Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar y gweithlu Iechyd a Gofal Cymdeithasol

This response was submitted to the Health and Social Care Committee consultation on Health and Social Care Workforce

HSC 44

Ymateb gan: | Response from: Y Coleg Brenhinol Meddygaeth Frys | Royal College of Emergency Medicine

A HEALTHIER WALES: OUR WORKFORCE STRATEGY FOR HEALTH AND SOCIAL CARE

The Royal College of Emergency Medicine response to the call for evidence

Emergency Departments represent one of the most intense working environments in the NHS. Increasing demand and high bed occupancy leading to exit block have resulted in crowded departments. The demanding nature of this setting is a frequent cause of staff dissatisfaction, attrition, and career burnout. The pandemic has exacerbated many of these challenges – there is now an urgent obligation to implement commitments in A healthier Wales: our workforce strategy for health and social care for the future healthcare needs of Wales.

RCEM conducted a workforce survey[1] earlier this year where we spoke directly to our members. They have been on the frontline of the NHS throughout the pandemic and are best placed to understand the challenges they are facing in carrying out their roles as Emergency Medicine clinicians. Through the report we examined what current working patterns look like for staff in the wake of the second wave of the pandemic coinciding with a challenging winter. The report then examines the impact this has had on staff in terms of their mental health and wellbeing, and the implications on the future workforce.

Centering the solutions on the people who know the ED environment best, we focus on what can be done to improve retention. The key theme emerging from our study was the intrinsic link between operational pressures and staff wellbeing. Emergency Medicine clinicians have increasingly been forced to do more with less. Capacity has not matched demand for many years, and it is often left to the discretionary efforts of staff to provide safe and effective care. This is not acceptable or sustainable.

When coronavirus struck the UK, Emergency Medicine staff were operating in understaffed and under-resourced departments. As illustrated in Table 1 below, the number of attendances is increasing every year, yet the physical size of hospitals has not increased accordingly. Most EDs have been stretched beyond the capacity for which they were designed and resourced to manage at any one time. As a result of this, crowding and corridor care have become common practice in our EDs. This is distressing and stressful for both patients and staff. Studies show that this environment is linked with lower quality of care for patients and increased mortality, with elderly and vulnerable patients most affected. This intense working environment puts a huge amount of strain on staff which can result in attrition from the specialty.

Additionally, ED workforce models are predicated on insufficient numbers of trained Emergency Medicine clinicians, who are expected to deliver safe care whilst quality assuring the actions of staff in training. Trainee staff form the majority of any ED workforce numerically and are expected to be delivering quality assured care in the same episode.

[1] https://www.rcem.ac.uk/docs/Policy/Retain%20Recruit%20Recover%20-%20Our%20Call%20for%20Action%20to%20Improve%20the%20Urgent%20and%20Emergency%20Care%20System.pdf

Added to this is the churn of learners through EDs and increasing the service delivery, supervision and teaching responsibilities on the existing number of trained clinicians.

The table below shows that despite the number of Emergency Medicine consultants increasing, the expansion in consultant numbers is still not happening fast enough to cope with the level of demand growth. [2] This results in continued understaffing in departments. Understaffing means the Emergency Medicine workforce consistently reports the highest levels of work intensity of all the medical specialties. This leads to high levels of attrition from training and the specialty. RCEM has previously stated that to staff EDs safely, we should aim for a ratio of 1 Whole Time Equivalent (WTE) consultant per 4,000 annual attendances. Table 1 shows we are nowhere near to achieving this in Wales

Year	Average Number of WTE Consultants	Attendances at Type 1 EDs	Attendances per Consultant	Additional WTE consultants currently required to safely staff EDs
2016/17	65	787,587	12,116	100
2017/18	75	809,127	10,788	
2018/19	77	825,507	10,720	
2019/29	84	735,902	8,760	

The attendance and consultant numbers must be considered in relation to the impact on patient care. 73% of our survey respondents indicated workforce pressures in their EDs had an impact on patient safety before the pandemic. We asked 16% of respondents who selected no, why patient safety was not impacted by workforce pressures and 28% expressed that it was down to the discretionary efforts of staff. This not only confirms that the workforce crisis facing the specialty existed before the pandemic but also demonstrates the importance of safe staffing in EDs.

Recent data for England published by GIRFT[3] show the importance of the staff to bed ratio. The results are relevant to all UK nations. Analysis was done on the interaction between major and resus cubicle numbers, staffing levels and bed availability. They analysed the interplay between the following key variables that determine the adequacy of ED capacity:

1. the number of senior medical staff per shift;

2. the ratio of major cubicles and resus cubicles to attendances; and

3. hospital bed occupancy, i.e. the number of available beds.

Unsurprisingly, patients spend less time in EDs whenever all three variables are better than average. Departments with sufficient senior staff to make key decisions, sufficient cubicles to accommodate patients, and sufficient hospital beds for admissions have the

[3] Emergency Medicine GIRFT Programme National Specialty Report

lowest patient times in the ED. Counterintuitively, the worst combination is not the opposite of the best. The worst combination is to have a lower number of senior medical staff but an above average number of cubicles. This effectively creates an ED with the worst ratio of doctors to patients, but little hospital incentive to move patients in a timely fashion because ED space is not at a premium. Capacity planning in emergency departments must take account of clinical staffing requirements involving the whole multi-professional team

Well being

Given the pressures placed on EDs over the past few years and the disruption caused by the pandemic, it is no surprise that ED staff are more burnt-out, demoralised and feeling less valued than ever. There have been numerous research studies showing the impact of burnout on doctors worldwide; notably studies show that burnout amongst doctors can lead to self-reported suboptimal care and medical errors.12 Furthermore, while burnout takes place on an individual level, it can have implications for the wider workforce as it is considered to be 'contagious' and subsequently creates an environment where levels of morale sink.13 Morale is generally described as a sense of well-being that comes from confidence, usefulness, and purpose – sentiments that are valuable to have when working in Emergency Medicine. 39% of respondents reported low or very low levels of morale among their colleagues before the pandemic. The rate of low morale has risen considerably since then with 67% of respondents currently reporting low or very low levels of morale among their colleagues. Good morale is important for a healthy productive workforce and is central to ensuring the NHS can provide safe and high-quality care to patients.

Due to the intensity of the specialty and the requirement to work unsociable hours, workload pressures can have a significant impact on the wellbeing of staff. The majority of our members who responded to the survey reported that workload affected their ability to function at work (82%), maintain healthy relationships (72%), maintain good physical health (76%), and maintain good mental wellbeing (83%). Additionally, 59% described their level of stress and exhaustion from having worked the second wave as being higher than normal.

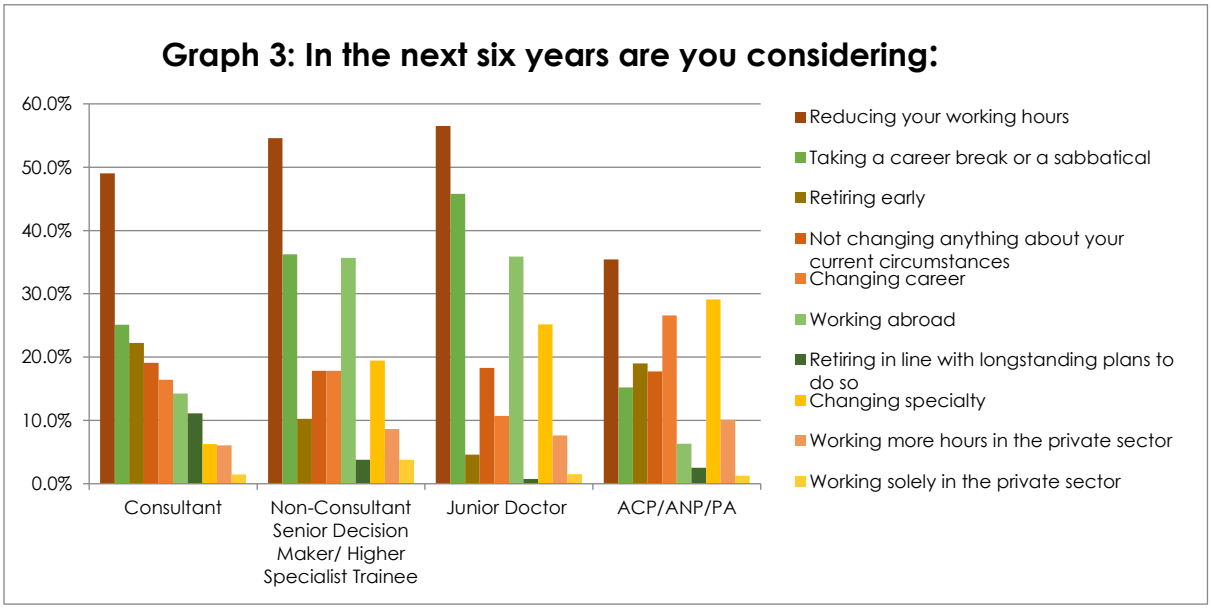
44% of respondents told us that they had experienced moral injury during the second wave of the pandemic. Moral injury is defined as the profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code. Staff frequently find themselves in this position due to resource constraints that do not permit them to provide the level of care they want to deliver, which in some cases can lead to patient harm that could have been avoided if adequate capacity and staffing had been available. In a recent BMA survey, the top cause given by respondents for these feelings of distress was not having enough staff to suitably treat all patients.14 The severe lack of workforce has created a vicious cycle whereby staff are not able to give the quality of care they would like to, and in turn this has an impact on their morale and wellbeing, ultimately causing the staff we do have to leave. This can subsequently compromise the quality of care offered to patients. Notably, while of course no stage of

the pandemic was easy for any staff, our survey found that Black and Asian respondents experienced moral injury considerably more than their White counterparts.

We asked our members how much time they felt they needed to recover from the pandemic – the most common answer (35%) was a few months, while over 7% said they needed a year or more. Although pressures from the pandemic will ease, unscheduled care cannot be scheduled or slowed down, meaning there will be no easing of pressures for EDs and little room for recovery for our staff.

Retention

- 50% of respondents are considering reducing their working hours within the next six years.
- 22% of consultants are considering retiring early in the next six years.
- 25% of junior doctors are considering changing specialty.



Substantial numbers of Emergency Medicine practitioners are considering a change in their employment patterns. Over the next six years, we can predict significant changes to the shape of the Emergency Medicine workforce as more members than ever are considering reducing their working hours. Graph 3 reveals the high proportions of staff who are considering substantially altering their working patterns. In the next two years, 50% are considering reducing their working hours and 26% are considering taking a career break or sabbatical due to workload pressures (32%) and burnout (36%). The responses to this question are illuminating when split by consultants, non-consultant senior decision makers/Higher Specialist Trainees, Advanced Clinical Practitioners (ACP) / Advanced Nurse Practitioners (ANP) / Physician associates (PA), and junior doctor grades.

The top three career consideration for consultants are as follows:

- Reducing working hours (45%).
- Taking a career break or a sabbatical (25%).
- Retiring early (22%).

The top considerations of junior doctors are:

- Reducing working hours (57%).
- Taking a career break or sabbatical (45%).

Additionally, a significant proportion of junior doctors are considering working abroad (36%) and changing specialty (25%). Assuming this is broadly representative of the Emergency Medicine workforce across the UK, these figures will have destabilising consequences for our health and social care system.

In the past few years, workforce strategies have been ambitious in scope, each failed to outline long term plans for growing the Emergency Medicine workforce and committing to recruiting additional staff. It can take up to as long as 10 years to train Emergency Medicine consultants. Although there are no easy fixes to address the staffing crisis now, action can be taken to secure the pipeline of doctors working in our EDs. The Workforce Strategy, to be successful, must create workforce projections that take into account the unique challenges faced by staff working in Emergency Departments.

Conclusion

EDs are unique working environments – they provide 24-hour service, seven days a week and are open to all. They are by far the busiest part of the hospital. Emergency Medicine staff provide specialist emergency care to the sickest patients in the hospital with life threatening illness and injury where immediate decisions and access to treatment are essential. When we ask staff why they chose Emergency Medicine as a career, they tell us it is about the breadth of practice, the excitement, and the variety of conditions that come through the door. More importantly, they tell us that they are passionate about delivering high-quality and safe care to all patients.

Unfortunately, the rising workload pressures has made this very difficult. Our survey found clear links between poor retention and mounting operational pressures. Urgent action is needed now to support the retention and recruitment of clinicians in the only part of our healthcare service that is open to all during their time of need. We need a coherent, joined up and long-term vision and strategy that places patients at the heart of the system and includes a clear plan to manage surges in emergency demand. There is an important economic case to be made for investing in the Emergency Medicine workforce; it is more cost-effective to grow the workforce and tackle operational pressures to encourage good retention than to deal with the high economic costs of sickness, training new staff to replace the ones who have left early, litigation and locum spending.

It is the resilience of staff working in EDs that makes Emergency Medicine such an incredible specialty, and this has been taken advantage of in recent years and is now stretched to the limit. RCEM's motto is 'we always help the sick'. To improve patient care, now more than ever, it is vital we help those who help the sick.