New Zealand Resident Doctors' Association

Omicron Planning

26 January 2022

This document has been drafted specifically for the Omicron surge expected to affect the NZ healthcare system in March/April 2022. It provides guidance on issues specific to the RMO workforce that should be considered given the surge environment. Any changes to normal practice that occur during surge should be reset to normal practice at the conclusion on the surge unless agreed otherwise.

DHBs should proactively consult with RMOs as soon as possible on what changes might be sought and invite the RMOs propose their own solutions to the impending crisis.

Rostering and Redeployment

Principles:

1. Retain as much normality as possible re rosters, but as cases volumes and pressure on hospitals rises, consider how we add additional resource in a logical and safe way.
2. Pipeline should be disrupted as little as possible. Be mindful of training programme prerequisites and protect trainees' minimum requirements.
3. Plan in advance: discuss with the RMOs to ensure people are on board, issues resolved, and any variation agreed.
4. The more senior the RMO is in a training programme the less flexible regarding scope of practice – in other words a senior reg in General Surgery should stay in General Surgery and work to maximise efficient care within that speciality. This is variable speciality by speciality so a first year Rheumatology AT is well trained in General Medicine via their first three years so is probably useful on a General Medicine roster (note point 2 about training requirements however).
5. PGY-3 and above are the most flexible until we get to the senior registrar ranks as per 4 above.
6. Support for PGY-1s at this time of the year is crucial so minimise losing PGY-2s from each service if possible (and note a PGY-2 was a PGY-1 only a week or so ago……)
7. The most inexperienced RMO (all our PGY-1s) should face the least disruption.
8. Maximise keeping our TIs with their teams to support the House Officers as much as possible. RDA MECA provisions apply to TIs (final year students) if they are deployed into work.

- MCNZ has again moved to recognise time spent on run overruns or other potential consequences for PGY1s and 2s.
- It would be valuable to have a stock take of who has done ED in the PGY-3, and above group as these doctors could be an ideal generic ED resource. Identify which are prepared to volunteer to move to ED as and when required.
- Are there any plans to have a team to fly into places like Gisborne if their staffing is at risk of collapse? If so this needs to be agreed in advance:
    1. what type of SMO and RMO?
    2. where do they come from?
    3. preparatory orientation or use of those who have worked there before?
    4. Accommodation, pay etc.

Additional support for each specialty in ED/ acute assessment:

Consider rostering to add increased presence for each acute speciality in ED especially for the evenings/ weekends as we must anticipate not only increased respiratory type presentations but a general decrease in ability of all patients to access Primary Care. Logic here is that the Triage nurse could for example refer any patient self-presenting orthopaedic injury straight to additional Ortho Surgical resource rather than having ED assess first and then refer on. This leaves ED staff to focus on the undifferentiated patient.

These types of rosters become logical especially if the planned care activity of the surgical specialties is reduced via lack of beds etc.

On the issue of leave. Recall from annual leave should be on a voluntary basis (given our situation, trying to force leave to be cancelled might just tip a stressed out RMO over the edge! It is also a breach of the RDA MECA).

If someone is prepared to give up their leave all out of pocket costs must be reimbursed promptly, and the full leave period credited back to the RMOs balance.

Study leave:

1. For the exam or required course, it must go ahead.
2. Study leave ahead of an exam:
    a. If the exam is an exit exam it must be allowed;
    b. If the exam is only sat once a year it must be allowed;
    c. If the exam can be sat later and not delay progress through the training programme that can be accommodated but will need discussion with the RMOs concerned.
3. NB RACP written exam is 14 Feb, an extremely stressful time for these people and a once a year opportunity. Study leave for this exam must be respected. If the exams are postponed (note - there is no indication this will be the case) recrediting used study leave to the RMO is appropriate.
4. Other critical exams and courses on the horizon should be identified so we can assess potential impacts.

Compensation

We do not want to have to "fight" to ensure RMOs are compensated for their work. The negative message it send to these essential workers about how valued they are, must be avoided. This includes:

- Additional duties for after hours shifts and changes to the run description.
- Short notice shift changes.
- 72/144 hour breaches.
- 2 categories for shift rosters

SMO Activity.

The RMOs have had some suggestions for SMO activity during this time, largely based on code black scenarios:

- Giving up clinic and associated admin.
- Asking SMOs to increase their FTE.
- Holding the acute pager.
- Providing immediate liaison with primary care.