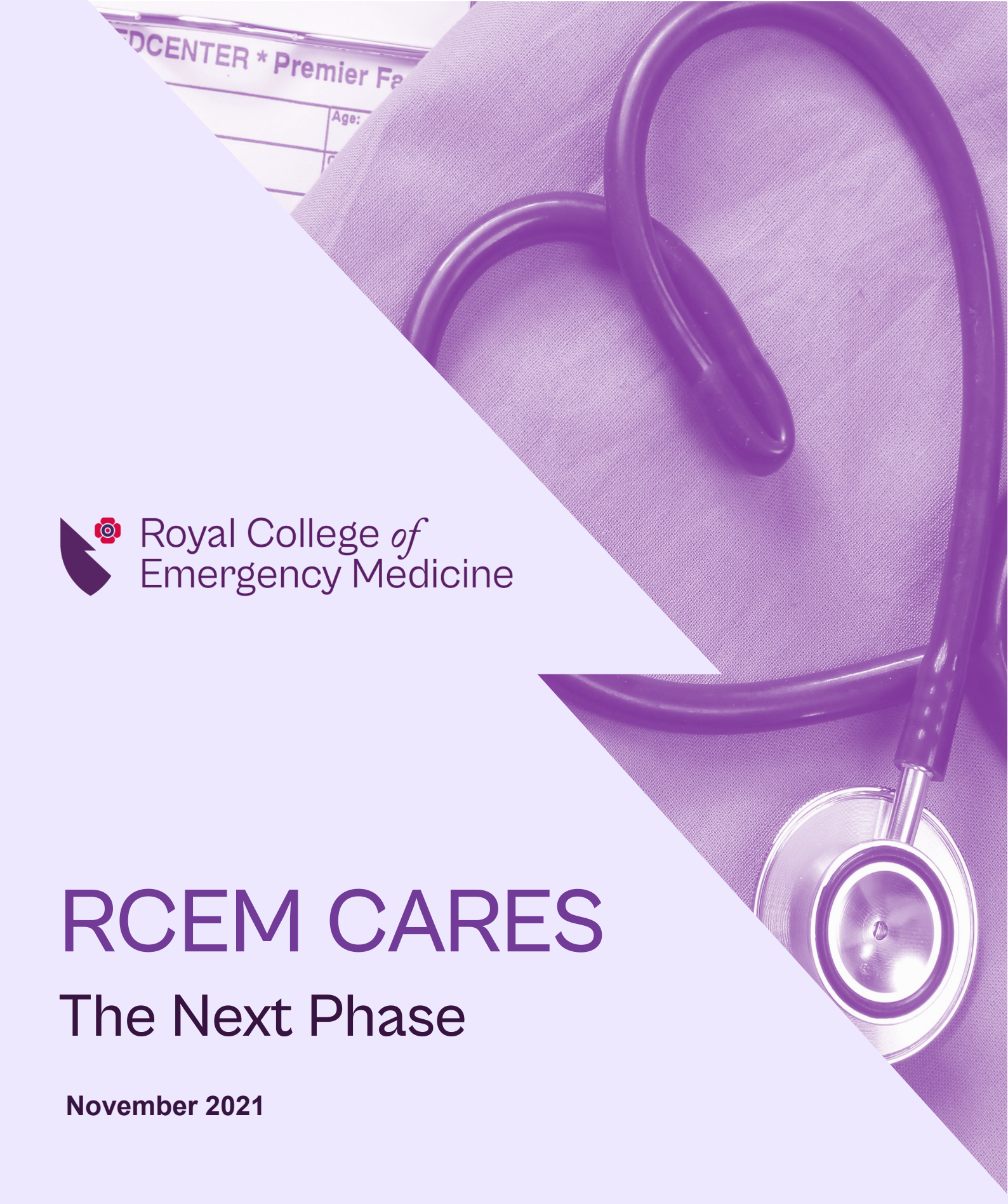

Royal College *of* Emergency Medicine

RCEM CARES

The Next Phase

November 2021

www.rcem.ac.uk

RCEM CARES: The Next Phase

This document outlines the Royal College of Emergency Medicine's (RCEM) system-wide plan to improve patient care. It will inform targeted briefings for other stakeholders such as patient groups, policy makers, governments, senior managers, Trusts and Boards, Emergency Medicine clinical leads, medical directors, heads of nursing, and regulators.

There is a severe mismatch between demand and capacity in the Urgent and Emergency Care (UEC) system. The number of people attending Emergency Departments (EDs) has risen substantially over time. In 2019/20, in the run up to the pandemic, there were over 19 million attendances to type 1 EDs across the UK. This unparalleled level of demand has not been met with sufficient investment into EDs and the wider system. EDs now sustain other parts of the system and are the first port of call for many patients, despite not always being the most appropriate place to receive care. The pandemic has exacerbated many of these challenges – there is now an urgent obligation to plan for the future healthcare needs of the UK and eliminating ED overcrowding must be the number one priority.

Emergency Medicine is the field of medicine that is practised at NHS EDs and is based on:

> "the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioural disorders; it further encompasses an understanding of the development of prehospital and in hospital emergency medical systems and the skills necessary for this development."[1]

The RCEM CARES campaign provides solutions to address these pressing issues so that ED staff can deliver safe and timely care for patients. The campaign focuses on five key areas: **C**rowding, **A**ccess, **R**etention, **E**xperience, and **S**afety.

[1] Definitions of Emergency Medicine by the International Federation For Emergency Medicine. Available here. Funding recommendations made in this document should be assumed to be applicable to the devolved nations according to the Barnett formula, unless otherwise specified.

Crowding

What is the problem?

Crowding is a consequence of exit block. This is usually because an acute hospital does not have enough beds to admit their patients.

Crowding existed long before the coronavirus pandemic and has returned to EDs across the UK. The loss of beds within hospitals is a key contributing factor: since 2010, over 29,000 hospital beds have been removed from the system. The UK has one of the lowest numbers of beds per capita in comparison to OECD nations.[2] Lack of adequate bed stock results in ED crowding and ambulance handover delays.

A lack of adequate social care further impedes patient flow. While medically fit to leave, patients may need help to recover in the form of a social care package, which may not be immediately available. This means that their hospital bed is unavailable to the next patient, resulting in further ED crowding.

Crowding is not only inhumane and undignified for patients; it is also dangerous. Studies show that patient mortality increases when there is ED crowding and long delays to admission. Data in the GIRFT Emergency Medicine report showed an increase in the Standardised Mortality Ratio associated with ED delays beyond 5-6 hours from time of arrival. Their logistic regression model found that of those patients delayed by 8-12 hours in the ED, there was an associated 30-day morality rate for 1 in every 67 patients.[3]

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Capacity

What is the solution?

Governments

- Restore staffed bed capacity to pre-coronavirus levels in order to achieve a desirable ratio of emergency admissions to beds. In the medium term, an additional 7,170 beds are required across the UK.
- Fund adult social care in the four UK nations to meet the needs of an ageing and growing population. Discharge to Assess and Home First models must be maintained and expanded to ensure patients are discharged safely and promptly when their hospital care is complete.
- Report metrics that promote patient flow and prioritise the care of the most seriously ill and injured patients.
    a. Continue to implement metrics which monitor and improve ambulance offload times.
    b. In England, report the metric on 12-hour stays from point of registration. No patient needs to stay in an ED for over 12 hours.
    c. The Scottish Government and NHS Scotland must retain the four-hour standard.
    d. Health and Social Care Northern Ireland must regularly collate and publish data related to delayed transfers of care.
    e. Health and Social Care Wales must standardise and simplify reporting rules around 12 hour stays.

(continued overleaf...)

[2] OECD (2021) Hospital Beds. Available here.
[3] Getting it Right First Time (2021) Emergency Medicine report.

Crowding

What is the problem?

Crowding additionally has an impact on staff morale as ED staff are less able to provide safe, timely and efficient care to their patients, and any subsequent patients who attend the department.

Capacity

What is the solution?

Senior Managers

- Improve clinician involvement with call handling services. Referral rates drop if there is ready access to an experienced clinician, to provide advice.

Trusts and Boards

- Performance standards should be a hospital-wide priority.
- Hospital-wide acute services need to match service availability to patient need throughout the whole week.
- Internal Professional Standards should be negotiated and delivered.
- Ensure patients can be discharged promptly from inpatient wards throughout the week, focussing on improvements in daylight and weekend discharges.
- Agree and evaluate escalation plans during times of overcrowding with the Trust Board.

EM Clinical Leads

- Advocate on behalf of patients on the harms that are caused by crowding.

Resources

- Tackling ED Crowding toolkit
- Essential facts regarding A&E Services
- IFEM Quality Framework

Access

What is the problem?

EDs should be a safety net for the patient, not the safety net for the system.

EDs have a powerful brand for offering round-the-clock care. Many patients go to their ED having tried – and failed – to get timely care and treatment elsewhere. EDs are increasingly providing care for patients who may have been better served elsewhere and Emergency Medicine staff are not trained to care for these patients. Access to care is variable across the health service.

The best and most cost-effective healthcare systems in the world are based on a strong primary care system; patients appreciate timely care, ideally with someone who knows their history. For primary care to be effective, capacity needs to match demand. Deprivation is the single most important factor in determining ED demand: the most deprived communities use ED services significantly more than the least deprived communities. These areas additionally have poor provision of primary and preventative care. This results in EDs sustaining other parts of the health and social care service.

Phone First services have the potential to improve patient experience and reduce crowding in EDs. However, these must be robustly evaluated, with the results and data published in full so we can understand patient behaviour and the impact on ED presentations. This must go hand-in-hand with an increase in clinical validation of these services and an increase in alternative provisions across the UK that services can direct patients to.

(continued overleaf...)

Alternatives

What is the solution?

Governments

- Make funding available to support inpatient teams to enable more effective UEC, including SDEC and AEC. These services improve the quality of care and staff morale, are cost effective, and reduce avoidable admission into hospital.
- Expand primary care across the UK and ensure out-of-hours provision is adequately resourced in areas of need.
- Expand co-located acute services around the ED, including frailty, mental health, pharmacy, and primary care to support patients being cared for in the best place.
- Rapidly expand SDEC and AEC provision so it is available 12 hours a day, seven days a week with the same access to diagnostic services as EDs.

NHS management

- Phone First services should evaluate their programmes and monitor the proportions of disposition codes to the ambulance service and ED. Equality of access to appropriate healthcare should be at the heart of this.
- Where appropriate, SDEC and AEC should be provided seven days a week and should be seen as one way that almost all specialties can deliver care.
- Ensure EM doctors work closely with inpatient colleagues to agree the case mix suitable for referral to SDEC and AEC units.

(continued overleaf...)

Access

What is the problem?

Patients should only attend hospital when it is essential, or when the clinical value outweighs the risk. Progress must be made in adopting a consistent, expanded model of Same Day Emergency Care (SDEC) and Ambulatory Emergency Care (AEC), which are available twelve hours a day, seven days a week.

Alternatives

What is the solution?

Medical Directors

- Ensure that patients who develop complications of specialist care can get expert advice and support in a timely manner from their specialist team.
- Ensure that there are reliable pathways so patients who are vulnerable to infection can avoid long waits in crowded EDs.[4]
- Ensure that job planning makes it possible for inpatient teams to deliver SDEC and AEC and for doctors to work closely with colleagues to agree the case mix suitable for referral to these units.
- Ensure that all specialities engage effectively with SDEC and AEC and the direct provision of specialist input into emergency care seven days a week.
- Ensure SDEC Units do not turn into secondary wards during busy periods.

[4] RCEM (2021) ED Infection Prevention and Control during the Coronavirus Pandemic. Available here.

Retention

What is the problem?

The NHS is struggling to cope with a workforce crisis and there is an urgent need to improve retention of staff working in EDs.

EDs went into the pandemic understaffed. Understaffing means our workforce suffers from burnout – more so than other specialties – leading to many staff leaving the specialty. Due to the intensity of the working environment, staff are now choosing to work less than full time. This creates a sustainable career but creates additional workforce demands.

The pandemic placed enormous amounts of pressure on Emergency Medicine staff. The second wave was particularly challenging, with its peak coinciding with the height of winter pressures. As we emerge from the pandemic, EDs continue to face unprecedented levels of demand. Our workforce survey carried out in May 2021 found that three quarters of respondents (74%) have considered changing their working patterns, with half (50%) indicating they are planning on reducing their working hours in the next two years.[5] This poses significant challenges for the functioning of our NHS – a challenge that needs to be tackled urgently by policymakers.

Additionally, workforce models are predicated on insufficient numbers of trained clinicians – who are expected to deliver safe care – whilst quality assuring the actions of staff in training. Trainee staff form the majority of any ED workforce and are also expected to deliver quality assured care.

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Retain

What is the solution?

Governments

- Act now to achieve safe staffing levels in EDs:
  - At present, there is a shortfall of 2,000-2,500 Whole Time Equivalent consultants in the UK.
  - In Scotland, account for the findings of RCEM's workforce census in the Shape of Training Transitions Group expansion review 2022.
  - There must be an accompanying increase in ED nurses, AHPs and SAS doctors, and the faculty to train them.
- Deliver additional ED Nurses to address the shortage in the workforce. The skill mix of the ED Nursing workforce should comprise of: 30% Emergency Charge Nurses, 40% Emergency Nurses, 10% Foundation Staff Nurses, 20% Nursing Associates or Clinical Support Workers.[6]
- Continue with current recruitment numbers of AHPs and promote the national strategy to support their career development.
- Fund a nationally coordinated programme of ethical international recruitment for Emergency Medicine nurses & doctors, focussing on attracting clinicians from nations with comparable training and health systems.

NHS Management

- Ensure patients are treated by staff who are trained in Emergency Medicine.
- Ensure job planning at all levels highlights sustainability as being paramount to workforce retention by facilitating flexible

[5] RCEM (2021) Retain, Recruit, Recover: Our Call for Action to Improve the UEC system. Available here.
[6] RCEM & RCN (2020) Nursing workforce standards for Type 1 EDs. October 2020.

Retention

What is the problem?

We recognise that Black, Asian, and minority ethnic staff have very different experiences of the NHS across the UK as a workplace. We urge NHS leaders to create an inclusive and equitable organisational culture and work to address incivility and bullying that exists in the NHS.

RCEM's RespectED campaign – developed in line with Civility Saves Lives – aims to raise awareness of incivility and bullying between colleagues. The campaign is a call to action to ask ED staff to address their own behaviours and proactively tackle bullying and incivility in EDs.

Consultant Staff
The changes in pension taxation in 2019 resulted in experienced Consultants reducing their working hours causing rota gaps. Future pension reforms must avoid these perverse incentives.

Staff and Associate Specialist and Specialty (SAS) Doctors
This important staff group needs sustainable career development as set out in the BMA SAS Charter[7].

Trainees
Recent initiatives increasing flexibility in training have decreased resignation from training rates but have also reduced the overall WTE workforce. Less than 50% of trainees completing training are directly taking up Consultant posts. We have improved training but not Consultant working.

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Retain

What is the solution?

working and the inclusion of all essential activities to an appropriate level within remunerated working. For example, education delivery and planning, clinical leadership, quality improvement, governance activity, and participation in Royal College activities.

- Develop and support effective multidisciplinary team working across the healthcare service.
- Create a workplace environment that values staff wellbeing and respects staff member's work-life balance.
- Proactively address bullying and incivility within and across all specialties in every Trust.
- Improve the experiences of Emergency Medicine staff from Black, Asian, and minority ethnic backgrounds and take urgent action on closing the disciplinary gap.
- Implement up-to-date policies around bullying and harassment, work-life balance, physical and mental wellbeing, and equality and inclusion.
- Increase flexibility for all staff who want to work less than full time or acquire experience outside a training program.

Medical Directors and Heads of Nursing

- Understand and support the continuous professional development needs of Trainees, Consultants, SAS Doctors and AHPs.
- Collaborate with clinicians to review workload in organisations to use resources in the most efficient way, to ensure workloads do not exceed clinicians' ability and capacity to deliver safe, high-quality care.

[7] BMA (2014) A charter for staff and associate specialist and speciality doctors. Available here:

Retention

What is the problem?

Allied Health Professional Roles (AHP)
AHP roles include but are not limited to the following: Emergency Care Advanced Clinical Practitioners (EC ACP), 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.

Nurses
Nursing staff play an essential role in maintaining patient flow in hospitals. The shortage of nursing staff across the four nations must be urgently addressed.

The flexibility that has been built into medical training must be made available to all staff delivering care in EDs.

Retain

What is the solution?

- Ensure Trusts adopt the GMC recommendations of 'ABC of Core Needs' for ensuring the autonomy of clinicians.

EM Clinical Leads

- Encourage staff in departments to undertake the Freedom to Speak Up (FTSU) Guardian training.
- Ensure annualised self-rostering to allow flexibility and control for clinicians.
- Develop a broader workforce that supports SAS doctors, AHPs and Physician Associates. They should be afforded enough support and development opportunities.
- Promote techniques and resources listed in the RCEM EMPower series.
- Staff at high risk of serious illness from infection should be supported and acknowledged in delivering useful tasks for their employers.

Resources

- **NHS & RCEM (2017) Securing the Future workforce for EDs in England**

Experience

What is the problem?

Patient experience should be at the heart of any world class health and social care system.

In England, the CQC survey shows that patient experience in EDs is overall "very good" with many patients expressing confidence and trust in the doctors and nurses examining and treating them.[8] However, there is certainly room for improvement in the patients' overall experience when attending an ED. Many of our existing EDs are too small, run down, and in need of repair. With rising attendances and admissions, the physical size of many hospitals and EDs have not increased. Most are now stretched beyond the capacity they were initially designed and resourced to manage. This is a poor environment for patients, especially for the frail and vulnerable.

Addressing the estates backlog must take priority over building new hospitals. Although the £5.9 billion capital funding announced by the Treasury is welcome, NHS England is facing a £9.2 billion estates backlog.[9] Similarly, in Scotland, while many EDs are in good condition, additional funding is required to physically expand EDs, so they are able to meet demands placed on them.

Any new rebuild must take on the principles of the Smart ED, which is sustainable and supports a positive patient and staff experience. The GIRFT report identified 28 EDs that require a complete rebuild or redevelopment in order to function adequately at their current level of demand. A third of EDs are too small to manage their current workloads effectively.[10]

We acknowledge that different patients experience care offered in EDs in different ways. Patients who are suffering a mental health crisis often report having a poor experience, with long waits in an environment that is stressful and stigmatising.

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Effect

What is the solution?

Governments

- Publish a new, actionable long-term health and social care strategy to enable the delivery of high quality UEC.
- Introduce a multi-year capital plan to ensure EDs across the UK are maintained and fit-for-purpose.
- Invest in facilities to meet the physiological needs of both staff and patients - this includes ensuring there is adequate access to rest facilities, space to carry out non-clinical work, and hot food available 24 hours a day, seven days a week.
- Consider a co-located service model in any new build hospital.
- Ensure any new builds for EDs follow the guidance in Health Building note 15-01 and take on the principles of the Smart ED.
- Develop a meaningful quality indicator for patient experience by working closely with RCEM's Lay Group and patient groups.
- Increase investment in mental health services, including alternative mental health facilities, Child and Adolescent Mental Health Services, and preventative services.
- Introduce a cross-government strategy to tackle health inequalities.

Regulators

- Use RCEM's ED Care Guide to ensure EDs are providing a quality service to patients.

NHS Management

- Ensure that the built environment of the ED complies with national guidance.

[8] CQC (2021) Urgent and Emergency Care Survey. Available here.
[9] NHS Digital (2021) Estates Return Information Collection (ERIC) 2019/20. Data Quality Report 2020. Available here.
[10] Healthcare Design and Management (2021) Cambridge A&E doctor among those shortlisted for hospital design prize. Available here.

Experience

What is the problem?

The post-pandemic world will look very different, presenting us with a new set of health challenges. A coherent and joined up vision for the future is required, that considers the health of the nation and of the healthcare service. This must include a plan to end crowding and the need to provide care for patients in a safe environment. To do this, we need to stop allowing our EDs to become overwhelmed and consign winter crises to the past. This requires long term solutions and greater coordination across the whole health and social care system.

Effect

What is the solution?

- Use patient experience quality indicators to inform changes in practice.

EM Clinical Leads

- In England, additional capital funding should be spent in organisations to improve Infection Prevention and Control.
- Implement RCEM's Patient Care in the ED guideline.
- Ensure waiting times are displayed.
- Ensure pain is promptly assessed and relieved.
- Ensure that staff are trained to respond compassionately and appropriately to people suffering a mental health crisis.

Resources

- **Friends and Family Test Data**
- **RCEM ED Care Standards Checklist**

Safety

What is the problem?

EDs must become safer places to look after ill and injured people.

Overcrowding and challenging working conditions can result in an environment where errors are more likely to happen. In England, over half of EDs 'require improvement' or were 'inadequate' in regard to safety. This is associated with expensive and potentially avoidable litigation. Emergency Medicine now accounts for the highest volume of NHS litigation liabilities. In 2019/20 it accounted for 12% of all claims against NHS trusts. The average liability per ED attendance is £19.39.[11] The new Health and Social Care Levy is expected to raise £12bn extra spending a year on health and social care services across the UK. There is a risk that this will fall short of what is needed to facilitate recovery in the health and social care system.

In June 2020, RCEM joined the Medical Royal College community to call for a rapid forward-looking review of the UK preparedness for a second wave of COVID-19. The upcoming public inquiry into the management of the coronavirus pandemic must examine the reasons why the UEC system was ill equipped to meet demand, along with the performance of the UEC system, to enable lessons to be learned for future pandemics.

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Systems

What is the solution?

Governments

- Increase NHS multiyear funding to recover the healthcare service. As modelled by the Health Foundation, the budget should increase by an average of 3.5% per year in real terms by 2030/31. This equates to £72bn in additional annual funding in 2030/31 compared to 2018/19.[12]
- Ensure that the upcoming public inquiry examines the resilience and capacity of the UEC system in the run up to the pandemic, as well as the performance of the system, to enable lessons to be learned for the future.
- Ensure that there is adequate capacity for COVID-19 testing for ED staff (and their households), with short turnaround times that allow quick and safe return to work.[13]

NHS England and devolved equivalents

- There is an urgent need for robust coordination of safety information produced by the new HSSIB, Coroner Prevention of Future Deaths reports, NHS Resolution, National Reporting and Learning Service (NRLS), NICE, and alerts currently available on the Central Alerting System.

Regulators

- Regularly disseminate examples of good practice occurring in EDs to support quality improvement.
- Use the RCEM Best Practice Guideline on 'Infection Prevention and Control (IPC) during the Coronavirus Pandemic' to inform inspections.[14]

[11] Getting it Right First Time (2021) Emergency Medicine report.
[12] Health Foundation (2021) Over a million more health and care staff needed in the next decade. Available here.
[13] ITV News (2020) Coronavirus test priority list revealed. Available here.
[14] RCEM (2020) COVID Infection Prevention and Control Guidelines. Available here.

Safety

What is the problem?

EDs face considerable challenges ahead. The scale of the elective backlog poses additional demand on EDs as patients may present with emergencies from delayed or cancelled procedures. With covid-19 now endemic in the population, the resurgence of flu and RSV pose additional challenges to providing emergency care. We need to ensure that EDs can safely manage undifferentiated patients whilst providing emergency care. Timely access to testing will help to support fragile rotas and avoid severe workforce shortages during seasonal pressures.

Systems

What is the solution?

NHS Management

- Implement RCEM's Safety Toolkit and ED 'Infection Prevention and Control (IPC) during the Coronavirus Pandemic' Best Practice Guidelines.
- Review whistleblowing procedures and ensure protection for whistle-blowers.
- Promote electronic patient records that integrate multiple systems efficiently, easily, and support clinical care.

EM Clinical Leads

- Promote a safety culture and embed the principles of the updated Patient FIRST guidance in EDs.[15]
- Ensure there are robust systems that guarantee the most ill and injured patients are quickly treated and deteriorating patients are quickly identified.
- Ensure that staff understand the rules about getting tested and self-isolating.
- Ensure that there are adequate supplies of PPE and that all staff are properly trained to use PPE.

Resources

- **Friends and Family Test Data**
- **Under pressure: Safely managing increased demand in EDs (CQC)**
- **RCEM Safer Care Toolkit**

[15] CQC (2021) Project reset in emergency medicine – Patient FIRST. Available here. RCEM Learning (2016) The Safety Toolkit. Available here