped reduce this.

INTRODUCTION

The COVID-19 pandemic has brought sweeping changes to organisational processes and the way care is delivered across the National Health Service (NHS). In response to the declaration of Level 4 National Incident and the anticipated surge and peak in patients with COVID-19,¹ many NHS trusts underwent an unprecedented and previously unanticipated mass deployment of staff to acute areas to deal with the projected surge and peak in patients with COVID-19. This was the fastest and most significant repurposing of services, capacity and staffing in the NHS history.² The speed at which this needed to be performed in association with the often incomplete and changing information regarding projections made this process

particularly challenging. Decisions being made in real time, without the usual support and governance processes, were akin to the military principle of ‘Mission Command’ where there is freedom of action at all levels to deliver the required outcomes³ as opposed to the traditional command and control structure.

This paper describes the process of redeployment of 232 doctors over a period of 14 days in response to COVID-19 in a busy university teaching hospital. Doctors were redeployed into two distinct acute areas, both with different approaches to onboarding and rotas. We share the feedback and lessons learnt from this dynamic and previously unplanned process, from both redeployed doctors and redeployment team, to inform teams planning for further COVID-19 peaks and help improve the experience of both redeployed staff and ultimately their patients.

Redeployment response to COVID-19

Due to the expected surge in patients with COVID-19 and associated staff sickness it was expected that the acute patients with COVID-19 requiring hospital care would grow beyond our current capacity of acute specialties to deliver sufficient care by early April 2020. Our Trust covers multiple sites and has >100 specialty medical rotas, including covering regional services, in addition to a large university and associated medical school. Given the variety of rotas and staffing experience ‘top down’ reallocation of staff was not feasible and so in the first wave of redeployment clinical leads were asked to volunteer potentially suitable staff to move to acute specialties. Concurrently, we developed an online secure portal which we asked all staff to complete which included up-to-date contact details, acute experience and suitability for front-line work. Medical staff were then cross-referenced with the portal information to allocate the most appropriate staff to each area. The portal was extended to university volunteers, some nursing staff and Allied Healthcare Professionals and ‘Bring Staff Back’ doctors,⁴ who were then redeployed chronologically in waves (see [figure 1](#)). A redeployment team containing individuals with experience in clinical areas, university, human resources and education was formed who met virtually, daily.

METHODS

Three weeks following redeployment all doctors and the redeployment team were contacted to provide anonymous feedback, both qualitative and quantitative, on the redeployment process in the form of an online questionnaire (see online



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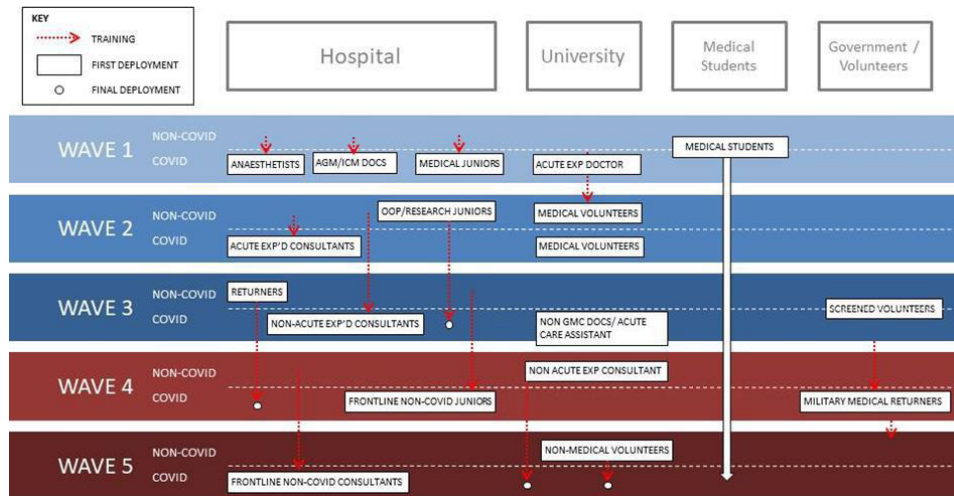


Figure 1 Planned wave model of medical staff redeployment in response to COVID-19. EXP = experience, ICM = Intensive Care Medicine, AGM = Acute General Medicine, OOP = Out of Program, GMC = Registered with General Medical Council

supplemental appendix 1 for redeployed doctors and online supplemental appendix 2 for redeployment team). The questions included a mix of Likert scale and free text responses. As this was a service evaluation, formal ethics approval was not required. Sixty-three redeployed doctors (25%) and five members (83%) of the redeployment team completed the questionnaires.

Medical staff were redeployed to two distinct acute areas. One area completely changed their rota, hours and ways of working in response to COVID-19 while the other responded to the projected increase in patients with COVID-19 by expanding the rotas already in place with reinforcement of overnight and weekend cover. Each designed a bespoke training programme and local induction with periods of shadowing for redeployed doctors. Approximately a third of the redeployed doctors were assigned to the area with a new rota with the remaining assigned to area with existing rota. The majority of redeployed doctors were doctors in training, mainly Foundation Year and Core Medical Trainee levels, drawn from all specialties and distributed between the two areas as need arose with the aim of keeping groups of doctors together if possible. These doctors were identified by clinical leads in all specialties (acute and non-acute) as having potential to be moved and more likely to have generic skills that would be useful in any acute area. The smaller number of consultant and Higher Specialist Training-level doctors was allocated based on specific skills, that is, orthopaedic specialists onto proning teams, interventional radiologists on lines team, and so on. Some redeployed doctors were initially redeployed to one acute area and later moved and fed back on their experiences of both.

RESULTS

Redeployment team

The redeployment team identified several key factors which contributed to the successful redeployment of doctors. The online portal was essential for rapid accumulation of relevant expertise and contact details and enabled quicker identification of the most suitable doctors to be relocated. The professional mix in the redeployment team and daily online meeting also meant decisions were made quickly, often in real time. Requesting clinical leads to identify potential doctors for redeployment, rather than top-down identification of who to move, resulted in a good representation by different specialties and training grades in

the redeployed staff and some imaginative locally owned solutions for rota gaps with teams very much owning their part of the redeployment process. This also happened quicker than a centrally controlled process could have.

Redeployed doctors

In response to questions regarding training, support and information, 76% reported they received the appropriate training and support with 59% reporting satisfaction with the information they received. Many understood the pressures and speed at which the process was being undertaken and reported it was '*as smooth as it could be*'.

Differences were seen in the qualitative feedback from the acute areas with different approaches to redeployment. Doctors relocated to the acute areas with the newly designed rota, composed of higher acuity patients and longer shifts, reported greater satisfaction with their redeployment than those who were redeployed to acute areas on existing rotas. Some doctors, particularly those in specialties significantly removed from the acute specialties, also reported feeling more secure in higher acuity areas.

Fifteen per cent of doctors were dissatisfied or very dissatisfied (3.3%) with the redeployment process and the majority of the feedback regarding this related to communication. The main focus of communication was on issues such as rotas, leave, equity and childcare once they had been redeployed. The difficulties in providing this in a timely manner were also widely appreciated.

On direct questioning with a 5-point Likert scale, 95% reported experiencing stress or anxiety associated with the redeployment process with 59% describing this as a moderate amount or greater (figure 2). Most (71%) were also aware of, and satisfied with, the clinical and well-being support available to help with stress and anxiety.

The main causes of stress and anxiety reported included logistical issues, such as not receiving advanced notice of placements or adequate training in relevant computer systems, but mainly focused on conflicting and changing information with one doctor concluding that '*the stress and anxiety was related to the unknown*'. These included concerns about potential infectivity to family members and adequate reassurance regarding infection control procedures and personal protective equipment (PPE). The qualitative feedback demonstrated that communication

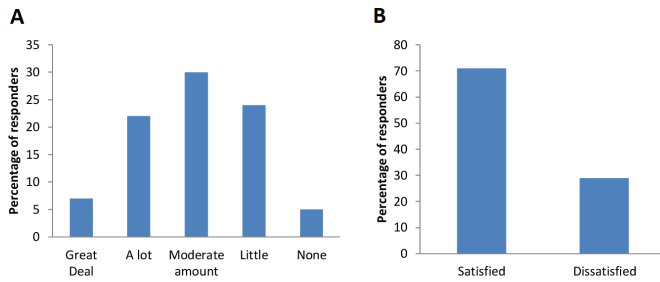


Figure 2 Summary of (A) self-reported levels of stress in redeployed doctors and (B) satisfaction with access to clinical and well-being support available to help with stress and anxiety.

played a large part in alleviating stress and anxiety and inadequate or incorrect communication increased it.

DISCUSSION

When asked retrospectively what they would have wanted from the redeployment process several key themes were highlighted. Perhaps unsurprisingly, adequate information and training was highlighted by most, which has relevance to many more situations than this redeployment. It also emerged that it was very important to doctors that they felt they were treated fairly by the process and the new teams by being kept informed and given an expectation as to how long things would last. The perception of unfair treatment, poor communication and negative redeployment experience was more common in the acute teams whose rotas and team structure continued as pre-COVID-19. This is potentially due to a less robust induction procedure, as the rotas were not new, greater reliance on peer-to-peer information resulting in potential unequal power dynamics regarding information and expertise and a perception of being outsiders joining an established team.

Another key theme from the feedback was around having a sense of purpose and belonging. Being part of a 'firm' or 'team' was reported as important, as was feeling useful and being acknowledged throughout the redeployment process, rather than simply ordered, '*Recognition of my difficulties even if you can't fix them*'. A difference was again seen between the two areas with greater perception of support, value and team dynamic in the areas with new rota structures as opposed to those carrying on business as usual, again potentially related to a greater amount of support available and the rotas being new for everyone. The acute areas with new rotas had the greater acuity and longer shift patterns. Although appearing counterintuitive initially, with doctors appearing to prefer to be in the higher risk, higher acuity areas, this again appeared related to increased levels of support, supervision and PPE which were highlighted as particularly important to doctors unfamiliar with acute working. Being part of a team was key, supporting the potential benefits of the medical 'firm' structure⁴ and previous suggestions that training schemes which create a modern firm structure could help improve junior doctors' morale.⁵ These findings also have much wider ramifications for medical training and rota planning outside the COVID-19 era. Redeployment can also be a negative experience for doctors and is associated with significant stress and anxiety in some individuals. Good communication, support and feeling part of a team were associated with a less self-reported anxiety with uncertainty associated with greater levels. Reducing uncertainty and balancing information to keep doctors as informed as possible with conflicting and changing communications is particularly challenging, but vital. Having a central

point for disseminating information and receiving queries is also crucial as without formal guidance resourceful teams can attempt to sort problems locally without appreciating the system-wide implications. In a perceived information vacuum rumours can run rife which are then difficult to undo.

Another key lesson identified by the redeployment team feedback was the importance of engaging with the local teams in problem solving. Each clinical service is very different and has different service requirements and rotas. There was no 'one size fits all' approach to redeployment and the service leads were in the best position to identify how this is best done. We did not experience resistance to doctors being released and, like has been seen elsewhere in response to COVID-19, the majority of teams took ownership and stepped up to cover changes and embrace new ways of working.

Our unique online portal, developed in collaboration with the University, which was completed by over 1000 doctors in the first week, was essential for planning redeployment. Having up-to-date information regarding previous acute experience, age and any reasons preventing front-line work was invaluable and allowed a real-time response to the staffing requirements. This information was not present in standard Human Resource records.

CONCLUSIONS

Redeployment of significant numbers of staff is a massive undertaking that takes time and needs to be planned and started as early as possible. Access to relevant information, such as via our online portal, and local expertise, as with recruiting our clinical leads, made a big difference to the speed and effectiveness of the redeployment process. Key lessons learnt are demonstrated in [box 1](#).

Information and communication was also associated with the stress and anxiety experienced by the redeployed doctors

Box 1 Key lessons learnt

What we would do differently:

- ▶ Start as early as possible.
- ▶ Communicate much more. Regularly clear emails, even when no change, and single point of contact for queries, linking in with well-being support on each communication.
- ▶ Use online portal or equivalent to assimilate information earlier and link to Human Resource and Occupational Health records.
- ▶ Engage local clinicians for 'bottom up' solutions earlier.
- ▶ Ensure all redeployed doctors were allocated to a 'team' and ensure relevant local induction and information prior to starting work in new area. Consider allocating 'buddies' with doctors already part of the team for extra peer support.
- ▶ Ensure level of COVID-19 competency in all staff via online training.
- ▶ Remind the redeployed staff that they are valued, as they clearly are, whenever possible.

How might it impact on clinical practice in the near future

- ▶ Influence redeployment of medical staff in response to further COVID-19 activity and for future pandemics.
- ▶ Implications for induction processes and how to best support staff through change.

with relatively simple, standard information regarding topics impacting on quality of life. In addition to emphasising the need for this, a central point of communication with regular updates is likely to be helpful in reducing uncertainty. Being part of a team or firm emerged as important and associated with greater satisfaction with their experience and lower stress and anxiety which has implications for training and rota planning outside the COVID-19 era and potentially for the structure of specialist teams in general.

As in the non-COVID-19 era, the importance of remembering that our highly skilled and dedicated staff are also still people, as opposed to commodities to be moved round, and treating them as such, cannot be underestimated. (2)

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