What Northern Ireland’s Emergency Department Consultants Really Think

Summary Report: April 2018
Introduction

In 2018, the College’s Northern Ireland Board designed a questionnaire for RCEM’s Fellows in Northern Ireland to better understand the pressures facing NHS staff on the frontline. The survey’s overarching aim was to highlight the difficulties facing emergency care within the context of insufficient resources. The Board also wanted to give a voice to Emergency Department (ED) consultants to hear about what it feels like to work in Emergency Medicine when faced with overwhelming pressures.

The survey was sent to the RCEM’s Fellows in Northern Ireland, totalling 88 recipients. From this, a total of 64 completed the survey. Our data largely illustrates themes at the RCEM. There is no suggestion that our project represents a complete or permanent scrutiny of the healthcare system.

The data was gathered in a two-week period and aggregated and anonymised to ensure the focus of consideration is on the wider health care system rather than individual Trusts or members of staff. We hope that the findings enable interested parties to broaden the debate around Emergency Medicine and bring the focus back to patient safety and care in the Emergency Department setting.

Summary of Findings

❖ 98% of respondents think that Emergency Medicine in Northern Ireland is in a state of crisis.
❖ 89% agreed that the situation in their Emergency Department felt worse than previous years.
❖ 94% considered that patient dignity is compromised daily because of crowding in their ED.
❖ 91% ‘strongly agreed’ that patients are at an increased risk of poorer outcomes due to crowding in their Emergency Departments.
❖ 98% of respondents agreed that there is an insufficient number of medical and nursing staff to cope with current demand in EDs.
❖ 97% said that they have at times felt stressed during their working day because of an inability to deliver high-quality care to patients.
❖ 91% do not believe that it is sustainable working in emergency care in the current environment.
❖ Increased social care capacity, more acute hospital beds, increased resource and recruitment to Primary Care and more nurses were listed as the main solutions to making EDs in Northern Ireland safer for patients.
1. The vast majority – a total of 63 contributors out of 64 - either ‘agreed’ or ‘strongly agreed’ with the following statement: “Emergency Medicine in Northern Ireland is in a state of crisis”. 75% ‘strongly agreed’ with the statement. In addition, 89% felt that the situation in their Emergency Department felt worse than previous years.

2. National data - in terms of demand, four-hour performance and 12-hour waits - shows that these responses are justified. Attendances at Emergency Departments in Northern Ireland have risen from 731,009 in 2010/11 to 797,666 in 2016/17 – an increase of 9.1%. In the same time frame, four-hour performance has deteriorated from an average of 82% to an average of 74.4% in 2017.¹

3. When we look at the 12-hour performance data, the picture is equally concerning. The graph below shows that there continues to be a substantial number of patients left waiting in busy and crowded EDs for eight hours, 12 hours or even more. The number of patients waiting over 12 hours has risen by 108.8% in the space of four years.²

¹ Department of Health, Hospital statistics: emergency care activity, 2009/10 to 2015/16 and 2016/17
² Ibid.
4. Prolonged ED waits are associated with several negative patient-oriented outcomes, including increased inpatient mortality rates\(^3\) - this was also highlighted by survey participants.

5. The questionnaire asked: “Do you agree / disagree with this statement: ‘Patients are at an increased risk of poorer outcomes due to crowding in my Emergency Department’”. 63 out of 64 contributors either ‘agreed’ or ‘strongly agreed’ with the statement (91% ‘strongly agreed’).

6. The survey then asked: “In your opinion, is patient dignity compromised on a daily basis because of crowding in your Emergency Department?” 94% answered ‘yes’ to that question (60 out of 64 participants).

7. As the Nuffield Trust suggests, longer waits in Emergency Departments are associated with the deeper issues of patient flow through the hospital. These include, congestion in hospital wards\(^4\) and insufficient social care provision in the community to enable timely patient discharge. Usually, four, eight and 12-hour breaches are a direct result of the lack of available and appropriate hospital beds – also known as ‘Exit Block’\(^5\).

8. Furthermore, since 2012/13 the number of people over 65 years of age has risen by 9.2%.\(^6\) As we have seen across the United Kingdom, an ageing population brings many associated challenges to those providing primary and secondary care in the NHS. Patients are more likely to have multiple co-morbidities and complex health care needs. This in turn leads to increased admission rates and rising numbers of hospital bed days.

9. Between 2012-13 and 2016-17 the number of inpatient and day case admissions in the Northern Ireland NHS has increased from 605,928 to 615,271.\(^7\) This represents a rise of 1.5%. At the same time, average length of stay in hospitals has shown an overall decrease from 6.4 days to 6.0 days.\(^8\) The total number of bed days have risen despite shorter lengths of stay meaning that capacity has not increased at the same rate as demand.

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\(^3\) A. Singer et al., *The Association Between Length of Emergency Department Boarding and Mortality* (2011)


\(^5\) RCEM, *Exit Block in Emergency Departments: what it is and why it is dangerous*

\(^6\) Northern Ireland Statistics and Research Agency, *Population Mid-2016*

\(^7\) Department of Health, *Northern Ireland inpatient, day case and outpatient hospital statistics for 2016/17*

\(^8\) Ibid.
10. The King’s Fund has also found that patients over the age of 65 can account for 70% of bed days.9 A frail person’s ability to recover their former independence is greatly affected by a prolonged hospital stay.10 The Health Foundation estimates that 8-12% of admissions into hospital will result in harm to a patient.11 The longer a person stays in a hospital bed, the greater the impact on their mental health and the more likely they are to develop a life-threatening hospital infection.12

11. Insufficient social care resource impacts the entire hospital system and contributes to ED crowding, ‘Exit Block’ and Delayed Transfers of Care. It is within this context that the RCEM takes the view that EDs have struggled in the face of rising demand, because we continue to systematically under-resource hospital and social care services.

12. The analysis above helps to explain the deterioration in performance and the consequential pressures upon ED staff. It also helps us to understand the reasons why 91% (58 out of a total of 64 contributors to the survey) considered that it is not sustainable working in emergency care in the current environment.

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9 The King’s Fund, Continuity of care for older hospital patients (2012)
10 Ibid.
12 Forbes, 4 Ways Hospitals Can Harm You (2014)
13. When asked to describe how it feels working day to day in an Emergency Department, contributors to RCEM Northern Ireland’s survey highlighted the stress and anxiety of working in an under-resourced and under-funded health service with words such as:

Ashamed, appalled, burnt-out, anxious, stressed, tired, fearful, helpless, impotent, guilty, let down, exasperated, angry, crushed, overwhelmed, worn-out, drowning, drained, deflated, demoralised, and disheartened.

14. Occupational burnout and stress is a well-recognised hazard to staff in the health and social care services - particularly in the Emergency Medicine specialty - both in the UK and abroad.¹³

15. ED staff repeatedly describe the excitement in the resuscitation room, the diversity of the case mix and the challenge of the generalist as some of the factors in their own choice for choosing a career in Emergency Medicine. One ED consultant commented:

“I feel challenged, enthused and stimulated on a daily basis. The variety of the role is great. Emergency Medicine is the best job in the world”.

16. Yet, tempering this enthusiasm is the reality of the modern ED as a busy, crowded and highly pressured environment.¹⁴ The consultant continued:

“However, the crowding has led to me being very frustrated at the inability to provide our patients with the timely and effective care that they deserve. The challenges in caring for vulnerable patients such as frail elderly and mental health are stark.... the ‘can do’ attitude has not been associated with appropriate commissioned support and is now all too often a safety net. If change does not happen as a matter of urgency the situation will progressively get worse”.

17. 97% (62 out of a total of 64 contributors to the survey) stated that at times they have felt stressed during their working day because of an inability to deliver high quality care to their patients. This shows that many ED staff are concerned that patients do not receive safe and timely care in Northern Ireland’s Emergency Departments.

18. Many survey respondents emphasised this latter point and submitted the following comments:

“I feel stressed by the risks associated with attempting to deliver safe and effective care in a crowded understaffed environment”.

“I feel happy in the nature of my work but frustrated when I cannot deliver the care my patients deserve, in terms of timely investigations and interventions, appropriate placement in beds, and the appropriate time and space to assess patients”.

“I feel anxious to give the best possible care to my patients and to support my junior colleagues in a department that is often crowded”.

“I feel that some patients are at a significant risk of dying unnecessarily due to failures in provision of adequate care due to horrific nursing staff shortages and appalling overcrowding”.

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¹³ Berger E. Physicin Burnout: Emergency Physicians see triple risk of career affliction (2013) and Basu S. et al., Occupational stress in the ED: a systematic literature review (2016)

¹⁴ RCEM, Creating successful, satisfying and sustainable careers in Emergency Medicine (2015)
“I feel frustrated due to external pressures that I have no control over and working in a Trust where the dignity of elderly, vulnerable patients is not addressed and there is morbidity and mortality associated with Exit Block”.

“I feel most under pressure when working evenings and at all times of the day we don’t have enough nurses or space to provide safe, quality, positive clinical to experience to patients. That’s very demoralising for all ED staff”.

“I feel ashamed that I have to repeatedly apologise for the lack of beds in the system, meaning frail and elderly patients are spending more than 24 hours in a hard, plastic chair. I also fear for my nursing colleagues who end up trying their best to look after 40-50+ emergency admissions with ‘nursing to patient’ ratios closely resembling a third world health care system”.

19. As demonstrated by the latter comment, several of the College’s Fellows responding to the survey noted that they are concerned by the lack of medical and nursing staff to treat patients in a timely manner. When answering the following question “Do you agree / disagree with this statement: My Emergency Department has an insufficient number of medical and nursing staff to cope with current demand”, an overwhelming majority either ‘agreed’ or ‘strongly agreed’ with the statement (63 out of 64 participants).

20. The College recommends that each ED should have at least 10 Consultants, rising in bigger Departments, to meet demand. In 2017, the RCEM Northern Ireland called for a minimum of 50 additional Emergency Medicine consultants - an increase of nearly 75% of the current consultant workforce - to reach safe, sustainable staffing levels. The College also recommends that there are a sufficient number of nursing staff to manage wards and provide safe care to patients.

21. Furthermore, while surveys have consistently shown that the majority of trainees enjoy their training time in the Emergency Department, the number of trainees that intend to pursue a career in the specialty is falling. Amongst other things, they cite poor working conditions, high workloads impacting on training, a harsh work-life balance and the lack of 24-hour support for their ED as barriers to their training and subsequently a long-term choice in Emergency Medicine.

22. We need to ensure that medical education and training is evolving to meet the needs of both patients and staff. Less than full time working is an increasing feature of Emergency Departments. This is despite the fact that historically ED departments have had one of the lowest proportions of part-time work compared with other specialties.

23. The GMC’s trainee survey has also shown that more can be done to support trainees to take study leave. 35% of doctors training in Northern Ireland did not feel that they had enough protected time to attend all the local/departmental teaching they needed to in their post.

24. We need to consider how best to encourage the recruitment and retention of staff in all areas. Increasing training posts alone will not make health and social care careers more attractive. It is widely agreed that better working environments promote the recruitment and retention of staff. Therefore, Northern Ireland requires adequate resources and staff, within and without the hospital, to manage demand – demand which historically has grown and will continue to rise.

16 GMC, Training environments (2017)
17 RCEM, Creating successful, satisfying and sustainable careers in Emergency Medicine (2015)
18 GMC, Training environments (2017)
19 Ibid.
Conclusions and Recommendations

25. Emergency Department performance is connected to the availability of acute beds and downstream variables - including the provision of appropriate care and support in the community. Northern Ireland’s health and social care workforce and resources need to match and meet the demands of a growing and ageing population. It is only with adequate resourcing and staffing in both health and social care that we can mitigate the prevailing issues of Exit Block, 12-hour Emergency Department waits and Delayed Transfers of Care.

26. The workforce should feel supported and valued so that a long-term career in our health and social care services is a viable option.

27. Participants in the survey suggested the following improvements that they consider would make Emergency Departments in Northern Ireland safer for patients:

- Increased numbers of acute hospital beds
- More Emergency Department nurses
- Increased social care capacity
- More Emergency Medicine consultants
- Elimination of ‘Exit Block' and increased flow through the system
- Increased resource and recruitment to Primary Care (including out of hours GP services)
- More nursing staff for acute wards to open wards and beds

28. The College’s Vision 2020 is our plan to fix emergency department Staffing, Systems and Support in Northern Ireland to deliver excellent patient centred care. Key elements include:

- A minimum of 10 consultants in every Emergency Department:
  A minimum of 10 consultants is essential to deliver safe and effective care. This number should rise according to size and need.

- A minimum of 50 extra Emergency Medicine consultants in Northern Ireland:
  An additional 50 Consultants are needed to achieve safe, sustainable staffing levels. Posts must be structured to allow good recruitment, retention and prevent career ‘burnout’.21

- Co-location of services:
  Locating and integrating other vital care services, including frailty teams, pharmacists, mental health specialists, ambulatory emergency care and GPs around Emergency Departments is cost effective and helps to reduce pressure.22

- Emergency Care Transformation Programme
  To achieve all of the above will require a robust workforce plan that will help to reduce the £14.7 million currently being spent annually on agency staff in Emergency Departments.23

- More social and community care
  To reduce Exit Block, increase flow through the system and decrease Delayed Transfers of Care, more social care and community resources is imperative.

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20 RCEM Northern Ireland, Vision 2020 (2017)
21 Based on 2016/2017 attendance figures at Type 1 Departments, we have banded EDs groups and then allocated numbers of consultants to deliver a service
22 RCEM, Co-Location - the Hub concept (2015)
23 Reference in the RCEM Northern Ireland, Vision 2020 (2017)