Written evidence submitted by The Royal College of Emergency Medicine (WBR0070)

About the Royal College of Emergency Medicine

The Royal College of Emergency Medicine (RCEM) is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides doctors and consultants to Emergency Departments in the NHS in the UK and other healthcare systems across the world. The Royal College works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Emergency Department workforce resilience pre-COVID19

It has long been acknowledged that Emergency Departments have one of the most intense working environments in the NHS. The intensity of the working environment is a cause of staff dissatisfaction, attrition, and career burnout.[1] Increased attendances and admissions, bed occupancy and delays in transfers of care has resulted in busy and crowded departments. This is at the heart of the challenge for sustainable careers for staff in Emergency Medicine. [2]

Staffing

Emergency Departments can only deliver safe care if they are adequately staffed. Before the coronavirus pandemic, Emergency Departments – like the rest of the NHS – were facing a workforce crisis. Understaffing means our workforce suffers from burnout – more so than other specialities, which leads to many staff leaving Emergency Medicine. This was probably evidenced best in the GMC National Training Survey 2019 which showed that 69.2% of EM trainees and 63% of trainers reported moderate or high levels of burnout (compared with the average 49.9% and 46.8% respectively across all specialties).[3]

The table below shows the number of Emergency Medicine Consultants are increasing at a constant rate. However, this has not kept pace with demand and complexity of work. The ratio of attendances per consultant has decreased by almost 1,500 in the last four years. The College has previously suggested that we should aim for a ratio of 1 consultant per 4,000, and the table below shows we have not yet achieved that.

Table 1 – Attendances per Emergency Medicine Consultant ratios

	Attendances	Consultants	Attendances/Consultant	Consultants if maximum 4000 attendances
2016/17	15,262,758	19,206	9,471	3,816
2017/18	15,372,467	20,478	9,015	3,843
2018/19	15,679,999	21,892	8,619	3,920
2019/20	15,811,453	23,324	8,105	3,953

The College estimates a deficit of 2,500 Whole Time Equivalent Emergency Medicine Consultants.[4] This workforce shortage partly explains why many Emergency Medicine doctors were working

[1] RCEM and NHS England. (2017) Securing the future workforce for Emergency Departments in England. Access here.
[2] Ed Smith & Sunil Dasan (2018). A system under pressure. British Journal of Hospital Medicine. Available here.
[3] General Medical Council (2020) National Training Survey 2019: Initial Findings Report. Available here.

unsustainable patterns prior to the pandemic, and this is likely to continue as we head into the Winter months.

Emergency Departments require a multi-professional workforce. Staffing models involve the use of clinicians from a range of professional backgrounds:

1. *Staff and Associate Specialist and Specialty (SAS) Doctors*
   The loss of the Associate Specialist grade has removed career progression options other than working towards Article 14 Accreditation/CESR and Consultant working. This important staff group need sustainable career development as set out in the BMA SAS Charter[5].

2. *Trainees*
   Recent initiatives increasing flexibility in training have decreased resignation from training rates but have also reduced the overall WTE workforce. However, retention remains a key issue for Emergency Medicine trainees. Less than 50% of trainees completing training are directly taking up Consultant posts.

3. *Allied Health Professional Roles*
   Allied Health Professional Roles include but are not limited to the following Emergency Care Advanced Clinical Practitioners, Physiotherapists, Pharmacists and Advanced Paramedics. There is a national strategy supporting the development of AHP roles. RCEM has established a clear credentialing programme for EC ACPs. We fully support the HEE National Strategy for all AHP roles to have similarly supported accredited development. Clear and supported continued professional development strategies post credentialing for all AHPs will ensure staff retention and sustainable careers.
4. *Nurses*
   Nursing staff play an essential role in maintaining patient flow in hospitals, the shortage of nursing staff be urgently addressed.

<u>Nature of work environment</u>

Before the pandemic, Emergency Departments across the UK were operating at maximum capacity. As illustrated above, the number of attendances is increasing every year, yet the physical size of hospitals and departments has not increased accordingly. Most Emergency Departments pre-COVID stretched beyond the capacity they were designed and resourced to manage at any one time. This Intense working environment puts a huge amount of strain on staff. In addition, studies show that this environment is linked with lower quality of care for patients and increased mortality, with elderly and vulnerable patients most affected.

The four-hour target was introduced in 2004; it refers to the operational standard that at least 95% of patients should be admitted, transferred or discharged within four hours. Despite this pledge, the standard has not been met in England, since July 2015, and the last time it was met over a full year was in 2013/14. The target has not been met at Type 1 A&E departments since June 2013 and has not been above 95% annually since 2010/11.

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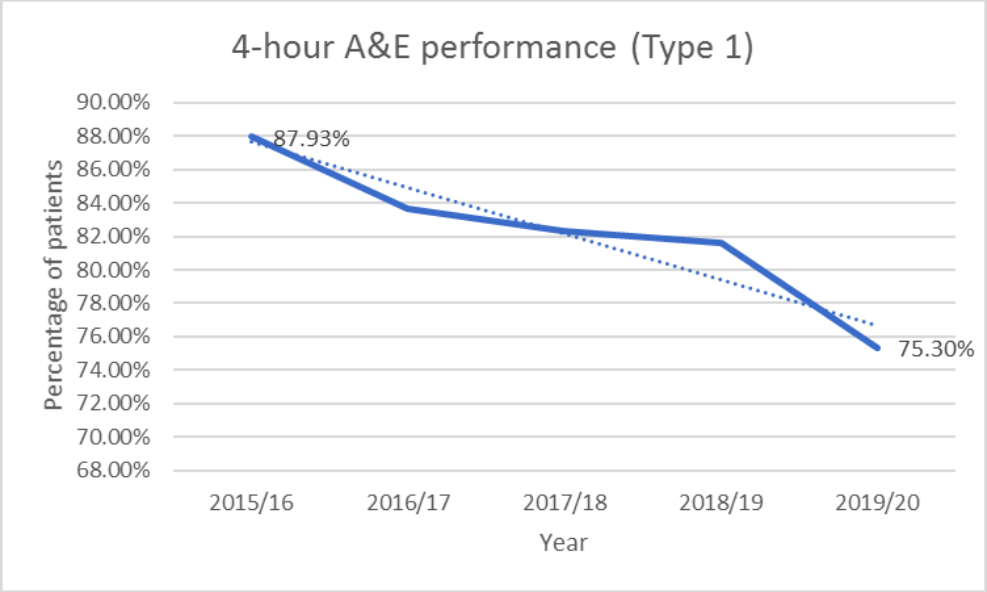
[4] RCEM CARES Campaign 2020. Available here.
[5] BMA (2014) A charter for staff and associate specialist and speciality doctors. Available here.

The standard acts somewhat like the canary in the coal mine – it is a crude target, yet it calls attention to failures in other parts of the system. A&E departments have constant interactions with other parts of the hospital, for example, to request diagnostic tests and to transfer patients. A&E performance is therefore dependent on processes and capacity in other hospital departments, as well as other parts of the health and social care system. High levels of hospital bed occupancy, delays in transferring patients out of hospital, and staff shortages throughout the urgent and emergency care system have all had an impact on A&E waiting times.

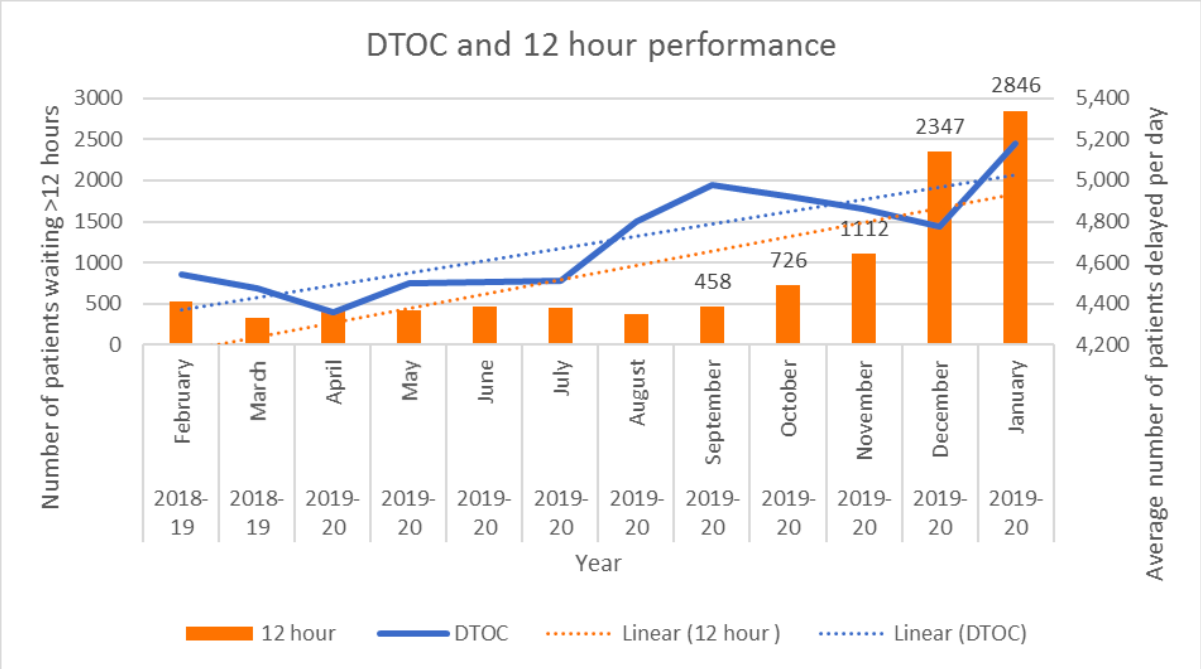
Graph 1 – Percentage of patients admitted, transferred or discharged within four hours 2015/16 to 2019/20



Graph 1 above illustrates four-hour performance in major departments in England over the last five years. The clear decline in performance is not due to a lack of trying but rather a sustained period of financial austerity and chronic staffing pressures. Staff are still being expected to aim for a target that is ultimately no longer achievable given the increase in number of attendances, rise in admissions and fewer hospital beds.

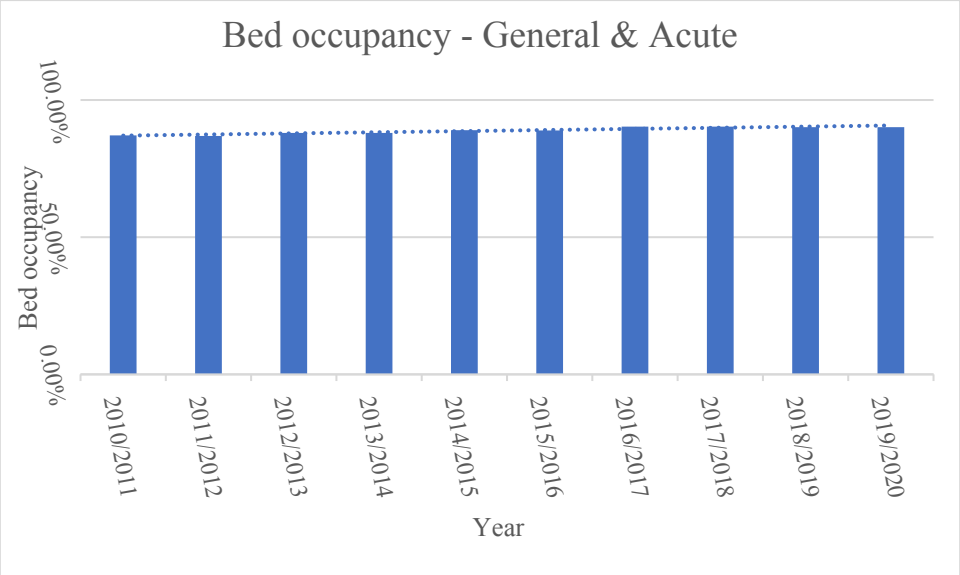
One of the greatest challenges facing Emergency Departments is the issue of crowding, the result of which has meant that trolley waits and "corridor care" have unfortunately become common practice. This can be upsetting and stressful for both patients and staff. Crowding is most commonly the result of high hospital bed occupancy, driven partly by Delayed Transfers of Care (DTOC). Failures in other parts of the health and social care system mean that though a patient may be ready to move on from the emergency department, they cannot get into a hospital bed, so they end up waiting in the ED until a bed is available.

Graph 2 - Delayed transfers of care and 12-hour performance (12 months pre-COVID)



Graph 2 above demonstrates how DTOC can have a direct impact on long waits. In England, 12-hour waits are measured from the decision to admit. This differs from the other Devolved Nations, where the clock starts from the patients' arrival. Nevertheless, the data in Graph 2 show the dramatic increase in 12-hour in the months leading up to the coronavirus pandemic.

Graph 3 – Average bed occupancy for General and Acute specialities 2010/2011 to 2019/2020



The graph above shows increasing bed occupancy rates for General and Acute specialities. RCEM supports 85% as the recommended safe level of occupancy as it allows hospitals to be able to cope with surges in demand. The table above shows that bed occupancy in 2010/2011 was 87% and has consistently increased ever since. The number of available beds has reduced consistently over several years, the result of this is that patients were being cared for in corridors as there were not enough beds to admit them to. This is inhumane and undignified for patients and puts a lot of pressure on staff.

Impact of Emergency Department workforce burnout on service delivery, staff, patients, and service users.

Burnout is a term first coined by Herbert Freudenberger to describe the exhaustion and chronic stress experienced by public sector workers.[6] It is a work-related health issue involving emotional exhaustion, depersonalisation, and a sense of reduced accomplishment.[7] Burnout amongst Emergency Department staff is increasingly a result of poorly structured working environments. This includes feeling 'used up' at the end of the day and having nothing left to offer patients; depersonalisation encompasses treating patients as objects rather than human beings; a sense of reduced personal accomplishment encompasses feelings of ineffectiveness in helping patients and the lack of value of professional achievements.[8] Burnout is also linked with job dissatisfaction, fatigue stress and depression.[9]

There have been numerous research studies which show the impact of burnout on doctors worldwide; notably studies show that burnout amongst doctors can lead to self-reported sub-optimal care and medical errors.[10] Burnout among doctors has the potential to affect the entire

[6] Freudenberger H. (1974) Staff burnout. Journal of Sociology. 30:159–165.
[7] Maslach C, Jackson SE, Leiter MP. Maslach (1996) Burnout Inventory Manual, 3rd ed. Palo Alto, CA: Consulting Psychologists Press.
[8] West, C.P, Dyrbye, L.N., Shanafelt T.D (2018) Physician burnout: contributors, consequences, and solutions. Journal of Internal Medicine. Available here.
[9] Williams ES, Manwell LB, Konrad TR, Linzer M. (2007) The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: results from the MEMO study. Health Care Manage Rev
[10] Shanafelt T. (2002). Burnout and self-reported patient care in an internal medicine residency program. Ann Int Med 2002; 136: 358

workforce as it is considered to be 'contagious'.[11] In 2017 a systematic review of burnout amongst doctors in the UK identified unhealthy coping strategies in response to burnout. This included: early retirement, taking work home, taking stress out on family, mixing less with friends, and avoidance.[12]

A study published in 2017 by the Emergency Medicine Journal examined the psychosocial distress and wellbeing in Emergency Medicine consultants. They found that research participants worked intensely to meet systemic demands which contributed to a 'diminishing sense of achievement and self-worth'. Consultants perceived their experience of physical and mental strain as unsustainable because it adversely affected their ability to function at work, relationships, and their wellbeing.[13]

In 2003 another study was published examining burnout among nursing staff in Emergency Departments. It found that nurses working in Emergency Departments experienced higher levels of emotional exhaustion than their Emergency Department counterparts and the impact of this was evidenced in their clinical practice and personal lives.[14] This is particularly concerning because international comparative research has found an association between nurse burnout and quality of care.[15]

There is growing recognition of the threat burnout poses to the safety and quality of care, and a 2019 Canadian study found that symptoms of burnout appeared to be associated with greater explicit and implicit racial biases; given the high prevalence of burnout and the negative implications of bias for medical care, symptoms of burnout may be factors in racial disparities in health care.[16] One study which surveyed 681 doctors working in emergency medicine suggested that compassion fatigue (one symptom of burnout or stress) was associated with reducing care quality standards in a way that could harm patients.[17]

Scale of Emergency Department burnout

The extent of burnout in Emergency Medicine is well documented. In a membership survey conducted in December 2018, we found that over 80% of respondents believe that Emergency Care is getting worse.[18] Staffing, sustainability, burnout, workload and increasing demand were the key issues more staff were concerned about. The Medscape National Physician Burnout, Depression and Suicide Report 2019 confirmed doctors working in Emergency Medicine and family medicine were among the most burned out. The BMJ carried out a cross-sectional study of doctors in 2018 examining resilience, professional quality of life, and coping mechanisms of UK doctors. They found that doctors who responded to the survey from Emergency Medicine were more burned out than any other speciality group. In addition to being more burned out, they also scored higher than any other group of physicians for secondary traumatic stress.[19]

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[11] Maslach C, Schaufeli WB, Leiter MP (2001) Job Burnout. Annual Review of Psychology.; 52():397-422.
[12] Udemzue, O.I. (2017) Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors. BJPsych Bulletin. 41(4): 197-204
[13] Fitzgerald K, Yates P, Benger J, et al (2017) The psychological health and well-being of emergency medicine consultants in the UK. Emergency Medicine Journal;34:430-435.
[14] Udemzue, O.I. (2017) Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors. BJPsych Bulletin. 41(4): 197-204
[15] Poghosyan, L., Clarke, S. P., Finlayson, M., & Aiken, L. H. (2010). Nurse burnout and quality of care: cross-national investigation in six countries. Research in Nursing & Health, 33(4), 288–298.
[16] Dyrbye L, Herrin J, West CP, et al. Association of Racial Bias With Burnout Among Resident Physicians. JAMA Netw Open. 2019;2(7):e197457. doi:10.1001/jamanetworkopen.2019.7457
[17] General Medical Council (2019) Caring for Doctors, Caring for Patients. Available here.
[18] RCEM (2018) 'Four out of five Emergency Medicine doctors believe emergency care is getting worse'. Available here.

In the 2019 National Training Survey, 69.2% of Emergency Medicine trainees reported moderate to high levels of burnout, the highest out of all specialities.[20] This is concerning as Emergency Medicine trainees are the future consultant workforce.

Impact of COVID-19 pandemic on resilience, levels of workforce stress, and burnout on Emergency Department staff

When the Coronavirus struck the UK, Emergency Medicine staff were already operating in understaffed and under-resourced departments as delineated above; conditions that we know are correlated with workforce burnout. While the number of attendances to emergency departments dropped significantly - 48% fewer visits to major units in April 2020 than the previous year - staff now had to grapple with challenges such as PPE shortages and lack of staff due to illness and self-isolation. This further exacerbated conditions for many who have had to work long hours in uncomfortable, hot and restrictive Personal Protective Equipment (PPE).

In the initial stages of the pandemic, uncertainty about access to adequate protection, lack of testing for staff and dubiety surrounding Public Health England (PHE)'s guidance meant that emergency medicine staff were often putting themselves at increased risk. An example of this is that until the 24th April, PHE did not recognise chest compressions as a potential Aerosol Generating Procedure. This did not fall in line with the World Health Organisation's guidance which stated that Level 3 PPE must be provided to health care professionals performing resuscitations.[21]

In June 2020 The Royal College of Emergency Medicine (RCEM) conducted a member's survey. The results of which revealed that 32% had episodes where they lacked access to PPE items when having clinical contact with suspected or confirmed COVID19 patients and 34% of respondents reported that they have had to reuse disposable PPE items. In addition, 97% of respondents felt that PPE had an impact on their ability to communicate effectively with patients. Paired with having to compromise their own safety, an inability to communicate effectively with patients left staff feeling exhausted, deflated and indeed burnt-out.

Furthermore, if we take a deeper look into staff experience with PPE by ethnic breakdown, the results are even more alarming. There was a discrepancy between the proportion of staff who had training in the use of PPE. 84.38% of Black, Asian and minority ethnic (BAME)[22] confirmed they had training whereas the proportion for White staff was much higher at 90.52%. In addition, 41% of BAME staff responded that they had had clinical contact with suspected or confirmed cases of COVID-19 where they could not use adequate PPE, compared to 24% of White staff.

The RCEM membership survey also asked questions about staff health concerns. 30% of BAME staff answered that they were 'very concerned' for their health compared to 8% of White staff. The Marmot report outlined that the impact of COVID-19 has replicated existing health inequalities, and in some cases, increased them – this, of course, extends to staff and not just patients. Racial disparities experienced by Emergency Medicine staff are a contributing factor to occupational stress and, ultimately, burnout.

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[19] McKinley N, McCain RS, Convie L, et al (2020) Resilience, burnout and coping mechanisms in UK doctors: a cross-sectional study. BMJ Open.

[20] General Medical Council (2020). National Training Survey. Available here.

[21] Resuscitation Council (2020). RCUK Statement on PHE PPE Guidance. Available here.

[22] We use the term 'Black, Asian and minority ethnic' for practical reasons. We acknowledge the limitations of this phrase and recognise the diverse and heterogeneous experiences of people both across and within different ethnic groups.

In conclusion, the COVID-19 pandemic has undoubtedly had on impact on the wellbeing of the Emergency Medicine workforce. The RCEM member's survey revealed that 50% of respondents felt their mental health had slightly or greatly worsened due to the pandemic. Moreover, according to a BMA members survey, 44% of doctors say they suffer from depression, anxiety, stress, burnout or other mental health conditions relating to or made worse by their work.[23] Additionally, staff have been reluctant to take leave, in part due to restrictions on travel, and hence this has contributed to staff being unknowingly fatigued and exhausted - a fact that has only become evident to them when they return from leave and see how different they feel.

Policy announcements

The People Plan

We welcome the focus on staff wellbeing and health and developing compassionate leadership cultures in the People Plan. We also welcome a renewed focus on addressing ethnic inequalities, our own membership surveys have revealed huge disparities in the experiences of white and BAME staff.

We are disappointed that the People Plan falls short on tackling the excessive workloads of Emergency Department staff, the key reason why staff working in Emergency Medicine experience higher levels of burnout than any other speciality. In addition, the People Plan failed to introduce a long-term workforce strategy. Workforce is chronically underprovided at all levels for Emergency Medicine. Emergency Medicine requires a workforce strategy accompanied with long term investment and concrete commitments to recruit staff.[24]

The People Plan also fails to address contractual issues required to achieve sustainable working in Emergency Medicine. As Emergency Medicine staff work antisocial hours round-the-clock, two contractual fundamentals need to be addressed. Firstly, annualised self-rostering needs to be implemented as standard across all Emergency Department rotas.[25] Secondly, appropriate weighting and tariffs need to be applied to antisocial hours and public holidays so if staff work antisocial shifts, they work fewer hours in total. This is fundamental to reducing burnout amongst Emergency Department staff.

Elderly and frail patients frequently use Emergency Departments. Given the nature of the relationship between 12-hour performance and delays in transfers of care, we assert that a coherent plan for solving the crisis for social care is more urgent than ever. This must include a plan for integrating health and social care, addressing the workforce crisis, improving the quality of care, and improving the provision of care homes.

Funding for Emergency Department facilities

RCEM welcomed the announcement of £300m to upgrade Emergency Department facilities ahead of winter. This funding will help Emergency Departments to expand capacity and ensure they are physically fit for purpose as we move into the winter months where we have to combat both COVID19 and flu.[26] Although this money will help us as we move into the winter, a multi-year capital plan is still required to expand and physically redesign and rebuild Emergency Departments so they are able to meet demands placed on them. Extra physical capacity will help staff deliver safer care

[23] British Medical Journal (2020). Stress and Burnout warning over COVID-19. Available here.
[24] King's Fund (2020). 'Another interim stop-gap': The King's Fund response to the NHS People Plan 20/21. Available here.
[25] RCEM (2019). EM-POWER: A practical guide to flexible working and good EM rota design. Available here.
[26] RCEM (2020) RCEM response to funding to prepare Emergency Departments this Winter. Available here.

and improve the working environment, but this must also be matched with additional *staffed* bed capacity, which will help Emergency Departments to manage workloads more sustainably.

Recommendations

To tackle and mitigate the causes of workforce stress and burnout, structural changes to urgent and emergency care need to take place. There needs to be sufficient staff in Emergency Departments to deal with rising patient numbers and to deal with surges in demand (including appropriate escalation triggers and actions). A whole systems approach to urgent and emergency care so that sufficient flow and capacity are maintained.

1. Deliver an additional 2,500 WTE Emergency Medicine Consultants by 2025 to address the shortage in the workforce.
2. Increase numbers entering EM training, including at least 50 extra Acute Care Common Stem (ACCS) and 50 extra Higher Specialty Training (HST) posts, to address the deficits in WTE trainees caused by increased flexibility in training in the short term and Consultant shortages in the longer term.
3. Deliver an additional 4,000 WTE Emergency Nurses by 2025 to address the shortage in the workforce.
4. Continue with current recruitment numbers of AHPs and promote the national strategy to support their career development.
5. Increase the staffed acute bed capacity in hospitals to maintain flow in Emergency Departments. Last winter we estimated 5,000 extra staffed beds are needed across the UK to achieve 85% bed occupancy, which allows adequate flow. This will need to increase alongside population growth.
6. The Treasury should introduce a multi-year capital plan to ensure Emergency Departments are maintained and fit-for-purpose or fast tracked for redevelopment to provide 21st century Emergency Care. This must include funding to address the £6 billion maintenance backlog. Ensure clinical and patient involvement in designs for any plans to build or refurbish Emergency Departments.

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