Behind closed doors...

If we believe what has been suggested in recent newspaper articles the future appears bleak for some specific groups of employees, who could find themselves replace by robots in the future! Accountants appear to be the highest risk category; with the least likely to be replaced robotically are our rehabilitation colleagues, occupation therapists. Very hands on specialists!

How then does that place perioperative staff? Our Association provides personal professional advice on a variety of subjects through our trustees, online communities and headquarters staff. The major concern still appears to be around staffing levels required for the delivery of safe care in the operating theatre environment. If we argue that our professional practice and identity provides total patient care within a critical care environment, what does the future hold?

We are aware that as managers seek to balance their budgets, meet quality of care standards and staffs work vs life expectations, some are seeking to reduce staffing levels below AHP’s recommendations. This includes the following, as a minimum, and after a risk assessment of patients’ needs and the skills and competencies required of the perioperative team:

- **TWO SCRUB PRACTITIONERS** as the basic requirement for each session, unless patient dependency and/or clinical service demand more or less. Two practitioners are recommended for a list of major surgery unless there is only one case. Two practitioners are recommended for a list of minor surgery that demands a quick throughput or has several cases on it such as for an elective day surgery list.

- **ONE CIRCULATING STAFF MEMBER** for each session unless there is a requirement for more, i.e. when two cavities are opened, for example anterior and posterior resection.

- **ONE REGISTERED ANAESTHETIC ASSISTANT PRACTITIONER** for each session involving an anaesthetic. This includes sessions where local sedation or regional anaesthesia is administered. There may be occasions when more than one assistant is required due to patient dependency/type of anaesthesia.

- **ONE RECOVERY PRACTITIONER** per patient for the immediate postoperative period. If the patient is not returning to a special care area such as a high dependency unit immediately after surgery, they need to be cared for by practitioners who are trained and experienced in post-anaesthetic care.

In supporting our members and enquiring managers I have been challenged on these levels, verbally abused and shunned, but I’ve always qualified the above staffing levels with the statement that comes before it in the text:

“It is the responsibility of the coordinator or designated team leader to ensure that every elective and emergency operating list is staffed by a team of appropriately trained and competent personnel who are equipped with the skills and abilities to administer high quality patient care and who are able to identify and minimise any risks to the patient as they journey through the perioperative environment.” (AHP 2014 p24)

Our revalidation process as Registered Nurses and Operating Department Practitioners should enable us to review, reflect and share key elements of our role over a period of time. As accountable and competent professionals, who delegate tasks and duties to other team members, our responsibility continues as we provide adequate supervision and support that delivers safe, compassionate care that meets the required standard.

Anecdotal and published evidence suggest that the number of those leaving the caring profession has risen by 25% over the last five years. Many years of management and clinical experience has been lost, often it would appear from fear of engaging with the revalidation process. At the other end of the generation divide, nursing degree applications demonstrate a 23% drop, a fall of 10,000, Royal College of Nursing general secretary Janet Davies said “These figures confirm our worst fears. The nursing workforce is in crisis and if fewer nurses graduate in 2020, it will exacerbate what is already an unsustainable situation" (Jones-Berry 2017).

Will similar concerns affect intakes of ODP students seeking a graduate career? As I write this my daily paper suggests that degrees in the future could be completed in two years rather than three, but with each year attracting a £13,000 academic fee and committal student loans. Three year degree fees will go up to £12,000 (£36,000 over three years) plus a living cost burden. As a parent it horrifies me, as have some of my coffee room conversations whilst preparing this piece.

RODPs: what professional changes will becoming Allied Healthcare Professional this April bring to this group of colleagues? Some have already moved out of the theatre domain to transfer skills to resuscitation, surgical, pain and intensive care outreach teams and advanced clinical roles, but have found the transition challenging and full integration difficult when not able to acquire the same outcome as established colleagues. Chatting to some of my “shop floor” RODP colleagues this week I heard that most just wanted, “professional recognition, academic progression, a chance to become a leader”.

I have not even started to discuss the emerging roles of perioperative “support staff” already in post or on the agenda of Health Education England; Assistant Theatre Practitioners (Wheeler 2017), Nursing Associates (Bradley 2017) and Theatre Support Workers as Nurse Apprentices (Mullen 2017). Research on plugging nursing gaps with less skilled staff that made it 20% more likely that patients would die in hospitals is alarming (Atkinson et al 2016), but as we prepare to greet these staff into our teams how will they impact perioperative care, support safe surgical outcomes and challenge existing collaborations? Already we are aware of departments who continue to maintain
roles that rely upon a “custom and practice” model- “we have always done it this way” - even though their archival practice parameters breach professional practice position statements and guidance issued by surgical colleges, professional associations and collaborative academics.

The recent BBC TV series Hospital, which followed a group of London hospitals, exposed the current daily realities facing the NHS. Their theatre teams demonstrated how seeking to support routine and emergency patient care is often frustrated. Your own personal clinical practice will, I am sure, reflect the concerns seen and voiced, and the outcomes demonstrated during this series.

Theatre managers nationally struggle with unfilled vacancies, staff missing scheduled breaks to fill team gaps, excessive costly overtime, concurrent high sickness rates and high agency bills. Individual theatre team leaders and departmental managers clearly need to support staff with timely and appropriate interventions that develop strategies and conditions to ensure that the right staff with the right skills are in the right place to support a positive staff experience and safe surgical outcomes.

Staff comments such as, “We never get appreciated, if one thing goes wrong, that’s it!” are not easy to hear but represent, I believe, one which reflects a significant challenge for all leaders to address.

Sir Clive Woodward - World Rugby Cup
Managers top tip – Listen to your team!

On promotion into a managers role I was advised, “Adrian, always remember that managers are there for their staff, not the other way round”, so thank you for reading this but now, what specific goals are you setting to manage your career, plus or minus the robots?

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