The Royal College of Emergency Medicine

RCEM CARES

during the Coronavirus Pandemic

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October 2020

#rcemcares

RCEM CARES

This document is designed to outline RCEM's system-wide plan to improve patient care. The plan will inform RCEM members and patients. The document also will inform targeted briefings for other stakeholders such as patient groups, policy makers, governments, senior managers, Trusts and Boards, EM clinical leads, medical directors, heads of nursing, regulators.

Last year – before the advent of the coronavirus pandemic – over 18 million people across the UK attended NHS Emergency Departments (EDs). Increasing numbers of people are living longer with a complex range of medical needs and as our wider Health and Social Care service has not been developed to address this need, EDs are now the first port of call for many patients.

Emergency Medicine is the field of medicine that is practised at NHS Emergency Departments 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]

In the UK, the emergency care system is not fit for purpose. Our EDs are inadequately resourced and the physical environment in most cases have been designed for a much smaller patient capacity. The wider hospital system is similarly inadequately resourced with insufficient workforce, acute bed capacity, and infrastructure to meet growing demand. Patient experience should be at the heart of any world-class health service, and yet these endemic pressures put patient safety at risk. To fix this, eliminating Emergency Department overcrowding must be the number one priority. The RCEM CARES campaign provides solutions to address these pressing issues so that ED staff can deliver safe and timely care for patients. This campaign is aimed at politicians, senior healthcare leaders and clinical leads of emergency departments.

The early phase of the Coronavirus pandemic showed that many of these problems were not insoluble. The later phases have shown that without system wide commitment, leadership, and investment these problems will come back and harm both patients and staff.

Funding recommendations made in this document should be assumed to be applicable to the devolved nations according to the Barnett formula, unless otherwise specified.

1. Definitions of emergency medicine by the International Federation For Emergency Medicine.

Crowding

What is the problem?

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

Before the coronavirus pandemic, Emergency Departments across the UK were dangerously crowded. The number of patient attendances were increasing every year, with roughly a third of these patients requiring admission to a hospital bed.

Crowding in Emergency Departments occurs as a result of reduced resources, namely reductions in beds numbers within hospitals. As a result, many patients received care in corridors, as there are no available beds to admit them to. The pandemic has further exacerbated this issue, resulting in a loss of 10,000 inpatient beds in the NHS in England as inpatient areas need to facilitate social distancing and so can be used less flexibly.

Many patients are being kept in hospital for longer than necessary due to a lack of social care. While medically fit to leave, many patients 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 Emergency Department crowding.

Crowding is inhumane and undignified for patients and puts huge pressure on staff. It also means that staff are less able to provide safe, timely and efficient care to those patients, and any subsequent patients who attend the department. Ambulances then cannot offload, meaning longer waits for these patients. The dual challenge of crowding and coronavirus means there is a further, real, and avoidable risk of people dying from an infection acquired in an Emergency Department.

Health is a devolved matter and key metrics should only be reconsidered in the context of devolved healthcare systems. In England, against the backdrop of dangerous overcrowding and reduced resources, the four-hour target has ceased to be effective as a way to improve performance.[2] There is a perverse

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Capacity

What is the solution?

Governments

- Across the UK, restore the staffed acute bed capacity to pre-coronavirus levels and increase the bed numbers to achieve 85%[4] bed occupancy in hospitals to maintain flow in Emergency Departments. After restoring bed capacity to pre-coronavirus levels, we estimate an additional 9,429 beds are required in England, 639 in Scotland, and 262 in Wales. In Northern Ireland, a recent population needs assessment revealed that the Urgent and Emergency Care system will require at least an additional 520 beds by 2026.
- Adult social care in the four nations of the UK face substantial challenges and require significant investment in order to ensure patients are discharged safely and promptly when their medical care is complete:
  A. In England, invest £3.9 billion in adult social care by 2023/4[5]
  B. In Scotland, invest at least £1.8 billion into the health and social care service by 2024 to address the funding shortfall and speed up the integration of health and social care.[6]
  C. In Wales invest an additional £1.1 billion in social care by 2030/31 to match demand.[7]
  D. The UK Government should work with the Northern Ireland Executive to provide investment for implementing the Bengoa Review as outlined in New Decade, New Approach.[8]
- Set, monitor, and review metrics that promote patient flow and prioritise care of the most seriously ill and injured patients.
  A. Introduce a metric which monitors and improves ambulance offload times.
  B. In England, replace the 12-hour Decision to Admit metric with a metric on 12-hour stays from point of registration. No patient should need to stay in an Emergency Department for over 12 hours.

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2 The Times (2020) 'A&E four-hour waiting times targets may end as doctors back change'. Available **here**.
4 National Audit Office (2018) Reducing Emergency Admissions. Available **here**
5 The Health Foundation (2019) The real cost of a fair adult social care system. Available **here**.
6 Auditor General (2019) The NHS in Scotland 2019. Available **here**.
7 The Health Foundation (2016) The Path to Sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31. Available **here.**
8 UK Government & Irish Government (2019) The New Decade, New Approach Deal. Available **here**.

Crowding continued

What is the problem?

incentive to focus on the lower acuity patients, to the detriment of the sickest and oldest patients who need the benefit of scrutiny beyond four hours. In Scotland, the four-hour standard remains an important safety indicator for the acute care system as it has helped to drive safe and effective care, as a result it should be retained.

The Urgent and Emergency Care system in Northern Ireland has faced unprecedented challenges in the past few years.[3] There is an urgent need to restore capacity in the health care system through increasing the numbers of available beds and investing in social care. In addition, in line with the rest of the devolved nations, data on delayed transfers of care must be published regularly in Northern Ireland.

Capacity continued

What is the solution?

C. The Scottish Government and NHS Scotland should retain the four-hour standard.

D. Health and Social Care Northern Ireland should regularly collate and publish data related to delayed transfers of care.

E. Health and Social Care Wales should resume the publication of Health and Social Care data so we can better understand the impact of the pandemic on the NHS in Wales. In addition, delayed transfers of care are not uniformly reported across Wales. A more robust metric is required to encourage patient flow.

Senior Managers

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

Trust 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

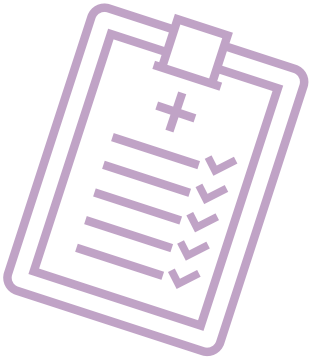
- Advocate on behalf of patients on the harms that are caused by crowding.

Useful resources

Tackling Emergency Department Crowding toolkit

Essential facts regarding A&E Services

IFEM Quality Framework



3 BBC News (2019) Increase in patients waiting at Northern Ireland's Emergency Departments. Available **here**.

Access

What is the problem?

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

Emergency Departments have a powerful brand for offering round-the-clock care. Many patients go to their Emergency Department having tried – and failed – to get timely care and treatment elsewhere, such as their General Practitioner. This has been exacerbated by the continuation of remote consultations after the first wave of the coronavirus pandemic.

Emergency Departments are increasingly providing care for these patients, who may have been better served elsewhere, because access to care is variable across the health service. This is adding to the problem of ED crowding.

Emergency Physicians should not be routinely caring for people who present with predictable complications of specialised care or minor long-term health issues. 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 match demand.

Call handling services, such as NHS 111 have proved popular during the early phases of the pandemic, but there is substantial variation in the proportions of people who have an ambulance called, or who are advised to attend the Emergency Department. This model of care is aimed at ensuring people get the right care at the appropriate place allowing Emergency Departments to focus on the very sickest patients whilst offering care in a COVID-19 endemic world.

Social care can also help prevent or reduce the need for medical treatment and help to get medically fit patients out of hospitals and so increase patient flow through the system. The current lack of Social Care means many more patients are ending up at their ED unnecessarily.

Same Day Emergency Care (SDEC) provides a valuable opportunity to reduce admissions.

Cuts to public and preventative health funding are having a major impact on local services which play a key role in improving and maintaining the population's health. This has further exacerbated

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Alternatives

What is the solution?

Governments

- Expand primary care across the UK
  - A. In England, future iterations of the NHS People Plan should detail the plan for delivering 6,000 WTE doctors in General Practice and 6000 more primary care professionals by 2024/25. New primary care services must expand provision to provide out-of-hours services in areas of need.
  - B. Welsh General Practice needs an increase in training places to ensure patients can receive the right care at the right place.
  - C. Accelerate the expansion of primary care across Northern Ireland. This requires an expansion of the GP workforce and ensuring all training posts are filled.
- Across the UK, expand co-located acute services around the Emergency Department, including frailty, mental health, pharmacy, and primary care to support patients being cared for in the best place.
- Rapidly expand Same Day Emergency Care and Ambulatory Emergency Care provision across all acute hospitals in the UK.
- Ensure Same Day Emergency Care and Ambulatory Emergency Care has the same access to diagnostic services as Emergency Departments.
- Local Authorities across the UK and Integrated Care systems in England must invest in preventative health to support the most vulnerable in society, this includes additional support for drugs and alcohol services, homelessness and immigrant health, domestic violence, and youth violence.

NHS management

- Call handling services such as NHS 111 and devolved nation equivalents should evaluate the 'Think 111' programs and monitor the proportions of disposition codes to the ambulance service and emergency department. Equality of access to appropriate healthcare should be at the heart of this.
- Same Day Emergency Care should be provided seven days a week and should be seen as one way that almost all specialties can deliver care.

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Access continued

What is the problem?

health inequalities with the most deprived areas experiencing disproportionate cuts. Furthermore, when preventative public health services are cut, the burden of health often shifts on to Emergency Departments. For example, in 2018/19 there were 358,000 admissions to hospital where the main reason was alcohol, representing a 6% increase from the previous year.

As pathways to the Emergency Departments change and adapt, system leaders must remain mindful of the ways in which this might impact the most vulnerable and ensure that these patients are still receiving access to high quality care. In addition, investment is required in population health and community care.

Alternatives continued

What is the solution?

- Ensure doctors work closely with inpatient colleagues to agree the case mix suitable for referral to Same Day Emergency Care Units.

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 that patients who are vulnerable to infection can avoid long waits in crowded emergency departments.[9]
- Ensure that job planning makes it possible for inpatient teams to deliver Same Day Emergency Care.
- Ensure that all specialities engage effectively with Same Day Emergency Care and the direct provision of specialist input into emergency care 7 days a week.
- Ensure Same Day Emergency Care Units do not turn into secondary wards during busy periods.
- Ensure doctors work closely with inpatient colleagues to agree the case mix suitable for referral to Same Day Emergency Care Units.

Useful resources

All the resources on this page

9 RCEM (2020) Emergency Department 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 Emergency Departments.

Emergency Departments cannot deliver safe care if they are not adequately staffed. Emergency Departments have insufficient resources to meet the minimum number of Consultants/senior decision makers required per 100,000 attendances. Understaffing means our existing workforce suffers from burnout – more so than other specialties – which leads to many staff leaving the specialty.

In the past few years, workforce strategies have been published in each devolved nation.[10] 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. There are deficits of Emergency Medicine Consultants across the UK, which is exacerbated by doctors working outside the NHS and early retirement of doctors burnt out by system pressures and the pandemic.

There is also an urgent need to improve the retention of staff working in Emergency Departments. Staff wellbeing and developing compassionate leadership cultures in the NHS is important. As the pandemic continues, we are acutely aware that coronavirus disproportionately affects Black and Asian and minority ethnic staff.[11] We also recognise that Black, Asian, and minority ethnic staff have very different experiences of the NHS across the UK as a workplace. We urge UK NHS leaders to create an organisational culture where all ethnic groups feel like they belong and urgently take action on closing the ethnicity gap in entry to formal disciplinary processes.

We are concerned by the lack of strategy for recruiting social care staff. The Migration Advisory Committee recognised the workforce shortage in the social care sector, yet the Government's new health and social care visa did not include social care in their list of shortage occupations.[12]

The supervision burden upon experienced staff and Consultants has increased with staff turnover and the introduction of novel roles. This is currently not respected in Job Planning.

The outdated and hierarchical culture that pervades clinical medicine and hospital practice fails to value the complexity and importance of the multi-skilled clinicians working in EDs and fails to empower their progressing patient care appropriately. This risks patient

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Retain

What is the solution?

Governments

- Every UK nation needs to deliver a long-term workforce strategy for Emergency Medicine with a commitment to recruiting additional staff and addressing shortages in the workforce. Recruitment of Emergency Medicine Consultants should be based on a ratio of one Consultant per 4,000 attendances. At present, that would translate to 2,500 Consultants in England, 70 in Scotland, 80 in Northern Ireland, and 120 in Wales.
- In England, increase numbers entering EM training by 120 per year to address the deficits in WTE trainees caused by increased flexibility in training in the short term and Consultant shortages in the longer term.
- Reintroduce the Associate Specialist grade.
- Across the UK, deliver additional Emergency Department Nurses to address the shortage in the workforce. The skill mix of the Emergency Department Nursing workforce should comprise: 30% Emergency Charge Nurses, 40% Emergency Nurses, 10% Foundation Staff Nurses, 20% Nursing Associates or Clinical Support Workers.[14]
- 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.
- The new Health and Care visa excludes social care staff. The Government should include social care in the list of shortage occupations.

NHS Management

- 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.
- Improve the experiences of Emergency Medicine staff from Black, Asian, and minority ethnic backgrounds and take urgent action on closing the disciplinary gap.

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10 NHS England (2020) We are the NHS: People Plan for 2020/21 – action for us all. Available **here**; COSLA & NHS Scotland (2019) An Integrated Health and Social Care Workforce Plan for Scotland; Health Education and Improvement Wales and Social Care Wales. A Healthier Wales: A Workforce Strategy for Health and Social Care. HEIW and SCW: Cardiff, 2019; Department of Health Northern Ireland (2018) Health and social care workforce strategy 2026: delivering for our people. Available **here**.

11 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.

12 Migration Advisory Committee (2020) Review of the Shortage Occupation List: 2020. Available **here**.

14 RCEM & RCN (2020) Nursing workforce standards for Type 1 Emergency Departments. October 2020.

What is the problem?

safety and demoralises staff.

Many staff are now choosing to work less than full time. This creates a sustainable career but creates additional workforce pressures.

Consultant Staff

The changes in pension taxation in 2019 meant Consultants were effectively having to pay to come to work if undertaking additional duties. This 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

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[13].

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.

Allied Health Professional Roles (AHP)Allied Health Professional 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.

Staff at high risk of serious illness from infection who are unable to face patients suffer disproportionately from stress and isolation.

What is the solution?

- Implement of 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.
- Ensure your Trust adopts the GMC recommendations of 'ABC of Core Needs' for ensuring autonomy of clinicians.

EM Clinical Leads

- 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.

Useful resources

All the resources on this page

Securing the future workforce for Emergency Departments in England

13 BMA (2014) A charter for staff and associate specialist and speciality doctors. Available **here**.

Experience

What is the problem?

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

More patients than ever before are staying in EDs for longer than four hours. Patients invariably value short waiting times. Timely pain assessment management is essential to patient experience.

Many of our existing Emergency Departments are too small, run down and in need of repair. With rising attendances and admissions, the physical size of many hospitals and Emergency Departments have not increased. Most are now stretched beyond the capacity they were initially designed and resourced to manage. This is a poor environment, especially for the frail and vulnerable.

In England, the additional funding announcements made in 2020, namely the £1.5 billion for hospital maintenance and improving Emergency Department capacity, and the confirmation of £3.7 billion capital funding for 40 new hospitals, were welcome. Along with the £13 billion NHS Trust debt write off, this funding will help expand Emergency Department capacity as we move into the winter months and contribute to addressing the £6.5 billion maintenance backlog in England but will not completely eradicate it. Addressing this backlog must take priority over building new hospitals. A multi-year capital plan is still urgently required to expand and physically redesign and rebuild Emergency Departments, so they are able to meet demands placed on them.

We acknowledge that different patients experience care offered in our Emergency Departments in different ways. Patients who are suffering a mental health crisis often repot having a poor experience, with long waits in an environment that is stressful and stigmatising. Across the UK, Liaison Psychiatry teams play a crucial role in the parallel assessment of mental health patients that attend Emergency Department who might also need medical care. Expansion of Liaison Psychiatry must go hand-in-hand with investment in preventative services, Child and Adolescent Mental Health Services, community support schemes and good telephone triage.

In addition, the coronavirus pandemic has exposed the shocking levels of inequality that persists in society. We do not underestimate the role Emergency Departments play in addressing health inequalities: the most deprived communities use Emergency Department services significantly more than the least

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Effect

What is the solution?

Governments

- The Treasury should introduce a multi-year capital plan to ensure Emergency Departments across are maintained and fit-for-purpose or fast tracked for redevelopment to provide 21st century Emergency Medicine care.
  - A. In England, this must include funding to address the £6.5 billion[15] maintenance backlog as a priority over building new hospitals.
- In England, the Department of Health and Social Care should ensure the 2020 funding is appropriately allocated to ensure Emergency Departments are maintained and fit-for-purpose or fast tracked for redevelopment.
- Consider a co-located service model in any new build hospital.
- Ensure clinical and patient involvement in designs for any plans to build or refurbish Emergency Departments.
- Ensure any new builds for Emergency Departments follow the guidance in Health Building note 15-01.
- Develop a meaningful quality indicator for patient experience through working closely with RCEM's Lay Group and patient groups.
- All four UK nations need to urgently increase investment in mental health services, including alternative mental health facilities, Child and Adolescent Mental Health Services, and preventative services
  - A. In England and Wales invest in 'Core 24' Liaison Psychiatry Services to achieve this in 70% of acute hospitals by 2023.
  - B. In Northern Ireland, improve standards for Liaison Psychiatry Services and improve access to mental health services.
- Embed action on health inequalities across government departments.

Regulators

- Use RCEM's Emergency Department Care Guide to ensure Emergency Departments are providing a quality service to patients.

NHS Management

- Ensure that the built environment of the emergency department complies with national guidance

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15 National Audit Office (2019) Department of Health and Social Care: Review of Capital Expenditure in the NHS. Available **here**.

What is the problem?

deprived communities. Addressing inequalities in health requires cross-government working, with all government departments taking responsibility.

What is the solution?

- Ensure patient experience quality indicators are used to inform changes in practice.

EM Clinical Leads

- In England, ensure additional capital funding should be spent in their organisations to improve Infection Prevention and Control
- Implement the 50 standards as outlined by RCEM Emergency Department Care best practice document.
- 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.

Useful resources

Friends and Family Test Data

RCEM Emergency Department Care Standards Checklist

Safety

Systems

What is the problem?

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

Emergency Medicine staff go above and beyond what is reasonably expected of them to deliver high quality care. For too long the personnel have been relied upon to provide a service based on chronic underinvestment. In 2018 the NHS received a multi-year funding settlement, confirming an increase in funding of an average 3.4% a year in real terms over the next five years. Whilst this reflects a substantial increase since the years of financial austerity, this is still below the 3.7% average increases in budget since the NHS was established. Although the increase in funding is welcome, it is not enough to improve the health and social care service.

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. As of October 2020, this has not taken place. As coronavirus may be present for many years to come, it is vital that the Government carries out a rapid review immediately to enable lessons to be learned for multiple successive waves of coronavirus.

As we enter Winter 2020/21, Emergency Departments face considerable challenges ahead. Some parts of the UK are focusing on recovering healthcare services that were disrupted due to the pandemic and others have cancelled elective operations due to growing numbers of coronavirus related hospitalisations. There is an unprecedented risk of managing the elective backlog presenting as emergencies, along with seasonal norovirus, flu, and COVID-19. We need to ensure that Emergency Departments can safely manage undifferentiated patients whilst providing urgent and emergency care and minimising nosocomial spread of COVID-19. This means timely access to Personal Protective Equipment and testing; Emergency Departments employ many staff who have young children and delays in test results for Coronavirus, either for staff or those that staff have caring responsibilities for, can create significant workforce problems.

Overcrowding and challenging working conditions can result in an environment where errors are more likely to happen. In England the CQC state that over half of Emergency Departments 'require

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What is the solution?

Governments

- Increase the NHS multi-year funding to reflect the increased pressures placed on the NHS. The budget should increase by an average of 5% per year in real terms over the next five years.[16]
- Carry out a forward-looking rapid review of the UK's preparedness for successive waves of the coronavirus pandemic. This will help Emergency Departments tackle the inevitable challenges of COVID-19, flu, and seasonal norovirus during the winters of 2020/21 and 2021/22.
- Ensure there is adequate stock and access to appropriate PPE for all Emergency Department staff for the foreseeable future of the pandemic.
- Ensure that there is adequate capacity for COVID-19 testing for Emergency Department staff (and their households), with short turn-around times that allow prompt and safe return to work.[17]

Regulators

- Regularly disseminate examples of good practice occurring in Emergency Departments to support quality improvement.
- Use the RCEM Best Practice Guideline on '**Infection Prevention and Control (IPC) during the Coronavirus Pandemic**' to inform inspections.[18]

NHS Management

- Implement RCEM's Safety Toolkit and Emergency Department '**Infection Prevention and Control (IPC) during the Coronavirus Pandemic**' Best Practice Guideline.
- Ensure that management is aware that some staff are disproportionately vulnerable to COVID-19 including those from a minority ethnic background and those with pre-existing conditions, and these staff have adequate safety, protection and support in place.
- Ensure the Clinical Review of Standards produces metrics that promote safe practice (England only).
- Review whistleblowing procedures and ensure protection for whistle-blowers.
- Promote electronic patient records that integrate multiple systems efficiently, easily and support clinical care.

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Useful resources

Friends and Family Test Data

Under pressure: Safely managing increased demand in Emergency Departments (CQC)

RCEM Safer Care Toolkit

16 NHS Providers (2018) The new long-term NHS funding settlement. Available **here**.

17 ITV News (2020) Coronavirus test priority list revealed. Available **here**.

18 RCEM (2020) COVID Infection Prevention an Control Guidelines. Available **here**.

What is the problem?

improvement' or were 'inadequate' on safety. The picture in the devolved nations is unlikely to be very different. This is associated with expensive and potentially avoidable litigation. Emergency departments are the leading source of claims in the NHS. One estimate suggests that around 13% of the cost of running an English ED is spent on litigation.

What is the solution?

EM Clinical Leads

- Promote a safety culture and embed the principles of Patient FIRST in Emergency Departments.[19]
- Ensure there are robust systems that ensure the most ill and injured patients are quickly treated.
- Ensure that staff understand the rules about getting tested and self-isolating.
- Work with clinical colleagues to implement the recommendations of the Improving Medical Pathways statement.[7]
- Ensure that there are systems to identify deteriorating patients.
- Ensure that there are adequate supplies of PPE and that all staff are properly trained to use PPE.
- Participate in the RCEM **Infection Prevention and Control Quality Improvement Project 2020/21**.

Useful resources

Friends and Family Test Data

Under pressure: Safely managing increased demand in Emergency Departments (CQC)

RCEM Safer Care Toolkit

7 RCEM (2020) Improving Medical Pathways. Available **here**.

19 CQC (2020) Project reset in emergency medicine – Patient FIRST. Available **here**. RCEM Learning (2016) The Safety Toolkit. Available **here**.

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