



Royal College
of Physicians



Keeping medicine brilliant: Improving working conditions in the acute setting

Mission:
Health

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Introduction

The morale of the medical workforce in the UK is at a low ebb and has continued to fall for much of the past decade. The breakdown in the relationship between the government and junior doctors, which began in 2013 and has resulted in the first doctors' strike in 40 years,¹ is merely a symptom of the underlying malaise that affects the whole medical workforce. Unless action is taken, this discontent will harden and continue to deepen.

In 2011, the Royal College of Physicians (RCP) embarked on an exercise to document the reasons behind low morale and the problems that it has caused, and to develop practical solutions. Through this work, it has become clear that a holistic approach is required to tackle the range of morale and wellbeing issues that affect a doctor's working life. If not, morale will continue to deteriorate, putting patient safety and quality of care at risk.

This report focuses on developing the evidence base to support new ways of assessing and improving doctors' morale. We have called this new paradigm *Keeping medicine brilliant*.

We believe that medicine is a brilliant career, but also recognise that tangible action is required by policymakers, employers and doctors themselves to ensure that it continues to be brilliant. Eight 'domains' of a doctor's working life that need to be assessed and supported have been identified by the RCP. We believe that it is essential that all eight domains are addressed in a holistic way to improve the morale and wellbeing of doctors.

Developing this report and its recommendations has involved consultation with over 500 doctors at all levels of training and we are very grateful for their valuable contribution. We are especially grateful to our colleagues in the Faculty of Occupational Health, whose input has been considerable.

This report will serve as an evidence base to allow us to develop practical solutions to the issues highlighted throughout. In particular, it will be used as the source material for a series of practical resources and tools that the RCP will produce over the coming months under the *Keeping medicine brilliant* banner.

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Background

The RCP has been concerned about the morale of physicians within the acute medical setting for over 5 years. In 2013, the RCP published *The medical registrar: Empowering the unsung heroes of patient care*,² which detailed a multitude of reasons for dissatisfaction and low morale within the rank of medical registrar. While not representative of all physicians working within the acute setting, the report made reference to several issues that transcend hierarchy: in particular issues around roles, responsibility, communication and teamwork in the acute setting.

The report also explored the issue of recruitment to the rank of medical registrar, and highlighted that the perception of on-call roles as being extremely stressful was a significant deterrent to recruitment. This perception was subsequently reiterated by the core medical trainee (CMT) survey carried out by the RCP and the Joint Royal Colleges of Physicians Training Board in 2014.³ It is also likely to be one of the reasons for the low fill rates of jobs with a significant commitment to acute medicine. For example, acute internal medicine has seen a gradual fall in specialty trainee posts being filled year on year (from 76% in 2013 to 46% in 2015).⁴ When practising in the acute setting, 21.3% of consultants and 65.1% of doctors-in-training have noted frequent rota gaps, which cause significant problems with patient safety.^{5,6}

The concerns raised in the report *The medical registrar* were also reflected in the 2014–15 RCP census,⁵ with higher specialty trainees reporting a significantly lower rate of satisfaction with their general internal medicine training (around 40% were satisfied) than with training in their parent specialty (more than 80% satisfaction).²

As such, there is a clear need to improve the morale and working conditions of physicians working in acute settings. We seek to explore the non-contractual issues that affect physician morale, and to outline measures that can help to improve physicians' perceptions and working lives. Quality standards for patient care in acute medical units have already been set by the Society for Acute Medicine.⁷ Our recommendations do not seek to replace these standards, but instead to complement them with practical recommendations to improve physician morale and, ultimately, patient safety.

Aims of this report

The aims of this report are:

To explore and highlight the causes and impact of low morale on physician wellbeing and patient care

To develop *practical recommendations* for clinicians, commissioners, policymakers and service leads that will help to improve the working lives of physicians at all grades, in order to create a productive workforce with high morale

For the purposes of this document, the 'urgent and emergency care setting' will be taken to mean all hospital settings in which urgent and emergency care is provided. This will include, among others:

- > the emergency department (ED), where medical patients are assessed
- > the acute medical unit (AMU)
- > the ambulatory care unit
- > wards where patients requiring urgent or emergency care are reviewed by the medical on-call team (both medical and non-medical wards, eg surgical, obstetrics and gynaecology)
- > medical wards that look after patients who are admitted urgently.

Why the focus on improving working conditions?

The need to improve the health and wellbeing of NHS staff in general has been recognised by NHS England. In 2015 the chief executive of NHS England, Simon Stevens, said:

‘NHS staff have some of the most critical but demanding jobs in the country. When it comes to supporting the health of our own workforce, frankly the NHS needs to put its own house in order. At a time when arguably the biggest operational challenge facing hospitals is converting overspends on temporary agency staff into attractive flexible permanent posts, creating healthy and supportive workplaces is no longer a nice to have, it’s a must-do.’⁸

However, in 2015, 44% of NHS trust staff reported that their manager did not take a positive interest in their health and wellbeing, while 11% said that their trust did not take a positive action on improving their health and wellbeing.⁹ That being said, there have been some notable improvements. For example, in 2014, 65% of NHS trusts had a plan for the health and wellbeing of their workforce, up from 41% in 2010.¹⁰

NHS England has estimated that sickness absence costs the NHS £2.4 billion a year. If that sickness absence was reduced by 1 day per person per year, the NHS would save £150 million, which is equivalent to 6,000 full-time staff.¹¹ These savings do not take into account money saved on agency and locum staff or the cost of recruitment to tackle staff retention issues, so are likely to be an incomplete picture of the true cost.

The NHS in general has a higher level of staff absence than the rest of the public sector.¹² In 2014–15, 16.4 million days were lost to sickness absence in the NHS in England.¹³ Some of this may be attributable to the fact that the NHS runs 365 days a year and 7 days a week, and involves work that is highly charged emotionally. However, rates of sickness and absence vary hugely between trusts, potentially showing an area where best practice can be shared and improvements can be made.¹⁴

Higher levels of staff engagement have been shown to relate to lower levels of mortality and improved patient safety.¹⁵ In addition, patient outcomes have been shown to be better in hospitals with higher levels of staff job satisfaction.^{15,16}

Improving the morale of physicians and wider healthcare staff, therefore, has the potential to help increase efficiency, improve patient outcomes and ensure patient safety. For these reasons, and more, it is vital that issues relating to staff morale in the NHS are investigated and acted upon appropriately.

Definitions

Throughout this report, we use several phrases that can be interpreted in very different ways by individuals depending on their background. We are therefore keen to clarify our meaning of the following words, phrases and concepts based on the relevant literature:

- > **Morale** – Employee morale can be defined as the extent to which ‘an employee feels good about his/her work and work environment’.¹⁷ It can be described as a meta-factor that covers multiple concepts, eg intrinsic motivation, job satisfaction, work meaningfulness, organisational commitment and pride in one’s work.¹⁷ It manifests itself in the degree to which an employee exhibits a positive psychological state. Wellbeing is often used interchangeably with morale, but wellbeing covers all aspects of an individual’s health and psychology.¹⁸
- > **Work motivation** – This can be defined as ‘a set of energetic forces that originate both within, as well as beyond, an individual’s being, to initiate work-related behaviours, and to determine its form, direction, intensity and duration’.¹⁹ In short, it is a force that stimulates and shapes the way in which a person carries out a work-related task. Although related, morale and motivation differ. It may be useful to think of morale as the expression of an attitude towards a particular organisational goal or task. Motivation, on the other hand, can be seen as a force that incentivises a person to complete that task.
- > **Medical engagement** – This can be defined this as ‘the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation, which itself recognises this commitment in supporting and encouraging high-quality care’.²⁰ This has been shown, by the same group, to have a positive correlation with organisational performance,
- > **Work-related stress** – The Health and Safety Executive (HSE) formally defines work-related stress as ‘the adverse reaction people have to excessive pressures or other types of demands places on them at work’.²¹ The HSE has further described six potential factors that can lead to work-related stress:²²
 - demands of the job
 - control over the way in which employees work
 - support and information from colleagues and superiors
 - relationships with colleagues
 - understanding of role and responsibilities
 - organisational change.

Defining causes for low morale in the workplace

We have laid out below the major factors we have identified that can reduce the morale of acute physicians. This list has been developed based on the results of previous RCP focus groups and surveys, as well as available literature on physician job satisfaction and wellbeing, which we believe represents the views of many physicians and trainees in acute settings. Importantly, these factors take into account theories of work motivation, of which two are especially relevant: Herzberg's hygiene-motivator theory, and Deci and Ryan's self-determination theory. These two theories of work motivation can shed light on the specific factors that affect physician morale.

Herzberg postulated that factors that cause dissatisfaction (termed 'hygiene factors') are different from factors that cause satisfaction (termed 'motivator factors').¹⁹ Without satisfying hygiene factors, the motivator factors will only give limited satisfaction. The breakdown of hygiene and motivator factors is as follows:

Hygiene factors (dissatisfiers)	Motivator factors (satisfiers)
<ul style="list-style-type: none"> > Job security > Working conditions > The quality of management > Organisational policy > Administration > Interpersonal relations > Salary 	<ul style="list-style-type: none"> > The sense of achievement and the intrinsic value obtained from the job itself > The level of recognition by both colleagues and management > The level of responsibility > Opportunities for advancement > The status provided

While salary is listed as a hygiene factor, it is not a motivator. In an organisational setting, salary is rarely a key driver of engagement and this has been found to be particularly true for medicine.

According to research, 'eventual financial prospects' were a contributing factor in only 8.1% of junior doctors' choice of specialty.²³ The influence of finances on specialty choice decreased between 1999 and 2012, from 14.7% to 11.2%.²³ Of junior doctors intending to leave the UK to practise medicine elsewhere, only 1% indicated that pay was an influencing factor in their decision.²⁴ Furthermore, in the group of over 200 medical registrars interviewed for *The medical registrar* report,² not one mentioned pay as an important factor that needed addressing. While salary and pay have been viewed by the government and the media as a significant contributory factor to recent industrial action, the research suggests that other, non-contractual issues may have had, if not more impact, then certainly as much impact as salary issues.

Deci and Ryan's self-determination theory suggests that there are three intrinsic factors leading to work motivation: autonomy, relatedness and competence.²⁵

Autonomy allows an individual greater control and so improves both health and job satisfaction. This has been shown in physicians, where a cohort of UK and New Zealand physicians linked clinical autonomy with a higher level of job satisfaction.²⁶

Relatedness refers to the social aspect of a task, recognising the importance of interpersonal relations in improving morale. In other words, this concept describes an individual's inherent need to feel connected to, and develop relationships with, others in a group. The value of relatedness is seen in research showing the impact of teamwork and role models in motivating and improving individuals' perception of a job.

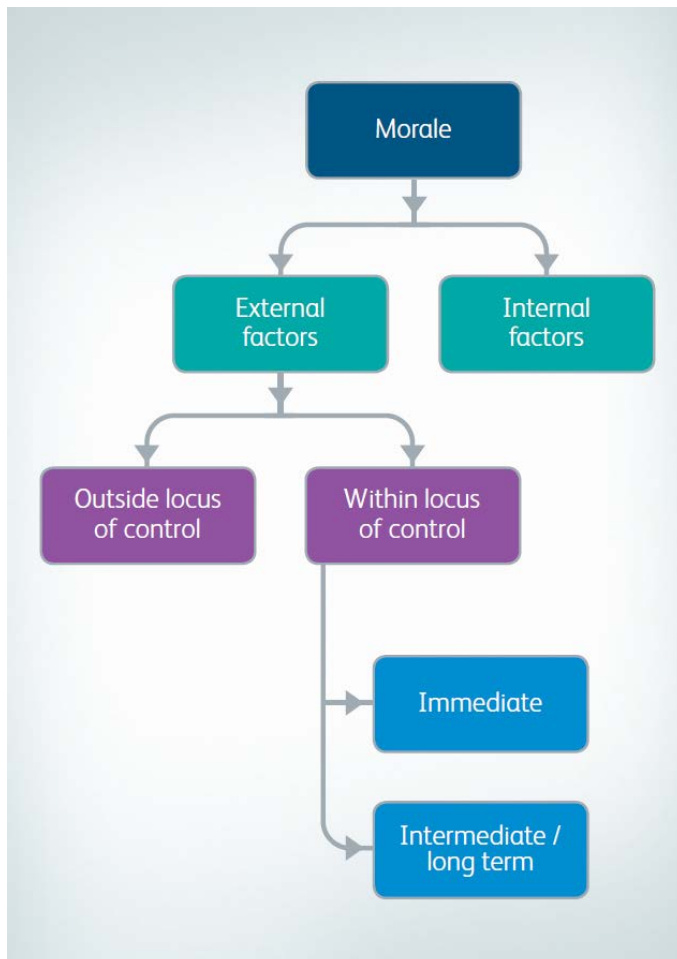
Lastly, a sense of competence is linked to achievement and status, whereby external recognition of the individual's ability in itself can boost morale.

In order to create a workforce with high levels of work motivation, staff will need all three factors to be accounted for in their daily work. Effective support from supervisors and line managers can help to achieve this.

Factors affecting morale of physicians in acute settings

The morale of a physician can essentially be influenced by two types of factor. Firstly, there are the external factors, ie events that happen to the physician (eg physical environment, workload and organisational culture). These factors can be either out of a person's control or within a person's immediate control. Where they are within a person's control, intermediate or long-term actions can be taken to alter these factors. Secondly, there are internal factors, eg an individual's personal characteristics that affect how they react to the external events, ie resilience to stress and concept of self, etc. See Figure 1 for a visual representation.

Figure 1



This document draws on the premise that physicians are resourceful and that many stressors and motivators – whether internal or external – are within our control. In the following pages, we will attempt to identify these factors, as well as potential actions that can be taken to alleviate stress or improve morale.

The eight domains of physician morale

We have categorised the many different factors that affect physicians' morale into eight major domains. These domains can be divided into those that predominantly affect the workplace environment, personal factors and patients.

Workplace environment

Domain 1: Work

Domain 2: Physical environment

Domain 3: Interpersonal relations

Domain 4: Hospital organisation and policy

Personal factors

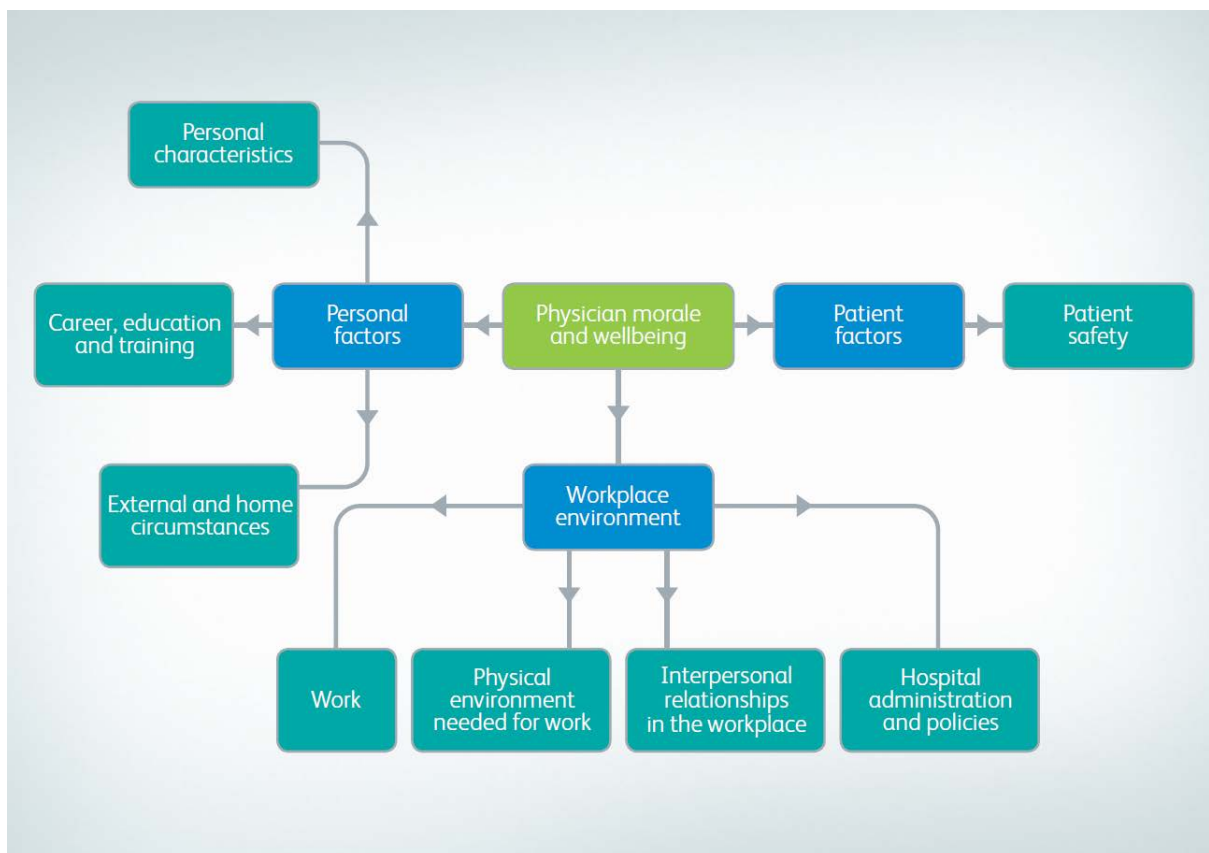
Domain 5: Personal characteristics

Domain 6: Career, education and training

Domain 7: External/home circumstances

Patient factors

Domain 8: Patient safety



<p>Work</p> <ul style="list-style-type: none"> > Intensity and amount of work > Staffing levels > Distribution of work over shifts > Complexity of work and allocation of responsibility > Work–life balance > Flexible working > Clinical autonomy > Nature of work 	<p>Personal characteristics</p> <ul style="list-style-type: none"> > Resilience and coping mechanisms > Optimism > Self-efficacy > Physical ability to perform tasks
<p>Physical environment needed for work</p> <ul style="list-style-type: none"> > Department layout > Facilities for rest and nutrition > Workspace > Equipment for work <ul style="list-style-type: none"> – Information technology (IT) infrastructure – Medical equipment – Others (continuation sheets, referral slips, request slips) > Diagnostic services 	<p>Career, education and training</p> <ul style="list-style-type: none"> > Opportunity for career advancement > Time for training > Educational opportunities (clinical and non-clinical) > Trainers and supervision > Patient support in training > Support for out-of-programme experience (OOPE) > Job security > Sustainability > Control over career – location, type of work > Career expectations and specific career counselling > Understanding of expectation > Perceptions of chosen career
<p>Interpersonal relations in the workplace</p> <ul style="list-style-type: none"> > AMU team <ul style="list-style-type: none"> – Medical staff – Nursing and allied health professionals > Patients > Other referring teams <ul style="list-style-type: none"> – ED, non-medical teams, other medical specialties > Medical teams in the community (eg GPs) 	<p>External and home circumstances</p> <ul style="list-style-type: none"> > Finances > Life events > Home support network > Relationships with family and friends
<p>Hospital administration and policies</p> <ul style="list-style-type: none"> > Rota and leave management > Pastoral support structures > Direct line-management > Clinical protocols > Non-clinical patient management protocols (ie transfer of care, allocation of responsibility) > Workplace culture > Shared vision > Communication > Recognition of success or hard work > Appreciation from patients 	<p>Patient safety</p> <ul style="list-style-type: none"> > Handover > Second-victim syndrome > Previous adverse experiences

Workplace environment and experience

Domain 1: Work

1.1 Workload

Excessive workload is commonly cited as a cause of dissatisfaction among physicians working in the acute setting. According to the 2014–15 RCP census, the two main reasons cited for consultant physicians who intend to take early retirement were pressure of work and length of working hours.⁵ In addition, the census showed that, on average, consultant physicians work one extra programmed activity (PA) per week than contracted.⁵

Among trainees working acute on-call shifts, 46% frequently / very often work over their rostered hours.²⁷ Of these, 48% regularly stay to complete routine paperwork or administrative tasks that could not be completed during working hours: 41% do so due to perceived pressure not to hand over work to other teams.²⁷ Looking at the higher specialty trainee census, despite being rostered to work a 42–43-hour week, trainees on average work 48 hours per week, a 2-hour increase since 2011.⁵

The reasons for the high workload and pressure are varied and difficult to prove. Likely causes include:

- > rising hospital admissions²⁸
- > an increasing need to provide guidance for junior colleagues, due to training and experience⁴
- > frequent rota gaps and insufficient staffing levels (21.3% of consultants report frequently having to deal with trainee rota gaps that cause significant patient safety issues)³
- > lack of knowledge of alternative management pathways that avoid admissions⁴
- > lack of clarity about the boundaries of the role of the medical team, with poor rationalisation of protocols that result in referral of patients to the team.⁴

Another issue that has been raised in the past is the 4-hour accident and emergency (A&E) waiting time targets, which increase both pressure and referrals to the medical team. This can mean that the assessment and management of patients admitted through A&E may be less than complete, which leads to longer turnaround times. This is one example of a situation where a target-driven environment has created an increase in workload and generated a sense of loss of control, both of which are widely recognised act as stressors and demotivating factors.²⁹ However, it must also be acknowledged that the 4-hour waiting time target has had benefits for patient care and is supported by the emergency medicine community.³⁰

Recommendations:

- 1 Redistribute the workload of the acute medical team using new ways of working (eg utilising allied health professionals, perioperative physicians or 'buddy teams')
- 2 Monitor the number of admissions and referrals made per shift, and allocate rotas or human resources from the AMU accordingly
- 3 Perform regular case-note reviews of patients who are discharged after staying less than 24 hours, with a view to identifying avoidable admissions. Results should be used to encourage alternatives to patient admission
- 4 Provide clear, easy-access databases of local clinical guidelines that include alternative routes to medical admission (eg ambulatory care or urgent access to appointments). This should be easily accessed by all staff and introduced at every clinical induction programme. This could be an area for future RCP work, to develop clinical induction standards and, subsequently, a standardised induction tool that can be used in all hospitals
- 5 Create clear definitions of the role and responsibilities of the acute medical team
- 6 Redefine the traditional roles of the acute medical team, for example allowing ED consultants to run the acute take lists, or to have all GP calls in certain hours directed to ambulatory care departments, and channelled accordingly
- 7 Build on the findings of the current RCP safe staffing working party group, which is due to report in 2017, when creating rotas and deciding work distribution locally
- 8 Provide acute physicians with flow management training to help them to organise the take.*

*The take is the cohort of patients admitted to a ward in a given 24-hour period.

1.2 Complexity of work and allocation of responsibility

The complexity of work is one factor that could affect morale positively or negatively, depending on the perception of the achievability of the task. On one hand, a task that stretches an employee can be perceived as interesting and challenging, and potentially improve morale; this is particularly true in the acute setting, where work is varied. However, if the task is perceived to be unattainable and overly daunting, this can instead cause low morale and avoidance of the task. This came to light in both the RCP CMT survey and *The medical registrar*, where it was noted that many CMT doctors are increasingly put off becoming a medical registrar because they do not feel that they will be able to cope with the required work.^{2,3}

This could be due to a decrease in senior house officer (SHO)-level responsibility, with a subsequent negative effect on training and confidence. The reasons for this decrease in responsibility are varied, and include:

- > hospital policy / pressure from other specialties for review of unwell patients to be carried out by a registrar
- > early senior review that may discourage decision making
- > concerns over patient safety and increasing pressure for care to be consultant led and consultant delivered.

Furthermore, the 2014–15 RCP census showed that around 10% of consultant physicians report that they are regularly asked to ‘act down’ to cover gaps in the junior rota. Although there is no direct evidence linking acting down to job dissatisfaction, it is certainly possible that it might contribute to lowered morale among the consultant population because they are likely to be working longer hours than expected with less support than usual, owing to rota gaps. Furthermore, the type of work that they are doing may be viewed as less challenging and therefore may lead to decreased motivation.

Recommendations:

- 1 Formalise a training scheme where trainees of all grades are given the opportunity to step up in a supervised, supported environment, eg a supervised CMT-led acute take or registrar-led post-take ward round. This should be taken as part of study-leave allowance, when the SHO is not scheduled to be on the acute team, so as not to create issues around staffing and workload.
- 2 Use a firm-based structure for the acute take to make it easier for teams to allocate responsibility accordingly.
- 3 Monitor the relevant skill mix of acute medical teams on a particular rota, and try to ensure that each team has sufficient numbers of staff who are able to perform common tasks, as determined by local need.
- 4 Rationalise the lines of responsibility for acute team members, rather than restricting work to the medical registrar. National-level guidance on the role of medical registrars could be issued to support this.

1.3 Work–life balance

Work–life balance is increasingly recognised as important to physicians, and was the top response given by junior doctors as a reason to reject hospital medicine.³¹

Furthermore, a study looking at reasons for early retirement in NHS doctors showed that having time for leisure and other personal interests was the most prioritised concern for the cohort of early retirees.³²

In the AMU, the variable shift patterns can make it difficult to maintain a good balance between work and external activities. Shift work can make it difficult for doctors to spend time with friends and family who work normal office hours, which can cause friction or social marginalisation. In addition, in places with fixed leave systems, taking leave for life events or educational events can sometimes be complicated and, if leave is not granted, it can breed resentment.

As mentioned previously, a large number of physicians on the AMU and acute wards work beyond their rostered hours, which infringes on their personal time. Although in the short term this may not be a major issue, the 2014–15 RCP census showed that length of working hours was the second most reported cause for early retirement.⁵ In addition, general internal medicine trainees have told us that their reasons for working overtime include (in order of importance):²⁷

- > clinical need (eg acutely unwell patient)
- > catching up on paperwork or administration that you have been unable to complete during rostered working hours
- > feeling pressure not to hand over tasks to the on-call team
- > in order to attend the consultant post-take ward round
- > in order to gain further training opportunities
- > at the request of senior medical staff or hospital managers
- > lack of appropriate handover.

Recommendations:

- 1 Establish mechanisms to allow for time off in lieu where overtime has been unavoidable, in order to show appreciation of discretionary effort.
- 2 Ensure earlier release of rota patterns, at least 8 weeks in advance, and allow physicians greater autonomy over their own shifts and therefore annual leave. Where possible, especially for consultant physicians, an annual rota could be agreed to allow better planning of personal time.
- 3 Undertake regular monitoring of staff working hours and in-house analysis of reasons for overtime.

1.4 Flexible working

In parallel with the issues around work–life balance set out above, there are also issues relating to flexible working, ie establishing ways of working that fit around the lives of employees (eg taking account of childcare arrangements or to undertake research). Portfolio careers are increasingly attractive to physicians, and permitting flexible working around this could serve to improve job satisfaction.

Acute medical settings can both aid and detract from flexible working. The multitude of shifts can make it easier for some physicians to adjust their working hours to suit their own or their family's schedule. However, the irregularity of the work can cause difficulty with personal scheduling and consistency.

One concern for doctors who work less than full time (LTFT) is the fulfilment of continuing professional development (CPD) requirements and revalidation. With LTFT work, physicians can sometimes struggle to find time to complete non-clinical requirements of their training such as research or quality improvement, which could ultimately be detrimental to their careers.

Another issue that is sometimes raised is the difficulty with returning to work following a period of non-clinical experience (eg maternity leave, research or non-clinical fellowships). There can be a difficulty in readjusting to the medical culture and work, irrespective of previous experience. At present, there is no formalised structure of reintroduction, which makes it difficult for many people to return to practice with confidence. Furthermore, many people in this situation may also be working LTFT, and so it takes them more time to regain the necessary experience to feel confident in their own abilities.

In addition, as our population ages and enjoys increasing years of healthy life, there is a need to take into consideration the needs of an older workforce. Allowing older physicians to pursue flexible working arrangements could improve the retention rates of more senior physicians and increase their job satisfaction and wellbeing (further details about the sustainability of working in older age are set out in section 1.6).

Lastly, the need for flexible working is not simply constrained to those with maternity or childcare needs. Increasingly, caring for older relatives is becoming common and may need to be considered when exploring the future of flexible working in the NHS.

Recommendations:

- 1 Create networks or mentoring schemes for physicians who work LTFT, to share experiences and best practice.
- 2 Improve or extend on-site childcare or flexible working in terms of start and end times.
- 3 Introduce staged reintroduction to practice after OOPE for all returning clinicians.
- 4 Appoint an LTFT working coordinator within the trust. Responsibilities could include maintaining a database of workforce capability and flexibility.
- 5 Ensure that physicians working LTFT are allowed an appropriate amount of supporting professional activities (SPA), ie that they are allocated time for other roles outside face-to-face clinical care.
- 6 Ensure that opportunities to explore flexible working are not constrained only to those with maternity or childcare needs.
- 7 Provide older physicians with the option of flexible working arrangements where possible.

1.5 The nature of work and clinical autonomy

The 'nature of work' here refers both to the value of the achieved outcomes and to the interest generated by the work. In the AMU, patients are seen very soon after presentation; there is therefore a lot of scope to make a big difference to how patients feel and are managed. However, in some situations, as patients are moved around the hospital, there are times when – despite being heavily involved in the admission and early treatment of patients – acute physicians do not get the opportunity to see the impact that their actions have had.

Considering the nature of work in terms of challenge and interest, acute medicine is a very varied specialty, where physicians are exposed to many different presentations and diseases. This makes it unusual and quite demanding. In addition, patients can be very unwell when they present, which makes the job even more challenging. However as noted in section 1.2, there is a limit to the amount of challenge that can be faced before it becomes overwhelming, and care must therefore be taken to ensure that sufficient support is provided to physicians.

With regard to clinical autonomy, acute physicians have a great deal of scope in terms of exerting their own influence within the acute medical setting, including patient management or departmental change. However, with the rotational nature of trainee physicians' work, clinical autonomy becomes somewhat more difficult. With the increase in early senior review, there is an increasing trend for junior team members to avoid making full management plans.² Furthermore, trainee physicians frequently view themselves as temporary staff within the department, and do not always take responsibility or ownership of the environment in which they work. This can diminish their perceived clinical autonomy, leading to unintentionally low morale.

Additionally, clinical and non-clinical management of patients is sometimes dictated by local resources and protocols. Although, in general, local protocols are well intentioned and useful, they may not always directly translate into work 'on the ground', and they may therefore be difficult to implement. This can lead to resentment and dissatisfaction from physicians, who may view local protocols – with little room for variance – as interfering with their clinical practice. Further to that, this may also contribute to a feeling of losing control of how they carry out their jobs, which is a major contributor to low levels of engagement from physicians with the organisation that they work in.³³ In particular, senior trainees can feel disempowered by this, as they may not have the authority to overrule local protocols, especially when working out-of-hours. This is exacerbated in situations where there are no mechanisms for feedback and change in the long term.

Making clinical decisions independently carries a risk, and the increasing tendency for doctors earlier in training to defer a decision until review by a more senior team member may be seen as the safe option. However, the earlier that physicians learn to be autonomous in decision making the better, and thus consultants should discourage the use of 'symptom – ?cause' as the diagnosis and 'await senior review' as the management plan.†

†In this context, 'symptom – ?cause' shows that a 'symptom' has been identified and the '?cause' means that the cause of the symptom is being queried.

Recommendations:

- 1 Share electronic records of patients seen with the acute medical team, so that acute physicians follow up patients who have left their units.
- 2 Begin local campaigns to make patients aware of the different departments that are involved in their care.
- 3 Refer to section 1.2 for suggestions on dealing with complexity of work.
- 4 Create opportunities for junior staff to make their own decisions in a supported fashion. This should include discouraging the use of 'symptom – ?cause' and 'await senior review' from hospital notes, to foster development of problem lists and management plans.
- 5 Create open and transparent avenues for feedback on local protocols, with regular review by multidisciplinary teams .
- 6 Increase face-to-face patient time, to help physicians to maintain their sense of purpose. This may be helped by devolving routine clinical or administrative tasks to other allied health professionals, such as physician associates or senior nurses.
- 7 Establish clear lines of responsibility for decision-making processes involving patient care, especially out of hours. This responsibility should usually lie with the senior physician on site, with support from other staff members.

1.6 Sustainability of work

It has been shown that older workers need more recovery time between working periods and that shift work becomes increasingly difficult for workers above the age of 40.³⁴ In urgent and emergency settings, the constant nature of work and shift patterns could potentially cause difficulties for older workers, if no suitable flexible/part-time options are available. This can be seen in the RCP's 2014/15 census, where the following were given as the top six reasons for intended early retirement:⁵

- > pressure of work
- > length of hours
- > dissatisfaction with the NHS
- > lack of support
- > domestic reasons
- > night duties.

Early retirement can contribute to an increased workload for remaining staff, leading to an increase in stress and triggering a cycle of further workforce attrition.

Shift work has also been shown to be linked to health issues such as fatigue, increased cardiovascular risk and mental health problems. In addition, the risk of errors, accidents and injuries is higher on night shifts, with shift lengths of more than 8 hours, and when there are not enough breaks.³⁵ These issues could create an unsustainable working environment, with high stress levels and workforce attrition rates.

Another important consideration on work patterns is the amount of autonomy or control that employees have over their work patterns. With fixed shift or leave systems, the loss of control over working time and schedules could also be a source of stress (as per HSE *Managing shift work* guidance)³⁶ and cause a decrease in work motivation.

Recommendations:

- 1 Make flexible or part-time working options available to older physicians where possible.
- 2 Develop mechanisms to allow issues around shift working and working patterns to be discussed and agreed between physicians and their line managers.
- 3 Ensure that policies and procedures are in place to manage shift-working arrangements, as per HSE *Managing shift work* guidance.³⁶

Domain 2: Physical environment

2.1 Departmental layout, available facilities and presenteeism

AMUs are not always co-located with A&E, nor are they often close to the medical wards. As a result, physicians may spend unproductive time travelling between departments. We recognise, however, that in many situations there is little that can be done about this, without a significant injection of funds.

Facilities for rest and nutrition also vary between hospitals. It can often be difficult to find non-patient areas for physicians to work, write up notes or have a break during shifts. Further to that, not all trusts have easily accessible, healthy food available for staff, in particular overnight. This has been noted by NHS England since March 2016 as a Commissioning for Quality and Innovation (CQUIN) target.¹¹ Some trusts also have a 'no hot drinks supplied' rule for members of staff, which can have a negative impact on morale, especially when staff are working over and above their rostered hours. Although many wards do collect money from staff to supply hot drinks, the rotational nature of physician positions on the AMU makes such collection difficult to coordinate. This can sometimes further alienate physicians working on the unit, especially trainees, as they may feel excluded from the AMU team.

The presence of rest facilities does not always mean that they will be utilised. One example of the phenomenon of 'presenteeism' is that physicians may sometimes avoid taking breaks owing to a misplaced sense of guilt, and a reluctance to hand over work. The effects of this phenomenon are magnified overnight, with evidence that sleep-deprived junior doctors have more attention-related failures, make more clinical errors and have poorer psychomotor abilities than when they are able to gain enough sleep.³⁶ In addition, physicians make 30% fewer medical errors when European Working Time Directive-compliant shift patterns are redesigned to promote sleep and circadian rhythm stability.³⁷ Presenteeism has further patient safety issues when related to infectious illness that can affect patient health. This unhealthy culture could lead to physicians risking patients' health owing to an 'overactive' sense of personal responsibility and a perception of guilt for letting down their colleagues, both junior and senior.

Creation of suitable facilities for adequate rest could also help to discourage presenteeism on shift. It is good practice to monitor rest breaks regularly and hospitals should, via their 'guardian of safe working', ensure monitoring occurs. Where such facilities exist and are of a high standard, but presenteeism persists on monitoring, assessment should be made as to the causes. Enforcement of breaks may be necessary, but when this is required it that suggests poor leadership has allowed a presenteeism culture to persist.

Recommendations:

- 1 Create a readily accessible, multidisciplinary rest area for all acute medical team members, away from patient-facing areas, with basic hot drinks and food. The distribution of responsibility during a shift should account for the physical location of physicians during the shift.
- 2 Ensure that physicians are encouraged to use rest area facilities, and enforce breaks where clinically appropriate.
- 3 Design shift patterns with rest and circadian patterns in mind, and educate doctors about sleep hygiene.

2.2 Workspace and IT infrastructure

In addition to rest facilities, workspace and access to basic IT requirements, such as computers, can also be lacking. It can be difficult to find a quiet space in which to work without interruption. Interruptions can be both time-consuming and stress-inducing and, by causing distractions, could also potentially endanger patient safety. However, it is important that staff are easy to locate if there is an emergency or they are needed urgently.

Increasingly, new technologies are being used to aid the day-to-day running of the acute ward. In most trusts, it is now commonplace to see a wide range of technologies being used to request tests, make referrals, write discharge summaries and check results. Some areas also use IT systems for prescribing, electronic patient handover lists and linking with community health providers to gain access to patient notes remotely. In addition, the internet is commonly used by physicians to provide best practice management for patients. In some trusts, this is supported by trust-wide subscriptions to evidence-based practice resources.

Given the preponderance of IT usage, it is vital that both hardware and software are up to date and fit for purpose. In addition, competition for the use of computers in hospitals can be high, leading to long waiting times and inefficiencies. No recent studies appear to have looked at physician satisfaction with IT; however, in 2001, both consultants and medical registrars listed 'better IT systems' as one of the top five measures that would improve the working lives of doctors.³⁸ Furthermore, improving IT capabilities could help physicians to provide better care for patients, which will lead to improved morale among physicians.

Recommendations:

- 1 Ensure that the number of computers or electronic devices that are available in a trust reflects the number of staff working.
- 2 Reserve underutilised electronic resources (eg vacant outpatient clinic space) for acute staff use if conveniently located.
- 3 Establish a hospital IT committee with multidisciplinary representation that provides feedback on the usability of software systems.
- 4 Develop or invest in interoperable systems that allow hospital staff to access primary care notes remotely, to improve communication between sectors.
- 5 Provide internet access for all staff members, to aid with information and knowledge gathering for the benefit of patients.
- 6 Provide specified multidisciplinary offices on AMUs, where staff members have sufficient workspace and equipment, with specific 'no interruption' zones. The acute medical take lists should be accessible to the whole acute medical team from anywhere in the hospital.
- 7 Designate a person or programme to monitor patients' locations at all times.
- 8 Set a single computer login for all software systems within a trust for ease of access by staff.
- 9 Engage computer-literate trainees or consultants in reviews and development of local IT systems.

2.3 Medical equipment and other work requirements

Acute medicine often involves many procedures being carried out, with multiple pieces of equipment needed for each procedure. In a high-intensity environment, where time is critical, the efficiency of the equipment-gathering stage for a procedure can create a great deal of stress for the physician. In this situation, equipment can include both what is required for examination (eg tendon hammers, fundoscopes etc) and procedural equipment. It is not uncommon for equipment for a particular procedure to be sourced from a different ward or theatres. Equipment may also be kept in an area that is not familiar to physicians and may be difficult to access. This can lead to increased time pressure and stress on doctors. It would not be cost-effective for all equipment to be easily available in every setting, but there is a case to improve access, and in particular the process for obtaining the equipment.

Similarly, many other small items are necessary for work, such as continuation sheets, referral pads and pens. These items are essential for efficient working and making them more easily available at would make staff's work less stressful.

Recommendations:

- 1 Provide lists (eg on the intranet) of items required for common AMU procedures, including their location, access and known faults.
- 2 Provide a simple mechanism to communicate changes in location, status or faults with the equipment.
- 3 Prepare pre-packaged kit or trolleys for the most common procedures in advance. Trolleys and kits should be standardised across the hospital, both in content and in location on wards.
- 4 Label and arrange standardised store cupboards, with guides on the side of the cupboards to allow quicker access to equipment.
- 5 Ensure that departmental induction on joining the team includes using the equipment stores and how to access them.

2.4 Diagnostic services

Diagnostic services are usually available in all hospitals; however, the processes and protocols to access different services can differ from place to place, making it difficult to navigate for a new starter. In addition, weekend and weekday availability of certain services may differ, which may not be immediately obvious to a physician who is new to the team.

Lack of clarity about the scheduling of diagnostic tests can also lead to physicians spending a substantial amount of time 'chasing' test results. These tasks are not always physician specific and arguably could be done by a different member of staff. Methods of communication between the diagnostic departments and other medical staff could also be improved to increase efficiency and effectiveness.

Recommendations:

- 1 Provide an easily accessible list of pathways and protocols for obtaining investigations on the hospital intranet.
- 2 Provide regular electronic updates to inform hospital staff about the status of diagnostic services, ie machine breakdown and expected times of repair.
- 3 Include a real-time scheduling component visible to clinicians in electronic systems for referrals and receiving results.

Domain 3: Interpersonal relations

3.1 Relationships within the medical team

Working in shift patterns has led to less continuity of staffing within medical teams. The subsequent lack of familiarity between the physicians in a team translates into difficulty in recognising team members' abilities and limitations. This can lead to training needs being unmet, as well as an inefficient use of human resources during a shift. These work patterns also mean that recognising good work and underperformance can be difficult.

In addition, the lack of personal knowledge and connection between team members can translate into less-than-ideal interpersonal relations, which is recognised both as a hygiene and a self-determination theory factor.

Recommendations:

- 1 Link or stagger rota patterns within the medical on-call teams so that there is better continuity of staffing, for example by creating acute firms that work on take together in blocks.
- 2 Begin each shift with structured introductions and identify learning needs, especially in the presence of unfamiliar team members. This should include all team members, including consultants and nursing staff.
- 3 Allow time for structured feedback or debrief sessions at the end of shifts, to help team members to get to know each other.

3.2 Relationships with nursing staff and allied health professionals

Disjointed periods of contact with permanent AMU staff make it difficult for physicians to get to know these staff. As a result, there can be a lack of understanding about other staff roles and responsibilities. This can lead to mistaken expectations and subsequent disappointment if expectations are not met, which can lead to further strain on relationships between team members.

Recommendations:

- 1 During the clinical induction, be clear about the roles of all team members.
- 2 Provide easily accessible information on the specific responsibilities of each team member at the start of each shift (eg indicate the named nurses for each bay on a central board, along with allocated cover).
- 3 Extend the 'Hello, my name is ...' campaign to introductions between members of staff.
- 4 Create and promote interdepartmental team activities and competitions that could foster team spirit and a sense of belonging.

3.3 Relationships with patients

Continuity of care for a patient admitted to an AMU can be difficult. Owing to frequently changing shift patterns and rest days, it is not uncommon for a patient to be seen by several different doctors who perform the same overall function over the course of a short stay.

This can contribute to a poorer experience, for both the patient and the doctor. Physicians involved with acute care are not always able to follow their patients' progress through the hospital, especially those with complex chronic conditions. It can also be more difficult for these physicians to receive feedback from patients and families about the care that they receive. In addition, the interactions between these physicians and their patients tend to take place during a shorter period of time, without repeated opportunities for them to get to know each other. The 2015 British Medical Association (BMA) cohort study reported that 88% of respondents indicated that interactions with patients bolstered their morale; conversely, therefore, it is reasonable to postulate that the sometimes-disjointed patient interactions experienced in the acute medical setting could contribute to lower morale.³⁹

Regular feedback surveys of patients provide a wealth of positive comments, as well as an opportunity to learn what can be done better. Many patients value the opportunity to say 'thank you', and a summary of such positive feedback at a regular time during the week would be beneficial for team morale.

Recommendations:

- 1 Discharge summaries could be sent to consultant physicians who had a lead role in caring for a patient in the acute setting. This could provide useful feedback and could also be helpful for physicians from a developmental point of view.
- 2 Discuss patients with unexpected outcomes from a 'no-blame' perspective with the rest of the team who were involved, to encourage personal and team reflection.
- 3 Improve local mechanisms for feedback to all teams involved in the care of a patient, focusing on teams upstream of a patient's stay.
- 4 Feedback cards could be freely available and easily accessible to all AMU patients and their families.
- 5 Positive patient feedback should be actively and regularly reported to the whole team.

Domain 4: Hospital organisation and policy

4.1 Rotas, fixed leave and leave management

A frequent concern that is noted – by trainees in particular – is late notice of rotas, and hence difficulty scheduling activities around work.⁴⁰ This causes significant discontent, as physicians perceive that work that is encroaching upon their personal time. In addition, late scheduling can also make it difficult for physician to attend study days, conferences or other educational activities. This area also impacts significantly on work–life balance (see section 1.3 for more information).

Trainees rotate between different hospitals and this will expose them to a range of rota planning methods. If a trainee has seen a system used elsewhere that works more effectively than the one used in their current post, this opportunity to share good practice should be grasped.

Recommendations:

- 1 Avoid fixed leave rotas whenever possible. If it is unavoidable, physicians should be allowed an advanced view (at least 2 months) of the potential rota design, and they should be allowed to indicate a preference of position in the rota.
- 2 Allow physicians to take a lead on rota design, with one elected lead having the final say.
- 3 Introduce annualised consultant rotas to improve personal planning.
- 4 Encourage trainees to share examples of good practice of rota planning from other hospitals where they have worked.

4.2 Support networks

In dealing with stressful situations, physicians do not only look inwards: they also look outwards to support networks within their workplace or at home. Pastoral support is a resource that should not be ignored when considering the morale of a workforce. Within the confines of the acute medical setting, pastoral support is usually thought to be delivered by educational supervisors or other colleagues.

However, given time pressures, shift work and workload intensity, it can be difficult to rely on this mechanism to provide emotional support to physicians. Owing to the rotational nature of physicians' work on the acute medical ward, physicians rarely work with the same teams on a regular basis, which can make it more difficult to build a support network within work. This can be particularly true for trainees, who may not work continuously for any one consultant. This can make it difficult for them to obtain progressive feedback on and supervision of their work and development.

Mentoring is one form of pastoral support that should be offered to trainees and new consultants. The RCP offers mentoring training, and consultant job plans will not be approved by the RCP without a clear offer of mentorship by the employing trust.

Recommendations:

- 1 Encourage the development of support networks within the workplace.
- 2 Ensure that supervisors are vigilant for issues relating to pastoral support.
- 3 Provide training for supervisors on pastoral care, to give them the tools to deal with issues relating to pastoral support and to offer proactive support rather than waiting until an issue arises.
- 4 Encourage coaching, mentoring, near-peer mentoring or 'buddying chain' systems to play an important role in providing support to physicians.
- 5 Create awareness of deanery resources, such as professional support units and external mentoring schemes.

4.3 Line management

Line managers have the responsibility of directly managing employees and teams. Line management is crucial in the engagement of employees in order to achieve organisational goals. They play an important role in leading, developing and mitigating stress within their teams, and have been highlighted by the HSE as playing a critical role in maintaining employee health and wellbeing.

However, in acute medical settings, and indeed in many clinical settings, the concept of line management is not a familiar one. During the training years, physicians have educational and clinical supervisors, who may or may not have regular contact with their supervisees outside appraisal settings. In the acute setting in particular, the make-up of the acute medical team frequently changes in shift systems, making it even more difficult to establish a regular line management relationship. In addition, until recently supervisors were not required to have training in order to take on these roles, and there was little way for trainees to feed back on their direct line managers/supervisors. This could lead to poor enactment of line management responsibilities, and cause a perpetuating cycle as trainees subsequently become line managers themselves.

Recommendations:

- 1 Ensure that all supervisors and line managers receive training on maintaining employee health and wellbeing, in particular understanding the *HSE management standards*.⁴¹
- 2 Ensure regular face-to-face meetings between physicians and their line managers.
- 3 Ensure that all new starters in a trust understand the impact of, and what can reasonably be expected from, a line management relationship.
- 4 Establish a mechanism for feedback on line management.
- 5 Increase awareness of the responsibilities and impact of good line management.

4.4 Clinical pathways and protocols

Many hospitals have local pathways and protocols that aid decision making within the acute medical setting. Knowledge of these local protocols can help physicians to increase their efficiency, as there is often no standard mechanism for accessing a pathway, or for making requests or referrals. As such, many physicians find that the initial stages of joining a new trust can be quite difficult, in terms of just learning how the system works. For example, *The medical registrar* report noted that referrals for admission could be avoided if pathways and protocols were more widely known and adopted, resulting in reduced workload.²

However, there is a danger that physicians perceive that they have a lack of autonomy when they are asked to comply with such protocols. Autonomy is one of the more important aspects of job satisfaction among physicians, and it is essential to motivation.⁴² As such, there must be a mechanism for feedback between physicians and the authors of the protocols, and encouragement for these mechanisms to be used in order to engage physicians and ensure that the protocols continue to be used.

Recommendations:

- 1 Include trainee and front-line representatives on clinical standards committees. All staff members should also be able to provide feedback to these committees. Clear lines of responsibility for patients who require cross-specialty care should be defined and reflected in referrals or documentation.
- 2 Create an accessible database of the most commonly used protocols, via either the intranet or a mobile phone application.
- 3 Develop national standards for clinical induction processes, in particular around working in the acute setting and signposting to commonly used guidance.

4.5 Transfers of care (within the hospital and into the community)

Transfers of care within the hospital can be a source of pressure and stress, not just for the acute medical staff, but also for the receiving ward staff. Handover of patient care is paramount to patient safety; however, it can be difficult to find the appropriate person to hand over to. Poor handover can result in potential harm to the patient if significant information about their case and comorbidities is not relayed, or if there is disjointed and delayed management, eg tests may be repeated, not carried out or even not followed up.

Delayed transfers of care (DTOCs) are a significant issue throughout all trusts. DTOCs result in an increase in workload for acute medical staff and also increase the demand on hospital resources. This is a complex issue that is currently being examined and addressed by several organisations, including the King's Fund.⁴³ There has been a dramatic increase in DTOCs since 2014, and the number of days lost owing to DTOCs increased by 23% between June 2015 and September 2016.⁴⁴ This has increased pressure on NHS services. Tackling this as matter of importance and urgency should be a priority for all healthcare organisations.

Recommendations:

- 1 Ensure that handovers are documented, for example by using electronic resources such as discharge summaries to continuously record patient management and outstanding jobs.
- 2 Ensure that there is a specified, protected time on ward rounds to identify patients who require direct handover (owing to case complexity or degree of illness) prior to transfer.
- 3 Establish a specific multidisciplinary taskforce in every hospital with significant DTOCs, to explore the process management of the situation.

4.6 Workplace culture

Medical culture and leadership have changed significantly since the Mid Staffordshire failings were reported, and much has been done to help with whistle-blowing and to embed a no-blame, open culture in order to improve patient care. Despite this, there is a continuing disparity in views between medical management and front-line staff. Of executive directors, 84% felt that their organisations were characterised by ‘openness, honesty and challenge’, but only 37% of doctors agreed with that.⁴⁵ The same research showed that, despite two-thirds of staff feeling comfortable about raising issues about patient safety, only 40% believed that their concerns would be dealt with appropriately.⁴⁵

Furthermore, there is a correlation between engagement and externally assessed outcomes.²⁰ The simplest definition of employee engagement spells out the relationship at its heart: it is when, according to ‘the business values the employee and the employee values the business’.⁴⁶ There is evidence that increased engagement among healthcare staff also can improve patient outcomes¹⁵ and even improve patient safety.⁴⁷

A range of issues are at play when trying to assess and affect engagement, including:¹⁵

- > staff autonomy
- > enabling staff to use a wide range of skills
- > ensuring that their jobs are satisfying – such as by being able to see something through from beginning to end
- > support, recognition and encouragement for staff
- > personal factors, eg resilience.

Medical engagement, specifically, can be measured using a scale composed of three other metascales:²⁰

- > metascale 1: working in a collaborative culture
- > metascale 2: having purpose and direction
- > metascale 3: feeling valued and empowered.

There is no doubt about the importance of ensuring that there is a supportive and open culture in the NHS, a sentiment that is supported in principle across the health economy.^{48,49} However, the challenge is in implementing that culture change. There needs to be an appetite for change that goes beyond hospital boards and translates to front-line staff – from board to ward. In particular, acknowledgement and understanding of the responsibilities of line management is crucial in promoting culture change, as noted above. Establishing a complete set of recommendations to facilitate this is beyond the scope of this document; however, the importance of awareness and proactive leadership to tackle this issue must be emphasised.

Recommendations:

- 1 Adopt a patient-centric collective leadership model that allows acute medical consultants and clinical leads can contribute to better leadership.⁴⁸
- 2 Implement routine feedback sessions to encourage AMU staff to raise concerns and normalise suggestions for improvement.
- 3 Monitor medical engagement within an organisation regularly and share results with all staff. This should be accompanied by an open feedback mechanism or pathway to suggest solutions.
- 4 Raise awareness of the importance of culture and medical engagement by including them in induction, teaching material for trainees, or in discussions at grand rounds.

4.7 Shared vision and communication

For some time, it has been recognised that medical leadership is essential to provide high-quality patient care. However, the relationship between doctors and medical managers could be significantly improved. A survey of a cohort of senior physicians listed 'management and NHS policy' as one of the five most criticised areas in the context of job satisfaction.⁴² In addition, more than 50% of a cohort of NHS doctors seeking early retirement stated that management changes were a related factor in their decision to retire early.³²

The reasons behind this dissatisfaction are complex; however, one potential reason could be that physicians view management as a threat to their clinical autonomy. Aside from this, previous research has also shown a fundamental difference in perspectives between doctors and medical managers. For example, there is significant evidence that, compared with medical managers, doctors placed less importance on issues of finance and accountability.⁵⁰

The differences in perspective are likely to be exacerbated by a lack of communication between the two groups and a lack of familiarity with each other's professional duties and responsibilities. This lack of familiarity can make it easier for a culture of blame to be propagated, because of to a reduced sense of relatedness and lack of shared outlook.

Recommendations:

- 1 Improve communication between management and front-line staff by holding regular face-to-face meetings or surgeries, increasing management visibility.
- 2 Encourage programmes where physicians work alongside managers to deliver local quality improvement projects.
- 3 Introduce change management training into regular hospital teaching slots, delivered jointly by managers and interested clinicians.
- 4 Encourage interested staff to join the board of governors or to observe trust board meetings on a rotational basis.
- 5 Trust board representatives could attend key departmental staff meetings in person to consider feedback or suggestions.

1.8 Recognition of effort and appreciation of success

Recognition and appreciation of effort are widely known to boost morale.¹⁹ However, in the high-pressure environment of the AMU, opportunities to show appreciation can be limited. In addition, praise and appreciation tend to be given by supervisors and by those with educational or training roles, rather than clinical peers or senior colleagues. This is exacerbated by shift patterns and lack of regular supervision, and may lead to a perception of staff being undervalued.

Furthermore, the national system for job applications can mean that hard work and effort, which is visible locally, may not be recognised during the application process. As such, motivation to perform above and beyond expected roles and responsibilities is low. In essence, there is no formal reward for performing well clinically, and performing to minimum standards will not necessarily impede a clinician's career progress. Indeed, consultants' opinions of trainees have little impact on trainees' advancement. In this situation, bar changing the recruitment system, much needs to be done on an individual basis to cultivate motivation.

Recommendations:

- 1 Establish team debriefs at the end of shifts, with particular emphasis on highlighting good performance.
- 2 Introduce achievement boards to display when a team member has performed above expectations. Consultants could show appreciation for trainees with letters of recommendation that acknowledge the trainees' contribution and effort.
- 3 Provide a mechanism for out-of-department successes or events (eg publishing papers, posters or job offers) to be noted and celebrated.
- 4 Hold intra-hospital audit or quality improvement project competitions to recognise quality and the effort made to improve local conditions.

Personal factors

Domain 5: Personal characteristics

5.1 Resilience, optimism and other coping mechanisms

Working as a doctor involves exposure to multiple stressors, ranging from the pressure of work, the potential impact on patients and a lack of control over the work that doctors do. Although we can work to improve working conditions, we cannot avoid the fact that physicians will have to deal with stressful situations. As such, it is important that we explore physicians' resilience in response to stress, their perspective and other coping mechanisms that can help with their daily jobs and improve morale.⁵¹

Training in medicine, as yet, does not routinely incorporate resilience training. In the practice of medicine, physicians need to be prepared to cope with situations where their desired outcomes are not obtained.

Many physicians and other doctors 'reflect' on clinical events or decisions that they have made; this is more correctly referred to as rumination.⁵² There is evidence that cognitive behavioural therapy can have a positive impact on work-related rumination, chronic fatigue and sleep quality.⁵² There is also evidence that resilience training can be beneficial to mental health and wellbeing in employees, as well as enhance psychosocial function and performance.⁵³

In addition to preventative measures, there is also a need to put in place mechanisms for supporting those who have been affected by stress or are struggling with mental health issues. A literature review has shown that admitting to and reporting help-seeking behaviour in doctors is difficult, owing to the complexities surrounding the role change from being a doctor to being a patient.⁵⁴ In addition, trainee physicians report a stigma in seeking help if they are struggling, particularly from those within their own hospital.⁴⁰

Specialist and anonymised services for clinicians that tackle these unique issues may help to overcome these barriers.⁵⁴ There are some good examples of support services for medical students in particular, such as the Medic Support Programme at Cardiff University, founded by Dr Debbie Cohen.⁵⁵

One aspect that is rarely considered is the impact that a physician's attitude has on the rest of the team. Good leadership is vital both for staff morale and for improving and ensuring the quality of patient care.⁵⁶ Although physicians are subject to a great deal of stress and worry, as clinical leaders they bear a certain responsibility to ensure that the image that they project does not cause despondence in their team members. Clinicians are frequently responsible for the image that they present to their patients, which helps to reassure, engage and encourage them. However, this may not be carried forward to their interactions with colleagues, which could create a negative atmosphere for staff to operate in.

Team members often reflect the behaviour of the team leader to fit in, or out of respect for that individual. Consultant physicians in particular need to be aware of this, and take active steps to manage their behaviour and attitudes with their colleagues, as well as with their patients.

Recommendations:

- 1 Establish resilience workshops for physicians and medical students working in the acute setting. Where hospitals do not, local education and training boards (LETBs) should make compulsory resilience workshops available for trainees in their area.
- 2 Establish leadership workshops looking at self-awareness and positive psychology, prioritising acute physicians in more senior positions.
- 3 Promote coaching and mentoring schemes to enhance reflection and self-awareness, in order to support mental wellbeing.
- 4 Establish mentoring schemes for trainees or peer mentoring for consultants to encourage personal development. This could include near-peer mentoring or 'buddying' schemes, which would provide local support and advice from someone who may have recently been in similar circumstances.
- 5 Consider establishing specialised services for clinicians that can provide anonymous support and advice.
- 6 Ensure that physicians have access to, or are aware of, organisations that specialise in supporting mental wellbeing in doctors.

5.2 Self-esteem

The concept of self-esteem refers to how a person values themselves and their qualities.⁵⁷ It can impact morale quite significantly, especially in a profession where one can be surrounded by other high-achieving individuals. Low self-esteem affects many physicians, particularly in the context of having made mistakes or errors,⁵⁸ and can lead to avoidance behaviour, self-criticism and negative emotions.⁵⁹ In the long run, this can escalate into depression and more severe mental health issues. Conversely, low self-esteem could also be a symptom of an underlying mental health issue.⁶⁰

Low self-esteem could also mean that physicians are less likely to speak up about issues relating to the hospital or patient management, for fear of becoming vulnerable. This could be detrimental to a culture of continuous improvement and could impact on the department as well.

Recommendations:

- 1 Train supervisors to understand how the perception of self may impact on a physician's work and team and to recognise signs of low perceptions of self.
- 2 Provide local workshops on self-esteem or assertiveness.
- 3 Produce cognitive behavioural therapy worksheets and make them available to staff to access in their own time.
- 4 Encourage the development and extension of coaching and mentoring schemes.

Domain 6: Career, education and training

6.1 Time, trainers and opportunity for training

One frequent complaint about training in the acute setting is that, owing to work pressures, there is little time for training.⁶¹ There is a perception that, owing to the intensity of the work required for service delivery, there is no time for educational events. However, it is important to acknowledge that there can be ample educational opportunity in performing tasks that are considered to be service delivery, which may not be being capitalised on.

Another issue to consider is difficulty with study leave, given the complexity of rotas and shift work. In this situation, there must be a degree of flexibility; however, patient safety must be considered as well. Much of this is referred to in the section on work (domain 1), as well as hospital administration (domain 4).

Recommendations:

- 1 Reward creativity in training by promoting local teaching awards. Allow medical registrars to lead ward rounds (or half ward rounds) with consultant supervision, to allow simultaneous training and service delivery.
- 2 Promote shared reflection and case debriefs to deliver quick lessons on the case at hand.
- 3 Ensure that all training programme rotations are well rounded and provide a good skill mix to their trainees. In addition, deaneries should consider complexity of jobs in particular trusts and the average competencies of trainees in those jobs, in order to challenge trainees appropriately.
- 4 Ensure that protected time for teaching is included in post-take ward rounds and during normal rota patterns, instead of using time after a shift.
- 5 Encourage attendance at grand rounds or morning reports and include attendance in compulsory local teaching hours accrument.

6.2 Job security and sustainability

Job insecurity is a potential source of stress and poor morale. This may be less of an issue for permanently employed consultants; however, for trainees, job insecurity can be quite concerning. Consultant physicians can support trainees to develop experience and skills to secure the job and career that they want.

In addition, the sustainability of work can be a source of worry for physicians. Highly pressurised environments and long working hours, although manageable for a few years, can take their toll, and physicians at the start of their careers can sometimes feel demoralised when they look ahead at their long-term future. It can be difficult to foresee how one's responsibilities and jobs will change, eg the work that is done by trainee physicians is very different from the work that is done as a consultant physician. This can be difficult to appreciate for doctors-in-training, especially as trainees spend less and less time with their consultants due owing to rotas, shifts and work pressures, and have fewer opportunities to see what being a consultant entails.

Recommendations:

- 1 Ensure that educational supervisors and RCP college tutors support trainees to achieve or improve their portfolios through advice or introduction to other consultants with similar interests.
- 2 Allow study days or taster weeks to be used to shadow a consultant as a career development exercise.
- 3 Provide and promote career-planning services for all trainees.
- 4 Ensure that long-term career supervisors for trainees are allocated by deaneries, to help them understand and consider their career paths.
- 5 Provide coaching and mentoring services to help trainees decide at an early stage what their priorities are, and provide career counselling.
- 6 Develop national information and guidance on the creation of consultant job plans for trainees (eg by the RCP).

Domain 7: External/home circumstances

7.1 Life events and finances

It can be difficult to separate emotions that are generated by circumstances at home and those at work. Worries that affect any individual at home have the potential to cause distraction and stress at work. Examples of these out-of-work issues include:⁶²

- family (death, relationships, childcare or caring for older relatives)
- personal or social issues (personal injury, finances, lack of social support)
- daily hassles (public transport, traffic jams, house maintenance)
- other (moving house, difficulty with neighbours, living environments).

As mentioned previously, interpersonal relations in acute settings could be greatly improved. However, it can be difficult for a physician who is experiencing issues outside work to find support among colleagues. In addition, they might be concerned that, by sharing information, they may appear to be weak or 'in difficulty'.

Supervisors should offer the opportunity for trainees and consultant colleagues to explore issues at home, with open questions such as 'how are things at home?' and 'how do you unwind?'. This gives doctors an affirmation that it is normal to discuss domestic issues, and that work and life are part of one continuum. Supervisors need to be aware of support services that are available locally.

Recommendations:

- 1 Provide or signpost physicians to anonymous helplines or services that can provide counselling or listening support if they are undergoing emotional stress. These services need to cover a variety of potential causes of stress, including family relationships, childcare, caring for older relatives, financial issues, legal issues etc.
- 2 Ensure that all physicians have a list of people who they can approach for help and to talk to, in confidence, to provide a safety net to make sure that their clinical practice does not suffer as a result of the stress.
- 3 Ensure that all healthcare professionals are equipped to provide peer support or to direct colleagues who approach them for help with stress or issues around mental health and wellbeing.

Patient factors

Domain 8: Patient safety

8.1 Handover

As part of the shift system, the acute medical team (including all members of the multidisciplinary team) are responsible for a series of handovers for each patient every day. As a consequence, miscommunication or loss of information could happen multiple times, which could potentially compromise patient safety.

In addition, handovers are occasionally performed between individual physicians, away from the rest of the medical team, rather than when the whole team is present. While this may be more efficient in terms of time, it also does not allow the medical team to appreciate the full complement of unwell or complex patients who have been handed over.

High-quality handovers can simplify work for the receiving physician, and play a part in reducing their workload. Furthermore, high-quality handover could lead to improved morale for the physician who delivers the handover, if it results in improved patient care and management.

Recommendations:

- 1 Improve handover systems and culture so that the handover of work is not negatively viewed by the medical workforce.
- 2 Encourage the use of electronic discharge summaries, paper handovers or electronic patient lists to improve the transfer of information.
- 3 Structure handovers using the principles outlined in the RCP's *Acute care toolkit 1: Handover*.⁶³
- 4 Encourage the documentation of clear plans, including ceilings of care and previous discussions with patients and their relatives.

8.2 Second victim syndrome

Taking into account all the pressures of the acute medical setting (time and work pressure, and critically ill patients) and acknowledging that doctors are only human, it is inevitable that mistakes will sometimes happen. The majority of mistakes do not result in harm to the patient.⁶⁴ However, while we must do our best to ensure that mistakes do not occur and seek to learn from them when they do, it will never be possible to completely eliminate the possibility of a mistake occurring that can cause serious harm to a patient.

The consequences of this unintentional harm can be devastating, both for the patient and for the healthcare giver. It can also create 'second victims' – healthcare staff who must deal with the fallout of the mistake that they made.⁶⁵ Second victims understandably suffer from guilt and feelings of incompetence and inadequacy. They can become isolated from their colleagues, and may suffer from mental health issues that subsequently hamper their return to work.^{66,67}

In many organisations, second victim syndrome is not a recognised phenomenon, and there are no obvious pathways to support medical professionals in this situation. This lack of recognition can lead to severe issues surrounding morale, as well as subsequent reporting of medical errors. It may also make it harder to discuss errors in an open and honest way.

Recommendations:

- 1 Establish counselling, peer mentoring, buddying and support groups for those involved in traumatic cases to address the 'second victim syndrome'.
- 2 Establish regular 'no-blame' meetings to discuss the most serious and common mistakes (eg Schwartz rounds or 'learning to move forward' meetings).
- 3 Ensure access to specialist clinical counselling and/or a psychologist where a team has been involved in the care of a patient where there was an unintended poor outcome.
- 4 Develop resources to help support physicians before the investigation of a serious untoward incident (SUI).

8.3 Reporting patient safety issues

Feeling unable to voice concerns about patient safety issues is likely to cause low morale. Apart from the obvious concerns over patients' wellbeing, difficulty with guarding patient safety can also reduce a physician's perception of their locus of control and can encourage a negative world view. There are many barriers to this, which have been discussed in this document and also in many other resources and publications.^{68,69}

As mentioned in the section on workplace culture, there is a perception among NHS staff that their concerns about patient safety in the workplace will not be dealt with appropriately (see section 4.6 for more information). Consideration needs to be given to methods and the complexity of reporting mechanisms that may deter staff members from reporting significant issues. Other barriers may also include the fear of blame or repercussions from whistleblowing. NHS Improvement has developed recommendations that can help to improve incident reporting.⁷⁰

Recommendations:

- 1 Ensure that all staff are aware of how to report incidents and near misses.
- 2 Create local patient safety groups that are open to all staff.
- 3 Disseminate news of resulting action taken via the trust's intranet or emails, to share learning and encourage further reporting.
- 4 Encourage a visible no-blame culture through regular learning meetings that normalise learning from mistakes.
- 5 Include involved staff members in the action and improvement processes instigated following a patient safety incident.
- 6 Deliver workplace-wide 'learning from mistakes' grand round sessions, to encourage all departments to share improvements following a patient safety issue and to highlight the action that is taken.

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