Written evidence submitted by the Royal College of Emergency Medicine (COR0001)

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 A&E 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.

In 2019 over 18 million people attended UK Emergency Departments as increasing numbers are living longer with a complex range of medical needs. This Winter, we showed that over 100,000 patients waited 12 hours or more from arrival to departure in our Emergency Departments[1]. We have consistently called for an end to corridor care and highlighted the impact of crowding on NHS staff and patient safety. Our RCEM CARES campaign, launched earlier this year, provided solutions to address these pressing issues, including increasing staff numbers and restoring bed capacity. The Coronavirus (COVID-19) pandemic illustrates the sheer importance of creating extra capacity in the emergency care system.

There is no doubt that the Coronavirus pandemic poses unprecedented challenges to our health and social care service. The UK Emergency Medicine workforce is well placed to respond to this. However, there is an urgent need to ensure the safety of NHS staff working in Emergency Departments. Testing NHS staff and provision of Personal Protective Equipment (PPE) must be prioritised. Keeping our staff safe is vital part of tackling this global threat. We welcome the Government's commitment to giving the NHS whatever it needs to tackle coronavirus, adequate resources must be deployed to Emergency Departments to ensure they have adequate capacity to meet accelerating demand.

Introduction

On the 11th March Coronavirus was declared a pandemic by the World Health Organisation (WHO). Emergency Departments across the UK were involved in the response to UK cases as early as January. In a very short time Emergency Departments devised plans for testing patients who were concerned, well, or those who displayed mild symptoms, and relevant travel histories. At this time the infection was designated a High Consequences Infectious Disease and so all patients were managed by staff in full Personal Protective Equipment (PPE).

In England it was the 111 service, the ambulance services and Emergency Departments that were immediately nimble enough to mount a scalable response to this problem. There were similar schemes in the other devolved nations. A huge amount of work was done by the emergency services to deliver the testing needed in the delay phase of the UK response. While this has progressed significantly, it helps to explain why frontline staff feel anxious about PPE and testing. They were there at the beginning when well, but positive patients were transferred to specialist units in special ambulances and corridors were cleared to allow them to access their negative pressure room on an isolation ward.

As of 19th March 2020, COVID-19 was no longer considered a High Consequence Infectious Disease. Now whole sections of Emergency Department are designated a 'hot' RED or Respiratory Zone and staff are no longer allowed to be in full PPE. It is not surprising that they are anxious and dismayed that their clinical environment of undifferentiated and now acute unwell patients is not formally considered to be high risk.

As ever, Emergency Medicine teams are rising to the challenge and it is great to see that one of the major calls we have had as a specialty – the end to silo working – is finally happening. The level of joint working,

[1] https://www.rcem.ac.uk/RCEM/News/News_2020/RCEM_launches_new_campaign_to_end_corridor_care_.aspx

mutual respect and support between teams is amazing. Turf wars that have lasted years are being solved in hours. Even the IT system changes are happening quicker.

However, there are some areas of key concerns including PPE, testing, and facilities of departments which will be explored in more detail below.

Personal Protective Equipment (PPE)

There are currently issues around the availability and supply of PPE, and Public Health England's guidance on wearing PPE. RCEM recognises the reality that a significant surge in demand has stressed the supply chain. We are glad to hear that this is being addressed urgently. It is a fundamental responsibility of the Government to protect Health care workers. We are worried that vulnerable patients being managed by social care may not be being protected and may get sick and require admission to the Emergency Department. Shielding does not work for patients who must have carers if those carers are not protected themselves. We are also worried about the variation in PPE available to ambulance crews bringing patients to the Emergency Departments.

The Emergency department is an open space, there are multiple people coming and going, doors open and close constantly. There are already multiple Covid-19 patients in our clinical areas and especially in our Resus rooms. Aerosol Generating Procedures – airway management- must happen in these areas and they are no longer confined to closed spaces.

Few, if any Emergency Departments, can provide appropriate spaces for donning and doffing PPE. If Emergency Departments become overcrowded, then there is a high risk of facilitating onward infection.

Public Health England's guidance on PPE differs from what is recommended by World Health Organisation (WHO). Resuscitation rooms and red areas need to classify as high-risk areas, it is unacceptable that staff are expected to work in these areas with less protection than recommended. Guidance that does not mention Resuscitation rooms and the risk of the undifferentiated patient in the Emergency Department is unhelpful.

We ask that:

- Emergency Department resuscitation rooms and intermediate and high risk COVID-19 respiratory areas to be recognised as high risk clinical areas.
- Staff are encouraged to wear an FFP3 mask at all time in a high risk clinical area and a mask/ face shield/ plastic apron/ gloves combination for any patient encounter.
- This protection is upgraded to include a long-sleeved gown if involved in an AGP
- In low risk Emergency Department areas manging patient with apparently no COVID-19 related problems, staff should wear a surgical mask and maintain COVID-19 levels of hand hygiene
- There is recognition of the need for capacity building in cleaning services so that cubicles can be made safe for the next patient.

Testing staff and patients

RCEM recognises the efforts that are being made to get both more rapid patient testing, staff testing, and eventually population testing. However, capability of inpatient testing is insufficient and there is wide variation around the country both on speed of getting results and where staff can be tested. The result of

this is that Emergency Departments are admitting patients who may have two day wait for a test result. This means Emergency Departments are admitting patients into cohort wards where people with suspected COVID-19 who subsequently test negative are alongside people who test positive. On Wednesday 24th March, the first patient died due to hospital-acquired coronavirus. A rapid result would make it possible to move a patient to a 'positive' or negative ward environment reducing delays in the Emergency Department for either type of bed.

Emergency Medicine staff have responded rapidly and professionally to the growing number of cases of coronavirus. However, despite increased exposure to the virus, priority staff groups are not being tested. The effects of staff absence due to sickness or quarantine is obvious and very difficult for many departments. The ability of workers to stay in hotel accommodation if a household contact becomes symptomatic has been helpful in reducing the quarantine time from 14 to 7 days but this is difficult for staff with families.

Facilities

Many of our existing Emergency Departments are too small, run down and in need of repair. The physical size of hospitals and departments have has not increased with increasing demand. Even before the pandemic most Emergency Departments were stretched beyond the capacity they were designed and resourced to manage at any one time. Our RCEM CARES campaign called for a multi-year capital funding programme to restore Emergency Departments to ensure they are fit-for-purpose.

Our Winter Flow project showed that in the third week of March there was a significant decrease in the number of unplanned attendances at Emergency Departments.[2] As a result of this crowding in the Emergency Department – a problem that has existed in Emergency Departments for several years– is now under control.

Emergency Departments have had to rapidly reconfigure to create capacity and segregation areas. The response in some places has been extra-ordinary. Working with inpatient colleagues Emergency Departments have expanded into new areas and changed the way they work. It is critical that all hospitals understand the need for this in the medium term and notice the improvement inpatient flow so that we keep this in the long term.

Clinical governance

We should be concerned about the governance of sending home patients rapidly with a lesser clinical assessment than we have had before. Several places are developing 'no touch' or 'light touch' triage at the front door.

Capacity

RCEM are heartened to hear that over 12,000 medical personnel have agreed to return to frontline service to combat the pandemic. We appreciate this is a fast-moving area and would like to see some additional information about where the Government plans to place returning staff.

RCEM has frequently highlighted concerns about high bed occupancy levels in hospitals across the UK, and the impact this has on Emergency Department performance and crowding. We welcome the actions taken by the Government and NHS England in securing additional bed capacity. We urge those involved to continue to monitor projection data to ensure that there is extra bed capacity within the emergency care service to deal with sudden spikes in demand.

[2] https://www.rcem.ac.uk/docs/Policy_Winter_Flow/200320_WFP_20_March_2020.pdf

Comment [PK]: I added this section because I thought it would be good to mention some aspects of CARES – feel free to amend/edit if necessary.

Although we've witnessed a significant decrease in the number of patients presenting to Emergency Departments, pressure still exists within the health and social care service. In February 2020, there were 11.5% more calls per day to NHS 111 than the previous year. In the same time period, there was a 91.4% increase in the numbers of abandoned calls to NHS 111. There is demand for these services which has a knock-on effect on Emergency Departments.

We welcomed provisions made in emergency coronavirus legislation to simplify processes to ease discharge of patients from acute hospital settings. We are concerned about the unintended consequences of easing requirements on local authorities to conduct needs assessments on adults who require social care. Although the Secretary of State has emphasised this will only occur in exceptional circumstances, we would like to emphasise that social care plays a valuable role in reducing Emergency Department attendances and admissions.