

The Royal College of
Emergency Medicine

RETAIN, RECRUIT, RECOVER

OUR CALL FOR ACTION TO IMPROVE THE
URGENT & EMERGENCY CARE SYSTEM



July 2020

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EXECUTIVE SUMMARY

Staff choose to work in Emergency Medicine because it is an exciting, rewarding, and varied specialty. Working in a high-stakes and high-pressured environment, where decisions are a matter of life and death, means our workforce are exceptionally resilient and adaptable. However, escalating demand and complexity of presentations coupled with the lack of investment into the NHS over the past decade has resulted in busy and crowded Emergency Departments (EDs). Not only has this resulted in unsustainable workloads for our staff but it is also inhumane and undignified for patients. In these conditions, staff are less able to provide safe, timely and efficient care to patients. Our workforce survey¹ revealed:

- 73% of respondents indicated that workforce pressures in their EDs impacted patient safety before the pandemic.
- 59% of respondents experienced burnout during the second wave of the pandemic.
- 59% described their levels of stress and exhaustion from having worked the second wave as higher than normal.
- In the next two years, 50% are considering reducing their working hours and 26% are considering taking a career break or sabbatical. When asked what prompted them to make this decision, 32% selected workload pressures and 35% selected burnout.
- In the next six years, trainee emergency physicians are considering reducing working hours (57%), taking a career break or sabbatical (45%), working abroad (36%), and changing specialty (25%).
- 69% of Clinical Leads revealed that locums were being used in their ED to fill permanent posts.

Our report found that operational pressures, patient safety and staff wellbeing are intrinsically linked. The acute pressures that have been building over the past decade have had detrimental consequences on our workforce and our patients, resulting in staff considering reducing hours, changing careers or retiring early. ED staff are working extremely hard just to meet current levels of demand. This has become the expectation over the past few years and if left it could have destabilising consequences for the NHS and the patients we care for. While we understand there are no easy fixes, there is an urgent need to act now. Only by tackling the root causes of poor retention and improving the staffing of our EDs can we facilitate recovery from the mounting pressures of the past decade.

The post-pandemic world will look very different, presenting us with a new set of health challenges. We need a coherent and joined up vision for the future that considers both the health of the nation and the healthcare service. Our staff insist on an end to corridor care 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. Staffing is at the heart of this issues: we cannot rise to this challenge without a sufficient number of appropriately trained, happy, healthy and well supported doctors, nurses, and clinicians working in our EDs.

¹ Please see Annex 1 for survey methodology

RECOMMENDATIONS

Operational pressures are seen by staff as the most significant reason for considering reducing hours, changing careers or retiring early. We cannot deliver safe care in Emergency Departments without making the job sustainable. The following recommendations will help support the retention of ED staff and improve patient care.

1. Governments must 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. Expansion of the workforce is needed to ensure patients are treated by staff who are trained in Emergency Medicine. This must also include an accompanying increase in Allied Health Professionals, SAS doctors, Emergency Nurses and the faculty to train them.
2. Across the UK, make funding available to support inpatient teams to enable more effective Urgent and Emergency Care, including Same Day Emergency Care and Ambulatory Emergency Care. These services improve the quality of care and staff morale, are cost effective, and reduce avoidable admission into hospital.
3. Previous long term health strategies are now redundant given the disruption to the healthcare system caused by the pandemic. A new, actionable, long term health and social care strategy is now required in all four nations to enable the delivery of high quality Urgent and Emergency Care.
4. Governments must immediately prepare and manage adequate capacity in order to minimise the harm to patients and staff caused by ED crowding and exit block. This will reduce the risk of emergency demand derailing the elective recovery and improve the working conditions of staff in EDs. Ahead of Winter, this must include but is not limited to:
 - a. Making funding available to local health systems to maintain or expand discharge to assess services so they are available all year round.
 - b. Expanding clinical validation of Phone First services to ensure patients receive care in the best setting based on their needs. These services are only effective if there are adequate levels of clinical involvement.

INTRODUCTION

Emergency Departments represent one of the most intense working environments in the NHS. Increasing demand and high bed occupancy leading to exit block have resulted in crowded departments. The demanding nature of this setting is a frequent cause of staff dissatisfaction, attrition, and career burnout. The pandemic has exacerbated many of these challenges – there is now an urgent obligation to plan for the future healthcare needs of the UK. Through our workforce survey we spoke directly to our members. They have been on the frontline of the NHS throughout the pandemic and are best placed to understand the challenges they are facing in carrying out their roles as Emergency Medicine clinicians.

Through this report we examine what current working patterns look like for staff in the wake of the second wave of the pandemic coinciding with a challenging winter. The report then examines the impact this has had on staff in terms of their mental health and wellbeing, and the implications on the future workforce. Centring the solutions on the people who know the ED environment best, we focus on what can be done to improve retention.²

The key theme emerging from our study was the intrinsic link between operational pressures and staff wellbeing. Emergency Medicine clinicians have increasingly been forced to do more with less. Capacity has not matched demand for many years, and it is often left to the discretionary efforts of staff to provide safe and effective care. This is not acceptable or sustainable.

WORKFORCE PRESSURES BEFORE AND DURING THE PANDEMIC

- The increase in ED demand outpaced the growth in the number of Emergency Medicine consultants.
- Burnout rates were highest before the pandemic, during winter 2019/20.
- 73% of our survey respondents indicated workforce pressures in their EDs had an impact on patient safety before the pandemic.

When coronavirus struck the UK, Emergency Medicine staff were operating in understaffed and under-resourced departments. As illustrated in Table 1 below, the number of attendances is increasing every year, yet the physical size of hospitals has not increased accordingly. Most EDs have been stretched beyond the capacity for which they were designed and resourced to manage at any one time. As a result of this, crowding and corridor care have become common practice in our EDs. This is distressing and stressful for both patients and staff. Studies show that this environment is linked with lower quality of care for patients and increased mortality, with elderly and vulnerable patients most affected.³ This intense working environment puts a huge amount of strain on staff which can result in attrition from the specialty.

Additionally, ED workforce models are predicated on insufficient numbers of trained Emergency Medicine 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 numerically and are expected to be delivering quality assured care in the same episode. Added to this is the churn of learners through EDs and increasing the service delivery, supervision and teaching responsibilities on the existing number of trained clinicians.

The table below shows that despite the number of Emergency Medicine consultants increasing at a constant rate, the expansion in consultant numbers is still not enough happening fast

² It is important to mention that there is a rich mix of staff members that work in EDs. Details on staffing types in the ED can be found in Annex 2.

³ The Guardian (2019) Thousands of patients die waiting for beds in hospitals – study. Available [here](#) and Morley et al (2018) Emergency department crowding: A systematic review of causes, consequences and solutions. Available [here](#).

enough to cope with the level of demand growth. This results in continued understaffing in departments. Understaffing means the Emergency Medicine workforce consistently reports the highest levels of work intensity of all the medical specialties.⁴ This leads to high levels of attrition from training and the specialty. RCEM has previously stated that to staff EDs safely, we should aim for a ratio of 1 Whole Time Equivalent (WTE) consultant per 4,000 annual attendances. Table 1 shows we are nowhere near 8to achieving that in England, Scotland, or Wales.⁵

Table 1: Attendance and WTE Consultant ratios in England

	Year	Average Number of WTE Consultants	Attendances at Type 1 EDs	Attendances per Consultant	Additional WTE consultants currently required to safely staff EDs
England	2016/17	1,601	15,262,758	9,533	2,012
	2017/18	1,706	15,372,467	9,010	
	2018/19	1,824	15,679,999	8,597	
	2019/20	1,941	15,810,616	8,145	
Scotland	2016/17	215	1,329,488	6,183	113
	2017/18	222	1,352,331	6,091	
	2018/19	228.5	1,393,238	6,097	
	2019/20	236.5	1,398,441	5,913	
Wales	2016/17	65	787,587	12,116	100
	2017/18	75	809,127	10,788	
	2018/19	77	825,507	10,720	
	2019/20	84	735,902	8,760	

The attendance and consultant numbers must be considered in relation to the impact on patient care. 73% of our survey respondents indicated workforce pressures in their EDs had an impact on patient safety before the pandemic. We asked 16% of respondents who selected no, why patient safety was not impacted by workforce pressures and 28% expressed that it was down to the discretionary efforts of staff. This not only confirms that the workforce crisis facing the specialty existed before the pandemic but also demonstrates the importance of safe staffing in EDs.

THE RUN UP TO THE PANDEMIC

Winter 2019/20 was the worst winter on record in terms of ED performance, with a record high number of attendances and admissions. Graph 1 reveals the number of patients staying more than 12 hours in an ED after time of arrival (ToA) in the devolved nations, and from the decision to admit (DTA) the patient in England. It is important to note that the figures for England are extremely misleading and represents only the tip of the iceberg as they do not publish total time spent in the ED. Nevertheless, the data shows record numbers of patients delayed in the

⁴ This was well evidenced 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 49.9% and 46.8% average respectively across all specialties). General Medical Council (2020) National Training Survey 2019: Initial Findings Report. Available [here](#).

⁵ Unfortunately, the Department of Health in Northern Ireland does not publish consultant workforce numbers by specialty, but we can reasonably assume that Northern Ireland follows a similar trend.

ED. Crowding and corridor care reached unprecedented levels and Emergency Medicine staff worked tirelessly throughout Winter 2019/20 to provide safe and timely care.

In October 2019, two thirds of English EDs were rated as 'inadequate' or 'needs improvement' in the domain of Patient Safety by the CQC, and NHS Resolution data shows that Emergency Medicine has the highest number of litigation claims of any single specialty.⁶ It was against this backdrop that Emergency Medicine staff entered the pandemic.

Graph 1: 12 Hour ToA Devolved Nations & 12 hour DTA England



THE FIRST WAVE

As the first wave of covid struck the nations of the UK, EDs were resilient enough to mount a scalable response to the pandemic. To cope with undifferentiated patients presenting to departments, EDs were rapidly reconfigured into streams to separate patients more likely to have COVID-19 from those less likely. EDs expanded into new areas of the hospital, changing the way that staff worked. There was a transformation in cross-specialty working, with an “all hands-on deck” approach, and what had previously seemed like an impossibility was achieved overnight. Inter-specialty communication and camaraderie meant that tackling healthcare pressures was no longer a siloed task. This created an environment in which staff felt able to do their job: caring for patients safely and efficiently.

Overall, during this time attendances to EDs fell by 51%.⁷ Although the large reduction in activity was uniform across the country, it varied by age, ethnicity, arrival mode and diagnostic group, but not by sex, deprivation, urbanicity or acuity.⁸ Staff had to grapple with challenges such as personal protective equipment (PPE) shortages, absences due to illness and self-isolation, as well as losing colleagues, friends and family to coronavirus. This further exacerbated conditions for many who had to work long hours in uncomfortable, hot, and restrictive PPE. Uncertainty about access to adequate protection, lack of testing for staff, and inconsistency surrounding PPE guidance meant that staff were often putting themselves at increased risk. Some clinicians had to 'shield' themselves or vulnerable family members from the risk of catching coronavirus. These challenges were felt differentially across our membership and understandably had an impact on wellbeing. The RCEM member's survey

⁶ NHS Resolution (2020) Annual Reports and Account 2019/20. Available [here](#).

⁷ Strategy Unit (2020) Strategy Unit analysis published showing changes in use of emergency departments under lockdown. Available [here](#).

⁸ Wyatt et al (2021) Impact of the SARS-CoV-2 pandemic and associated lockdown measures on attendances at emergency departments in English hospitals: A retrospective database study. Available [here](#).

conducted in May 2020 revealed that half of respondents felt their mental health had worsened due to the first wave of the pandemic.

When asked about burnout during the different phases of the pandemic our members expressed that they experienced the lowest rate of burnout during the first wave (33%) with highest rates during the second (59%). This was higher than burnout rates of 45%, reported just before the pandemic in winter 2019/20. The first wave of the pandemic uniquely demonstrates that operational issues largely disappear when EDs can keep pace with demand, making the workload of an Emergency Medicine clinician manageable.

There were disparities in experiences of the pandemic across our membership. Survey findings reveal that while burnout rates amongst White members improved during the first wave, decreasing from 46% in Winter 2019 to 28%, they doubled for Black respondents, from 16% to 32% in the same timeframe. 50% of Asian respondents reported experiencing burnout in this time, an increase from 46% during winter 2019 and a considerable 27 percentage points higher than the average rate for all groups (33%) during the first wave. These disparities are potentially explained by the PPE shortages experienced during the first wave that disproportionately affected Black, Asian, and minority ethnic staff. We explored this issue in detail in our report examining PPE, ethnic minorities, and occupational risk in EDs.⁹

THE SECOND WAVE

The second wave of the pandemic was particularly challenging for ED staff, as its peak coincided with the height of 2020/21 winter pressures. Important infection prevention and control (IPC) measures, as well as a lack of adequate staffing, contributed to a loss of 10,000 inpatient beds by September 2020. This seriously impeded patient flow through the hospital during a time of increasing hospital admissions. As Graph 1 shows how, in England, this resulted in record high numbers of patients waiting 12-hours or more from 'decision to admit', as crowding not only returned to pre-pandemic levels but surpassed them.

These challenges introduced significant staffing pressures into a service that was already understaffed. This was compounded by increased staff sickness and absence due to self-isolation, which continued to stress fragile rotas. Our Winter Flow Project revealed that the number of shifts missed due to sickness and self-isolation increased by 77% from the first week of December 2020 to the first week of January 2021.¹⁰

WHERE ARE WE NOW?

Staff working in EDs have emerged from the most difficult winter the NHS has ever faced. Despite this, at the time of writing EDs continue to face almost unprecedented levels of demand. Performance figures for May 2021 revealed the second highest number of attendances on record, with a third of patients requiring admission to hospital. EDs are now caring for patients with increasingly complex conditions from long covid, delayed or cancelled operations, and delayed access to health services during lockdown. Moreover, capacity pressures can be felt even more acutely due to the continuing IPC measures that have resulted in fewer beds in the system.

Our workforce survey found that three quarters of respondents (74%) expressed that they have considered changing their working patterns, with half (50%) indicating they are planning on reducing their working hours in the next two years. This poses significant challenges for the functioning of our NHS – a challenge that needs to be tackled urgently by policymakers.

⁹ RCEM (2021) PPE, Ethnic Minorities and Occupational Risk in EDs during the Pandemic. Available [here](#).

¹⁰ RCEM (2021) Winter Flow Project 2020/21. Available [here](#).

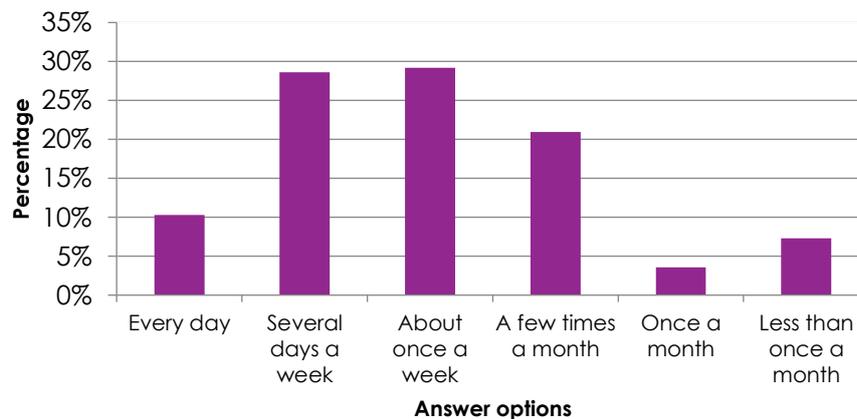
WHAT DO CURRENT WORKING PATTERNS LOOK LIKE?

- 76% of Clinical Leads expressed that CPD time has been fully reinstated.
- 42% of respondents indicated that since the start of the pandemic, they are working beyond their regular hours more often.
- 41% of ED staff did not take their full entitlement of annual leave during 2020.

Continuing professional development (CPD) is essential for all clinicians working in the ED. The pandemic presented many challenges for staff in terms of CPD, with many having this time stopped or reduced. The majority (76%) of Clinical Leads expressed that time for CPD has now been fully reinstated by their Trust. Only 11% indicated it has been partly reinstated and 4% indicated it has not been reinstated. Although these are relatively small numbers, these findings would affect all staff working within these Trusts. CPD is important and valuable to all, especially for trainees and SAS doctors. All Trusts must fully reinstate CPD time for all grades of clinician working in the ED.

Our study asked members how often they have found themselves working beyond their regular hours before and during the pandemic. Graph 2 below shows that before the pandemic, our members were regularly working beyond their regular hours. Since the start of the pandemic 42% expressed they were working beyond their regular hours, and 44% expressed they were working the same as before.

Graph 2: Before the pandemic, how often did you find yourself working beyond your regular hours?



We asked Clinical Leads if they had annualised self-rostering in their EDs for three different grades: consultants, trainees, and SAS doctors. We know that annualised self-rostering can be sustainable, giving clinicians working in EDs a sense of ownership, and empowerment for trainees and SAS doctors. Only half of Clinical Leads reported that annualised self-rostering was available for consultants and just under a third reported that this method of calculating shift patterns was available for trainees and SAS doctors. This is a concerning disparity as trainees and SAS doctors make up a significant proportion of the EM workforce. SAS doctors are an important staff group in the ED, and it is well evidenced that this staff group suffers from poor retention as they often work unsociable hours with job plans that have little to no room for CPD.

Table 2: Annualised self-rostering in EDs by Grade

	Yes	No
Consultants	51%	49%
Trainees	31%	69%
SAS Doctors	32%	68%

When we asked our members what could be done to improve wellbeing at work, rotas were mentioned 67 times, particularly in relation to junior doctors and trainees. Shift patterns and taking sufficient breaks are crucial to creating sustainable careers. Despite this, only three fifths (59%) of respondents took their full entitlement of annual leave in 2020/21. Many indicated that it would have felt morally wrong to take leave during the pandemic because of the mounting workforce pressures and instead opted to roll over the days until this year. This suggests staff are compromising their rest and wellbeing in order to care for patients. Analysing this further, only 32% of Black respondents took their full entitlement of leave, compared to 47% of Asian members and 62% of White members. This is consistent with our finding of racialised patterns of occupational risk for ethnic minority staff during the pandemic.

While the current threat of covid in hospitals is not as high as in 2020, pressures in EDs have not gone away. The post-pandemic context has very quickly changed into a rise in regular demand, with high numbers of long delays in all four nations. With the ever-present threat of a third wave, demand soaring, a depleted bed stock, and the worst NHS backlog in history, the Urgent and Emergency Care system needs to be armoured for the coming winter. Those on the ground often have an acute understanding of what their EDs need at a local level. We must listen to them if we are to facilitate their recovery but also promote their retention and allow them to deliver safe, high-quality care to patients.

OVERRELIANCE ON LOCUMS

There has been a historic overreliance on locum ED staff as a way of addressing the shortages in the workforce. 69% of Clinical Leads expressed that locum staff were being used to fill permanent posts.

- Over the course of the second wave, locums were used very often to cover both the Higher Specialist Trainee/non-consultant senior decision maker Rota and the junior doctor rotas.
- 20% of Clinical Leads expressed they are not able to comply with the BMA Junior Doctor Contract that stipulates a weekend frequency of no more than 1 in 3.
- Over half (56%) expressed they could only comply with an increase in locum staff.

It is well evidenced that the use of locum, bank and agency staff is a costly and inefficient way of plugging the workforce shortages. An NHS Benchmarking report published in 2019 found that 21% of ED consultant expenditure is on locums – approximately £56 million per year and 27% of total ED workforce expenditure pays for locum, bank, and agency staff – a cost of £523 million a year.¹¹ This historic overreliance on locum staff is financially unsustainable for the NHS and must be tackled through a workforce strategy aimed at growing numbers of clinical staff working in EDs.

¹¹ NHS Benchmarking (2019) Emergency Department Workforce Benchmarking. Available [here](#).

IMPLICATIONS FOR STAFF WELLBEING

- 59% of respondents experienced burnout during the second wave of the pandemic.
- 82% of respondents indicated that their workload affected their ability to function at work.
- 44% of respondents experienced moral injury during the second wave of the pandemic.

Given the pressures placed on EDs over the past few years and the disruption caused by the pandemic, it is no surprise that ED staff are more burnt-out, demoralised and feeling less valued than ever. There have been numerous research studies showing the impact of burnout on doctors worldwide; notably studies show that burnout amongst doctors can lead to self-reported suboptimal care and medical errors.¹² Furthermore, while burnout takes place on an individual level, it can have implications for the wider workforce as it is considered to be 'contagious' and subsequently creates an environment where levels of morale sink.¹³ Morale is generally described as a sense of well-being that comes from confidence, usefulness, and purpose – sentiments that are valuable to have when working in Emergency Medicine. 39% of respondents reported low or very low levels of morale among their colleagues before the pandemic. The rate of low morale has risen considerably since then with 67% of respondents currently reporting low or very low levels of morale among their colleagues. Good morale is important for a healthy productive workforce and is central to ensuring the NHS can provide safe and high-quality care to patients.

Due to the intensity of the specialty and the requirement to work unsociable hours, workload pressures can have a significant impact on the wellbeing of staff. The majority of our members who responded to the survey reported that workload affected their ability to function at work (82%), maintain healthy relationships (72%), maintain good physical health (76%), and maintain good mental wellbeing (83%). Additionally, 59% described their level of stress and exhaustion from having worked the second wave as being higher than normal.

44% of respondents told us that they had experienced moral injury during the second wave of the pandemic. Moral injury is defined as the profound psychological distress which results from actions, or the lack of them, which violate one's moral or ethical code. Staff frequently find themselves in this position due to resource constraints that do not permit them to provide the level of care they want to deliver, which in some cases can lead to patient harm that could have been avoided if adequate capacity and staffing had been available. In a recent BMA survey, the top cause given by respondents for these feelings of distress was not having enough staff to suitably treat all patients.¹⁴ The severe lack of workforce has created a vicious cycle whereby staff are not able to give the quality of care they would like to, and in turn this has an impact on their morale and wellbeing, ultimately causing the staff we **do** have to leave. This can subsequently compromise the quality of care offered to patients. Notably, while of course no stage of the pandemic was easy for any staff, our survey found that Black and Asian respondents experienced moral injury considerably more than their White counterparts.

We asked our members how much time they felt they needed to recover from the pandemic – the most common answer (35%) was a few months, while over 7% said they needed a year or more. Although pressures from the pandemic will ease, unscheduled care cannot be scheduled or slowed down, meaning there will be no easing of pressures for EDs and little room for recovery for our staff.

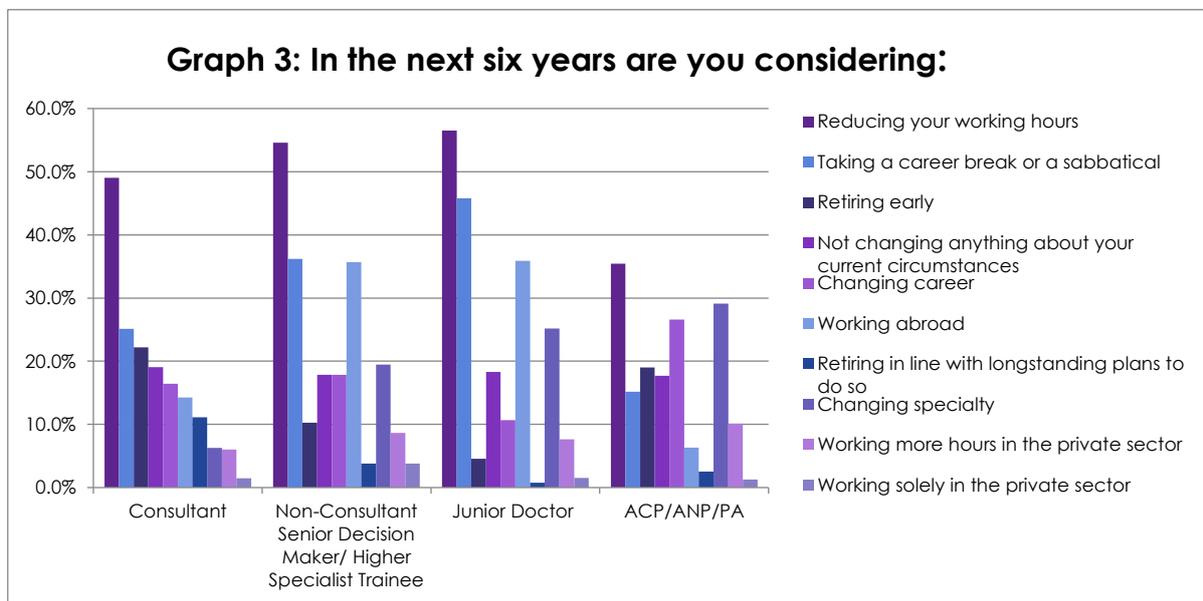
¹² Shanafelt T. (2002). Burnout and self-reported patient care in an internal medicine residency program. *Ann Int Med* 2002; 136: 358

¹³ Maslach C, Schaufeli WB, Leiter MP (2001) Job Burnout. *Annual Review of Psychology*.; 52():397-422.

¹⁴ BMA (2020) Moral distress in the NHS and other organisations. Available [here](#).

IMPLICATIONS ON THE FUTURE WORKFORCE

- 50% of respondents are considering reducing their working hours within the next six years.
- 22% of consultants are considering retiring early in the next six years.
- 25% of junior doctors are considering changing speciality.



Substantial numbers of Emergency Medicine practitioners are considering a change in their employment patterns. Over the next six years, we can predict significant changes to the shape of the Emergency Medicine workforce as more members than ever are considering reducing their working hours. Graph 3 reveals the high proportions of staff who are considering substantially altering their working patterns. In the next two years, 50% are considering reducing their working hours and 26% are considering taking a career break or sabbatical due to workload pressures (32%) and burnout (36%). The responses to this question are illuminating when split by consultants, non-consultant senior decision makers/Higher Specialist Trainees, Advanced Clinical Practitioners (ACP) / Advanced Nurse Practitioners (ANP) / Physician associates (PA), and junior doctor grades.

The top three career considerations for consultants are as follows:

- Reducing working hours (45%).
- Taking a career break or a sabbatical (25%).
- Retiring early (22%).

The top considerations of junior doctors are:

- Reducing working hours (57%).
- Taking a career break or sabbatical (45%).

Additionally, a significant proportion of junior doctors are considering working abroad (36%) and changing speciality (25%). Assuming this is broadly representative of the Emergency Medicine workforce in the UK, these figures will have destabilising consequences for our health and social care system.

Assuming a reasonably constant rate of increase in terms of demand, to ensure a ratio of 4000 attendances per consultant in six years' time (the training cycle), 5,063 consultants would be needed in England, Scotland, and Wales by 2027/28. At the current rate of recruitment to and departure from the specialty, this means there will be around 3593 consultants working in

Emergency Medicine in England, Scotland and Wales, leaving a shortfall of 1,470. The gap between the number of consultants required and the number actually in the workforce has been steadily diminishing in recent years, and if recent trends hold steady, will continue to do so. However, the troubling findings relating to members considering leaving the speciality or taking early retirement suggest that training and recruitment will need to increase in order to ensure that this trend does not reverse.

In the past few years, workforce strategies have been published in every UK nation. Although they have been ambitious in scope, each failed to outline long term plans for growing the Emergency Medicine workforce and committing to recruiting additional staff. It can take up to as long as 10 years to train Emergency Medicine consultants.¹⁵ Although there are no easy fixes to address the staffing crisis now, action can be taken to secure the pipeline of doctors working in our EDs. RCEM is collaborating with other medical Royal Colleges to ensure the upcoming Health and Social Care Bill includes a statutory duty for HEE or other designated bodies to publish regular workforce projections, with a duty on the Secretary of State to respond. We have also supported calls for robust workforce planning led by the Academy of Medical Royal Colleges and would like to see workforce projections take into account the unique challenges faced by staff working in Emergency Departments.

Recommendation: Governments must 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. Expansion of the workforce is needed to ensure patients are treated by staff who are trained in Emergency Medicine. This must also include an accompanying increase in Allied Health Professionals, SAS doctors, Emergency Nurses and the faculty to train them.

TACKLING THE ROOT CAUSES OF POOR RETENTION

There will be no time to facilitate the recovery of ED staff ahead of winter 2021. However, we can facilitate recovery in the long term by tackling the root causes of poor retention. We asked our members what could be done to improve their wellbeing and the most common recurring theme was addressing operational issues. Common themes included increasing the number of staffed beds, improving patient flow and eliminating exit block. Many of these responses commented on the impact that operational issues have on patient care. The following responses represent the underlying sentiment:

“Stop trying to patch the problem and improve resilience - focus on addressing the root causes: exit block, overcrowding and poor response from speciality teams and wards.”

“Improving flow out of department and not being overwhelmed by patients who would be better served by other part of the system so we can have the time and space to do our jobs well.”

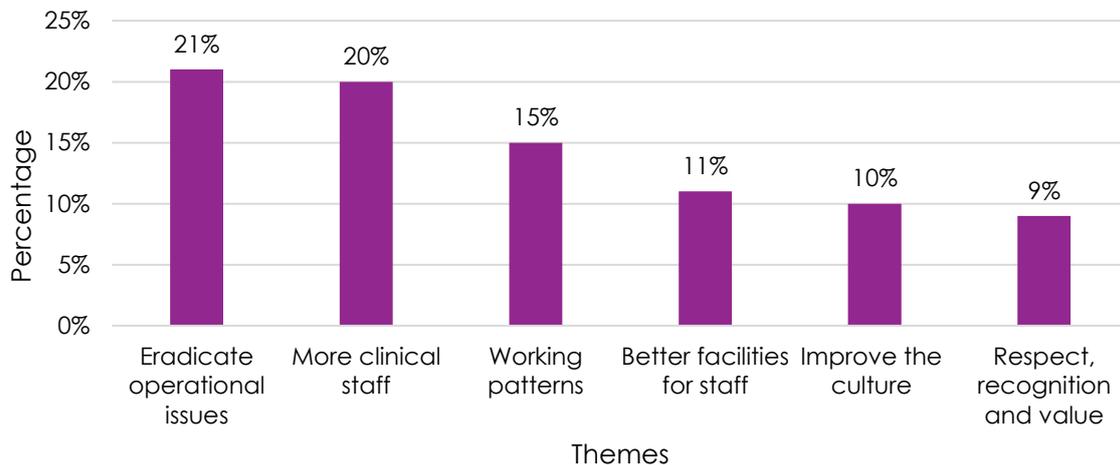
“I don't want cake, or chocolate. I want to be able to look after people properly, not in the back of an ambulance, and not for 18 hours at a time.”

As Graph 5 demonstrates, many of the popular solutions provided for improving staff wellbeing are less about the individual and more to do with the experience in the ED. More than 1 in 10 answers explicitly mentioned improving patient flow as a solution to improving staff wellbeing. These solutions could go a long way in improving not only the working lives of staff but also the patient experience. This highlights the intrinsic link between the recovery of the speciality and the recovery of staff.

¹⁵ Please see Annex 2 for training routes into Emergency Medicine

As discussed earlier, these operational pressures are likely to intensify further as we enter the winter months. We anticipate winter 2021/22 will be a particularly challenging period for the NHS, as it attempts to tackle the elective backlog, deal with a potential new wave of coronavirus and a potentially difficult flu season and address rising patient demand for Urgent and Emergency Care services. At present in England there has been no assessment made of the impact of emergency demand on the elective recovery.

Graph 5: Emerging themes from improving staff wellbeing response



Recommendation: Governments must immediately prepare and manage adequate capacity in order to minimise the harm to patients and staff caused by ED crowding and exit block. This will reduce the risk of emergency demand derailing the elective recovery and improve the working conditions of staff in EDs. Ahead of Winter, this must include but is not limited to:

- **Making funding available to local health systems to maintain or expand discharge to assess services so they are available all year round.**
- **Expanding clinical validation of Phone First services to ensure patients receive care in the best setting based on their needs. These services are only effective if there are adequate levels of clinical involvement.**

PLACING PATIENTS AT THE HEART OF THE SYSTEM

The patient must be at the heart of our healthcare system. The best outcomes are achieved when patients have access to appropriate, well-resourced pathways that are able to deliver timely care. Due to chronic underfunding over the last decade, there has been a deterioration in access to these pathways, resulting in patients accessing healthcare in whatever way they can. This has been clearly demonstrated by the rise in patients arriving to the ED having been directed there by phone-first services, despite the fact their needs would be more appropriately met elsewhere if these facilities existed or were more easily accessible. 51% of members felt as though phone-first services had increased or significantly increased demand in their department – in other words the opposite to the intended outcome. There is an urgent need to increase clinical validation in phone-first services, this strengthens clinical risk management, which in turn results in reduced attendances.

At present, all parts of the system are struggling to cope with increasing demand in the face of insufficient resource, however, this overspill in demand is routinely funnelled to EDs where patients will not be turned away. The unscheduled care system is a spectrum, of which only a portion is made up by EDs. Other parts of the system, such as primary care, other secondary care services, and community care make up the remaining elements of the unscheduled care

patient pathway. In order to address the discrepancy between system capacity and patient need, a whole system approach is required.

As outlined in RCEM CARES, the best and most cost-effective health care 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 be expanded, allowing them to take ownership of those unscheduled patients that do not require urgent or emergency treatment. The system must be redesigned based on patients' clinical need rather than service availability. The section above demonstrates that staff wellbeing and morale are compromised as a direct result of not being able to deliver the quality of care they would like to due to resource constraints.

Recommendation: Previous long term health strategies are now redundant given the disruption to the healthcare system caused by the pandemic. A new, actionable, long term health and social care strategy is now required in all four nations to enable the delivery of high quality Urgent and Emergency Care.

CROSS SPECIALTY WORKING

Patients should be at the heart of the hospital system. The first wave of the pandemic brought important transformational changes in the way of working and delivery of care within hospitals. This brought a sense of camaraderie and common purpose across the hospital, which empowered staff in EDs. outlined the need to retain this in our *COVID-19: Resetting Emergency Care* position statement, emphasising the importance of clinicians from all spheres of practice becoming more involved in the Urgent and Emergency Care pathway so that patients receive joined up, rapid and definitive care within the hospital.

Unfortunately, as we progressed beyond the peak of the first wave of the pandemic, hospitals reverted to their old ways of working. Qualitative responses from our surveys revealed that a whole hospital approach to managing the front door could help improve wellbeing in departments along with equalising the workload pressure throughout the hospital. Many responses highlighted the role Same Day Emergency Care (SDEC) can play in tackling operational pressures and therefore supporting ED staff wellbeing. SDEC is about cross-functional working and helps to improve patient flow in the hospital, creating a more efficient process for both staff and patients.

Recommendation: Across the UK, make funding available to support inpatient teams to enable more effective Urgent and Emergency Care, including Same Day Emergency Care and Ambulatory Emergency Care. These services improve the quality of care and staff morale, are cost effective, and reduce avoidable admission into hospital.

CONCLUSION: THE CASE FOR CHANGE

EDs are unique working environments – they provide 24-hour service, seven days a week and are open to all. They are by far the busiest part of the hospital. Emergency Medicine staff provide specialist emergency care to the sickest patients in the hospital with life threatening illness and injury where immediate decisions and access to treatment are essential. When we ask staff why they chose Emergency Medicine as a career, they tell us it is about the breadth of practice, the excitement, and the variety of conditions that come through the door. More importantly, they tell us that they are passionate about delivering high-quality and safe care to all patients. Unfortunately, the rising workload pressures has made this very difficult.

Our survey found clear links between poor retention and mounting operational pressures. Urgent action is needed now to support the retention and recruitment of clinicians in the only part of our healthcare service that is open to all during their time of need. We need a coherent, joined up and long term vision and strategy that places patients at the heart of the system and includes a clear plan to manage surges in emergency demand.

There is an important economic case to be made for investing in the Emergency Medicine workforce; it is more cost-effective to grow the workforce and tackle operational pressures to encourage good retention than to deal with the high economic costs of sickness, training new staff to replace the ones who have left early, litigation and locum spending.

It is the resilience of staff working in EDs that makes Emergency Medicine such an incredible specialty, and this has been taken advantage of in recent years and is now stretched to the limit. RCEM's motto is 'we always help the sick'. To improve patient care, now more than ever, it is vital we help those who help the sick.

ANNEX 1: METHODOLOGY

RCEM's Workforce Survey was administered from 14 May to 14 June 2021. We received 1039 responses in total from our membership and 88 responses from Clinical and Deputy Clinical Leads. We received a total of 684 responses from members in England, 72 in Scotland, 28 in Wales, and 33 in Northern Ireland.

The survey was conducted online and rolled out through a series of emails sent to members and fellows. To boost the sample size, we employed a snowball sampling technique whereby we asked members to inform their networks about the survey. As both surveys contain self-selected samples, we have been cautious not to make generalisations about the results. However, we believe this does not downplay the importance of the findings of this report.

There were a number of free text responses from the survey, to analyse this data we employed a grounded theory approach to allow us to examine emerging patterns from the data.

ANNEX 2: STAFFING IN EMERGENCY DEPARTMENTS

Consultant Staff

Type 1 EDs provide consultant-led 24-hour service.

Staff and Associate Specialist and Specialty (SAS) Doctors

SAS doctors are a diverse group with a wide range of skills, experience, and specialties. They work as staff grade doctors, associate specialists, specialty doctors, hospital practitioners, clinical assistants, senior clinical medical officers and clinical medical officers. This important staff group need sustainable career development as set out in the BMA SAS Charter.

Trainees

Recent initiatives increasing flexibility in training have decreased resignation from training rates but have also reduced the overall Whole Time Equivalent workforce. There are three points of entry for Emergency Medicine training:

- Acute Care Common Stem Pathway (ACCS)
- Defined Route of Entry into Emergency Medicine (DRE-EM)
- Higher Specialty Training

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 Emergency Departments.

RETAIN, RECRUIT, RECOVER

OUR CALL FOR ACTION TO IMPROVE THE
URGENT & EMERGENCY CARE SYSTEM

