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SUPPLEMENT

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# RCEM Presidential News

April has brought Spring and the 'winds of change'.

It was a great pleasure to be able to announce last month that Dr Katherine Henderson will be the next RCEM President. I have known Katherine for well over 20 years and have absolutely no doubt that she will do an absolutely fantastic job for us when she starts in October. I look forward to working closely with Katherine in the coming months as she prepares for presidency. We must of course also pay tribute to the other two candidates in the race, Chris Moulton & Carole Gavin, who provided such strong competition – and I have known them for even longer. RCEM is indeed fortunate to have such excellent people in so many leadership positions and we hope that they can continue to contribute to the work of the College. Speaking to them I know they are keen to do so.

The other major news of the past few weeks has been of course the decision by NHS England to publish its proposals for new standards in emergency care as part of the Long Term Plan. This unfortunately has got off to a rather inauspicious start as there was not much consultation or collaboration prior to the launch. Indeed it seems at face value that there has not been much consultation generally that has involved any of the Colleges.

I would say three things to assuage concerns and I hope to create a strong way forward.

## COMPLEXITY

The 4hr ECS is as we know a highly complex metric.

The College has held a firm view that it is the best available 'patient flow metric' of system performance as a part of a wider suite of quality standards that should be used by policymakers and provider organisations. This approach allows a consistent way to monitor performance and target areas for improvement and resource allocation. It also acts as a powerful surrogate marker of safer care by helping to monitor crowding which has been proven to add a graduated risk of avoidable harm to patients.

The publication by NHSE of its proposals occurred on the same day that RCEM published its guidance on *Quality Standards in EDs*. Discussion has confirmed that there is agreement that any revised standards must have a 'patient flow metric' which is at least as effective and meaningful to emergency care as the 4hr ECS. There is also agreement on the need for additional quality standards that will reflect the domains of safety and which measure clinical care in the ED. However the RCEM and the Royal College of Nursing Emergency Care Association strongly believe that such quality standards should not be condition-specific, but should be based on markers of urgency or acuity. These would build upon and complement well established internationally recognized existing triage systems that already prioritise the care of the critically ill and injured.

## CONSENSUS

We also know that good systems build consensus and take ownership of the 4hr ECS as a true system metric. This minimizes the likelihood of 'gaming' and maintains the patient at the very heart of the quality matrix. Similarly, when attempting to review standards in emergency care at a national level it is quite right that the major specialties who are involved should come together to build consensus on how best to move forwards. Sir Harry Burns in his review of healthcare standards in Scotland did just that in 2017 for example and the 4hr ECS was retained as being the best available. We therefore strongly support the need for careful design and evaluation of any testing in clinical environments of proposed revised standards in emergency care.

We know of course that many emergency care systems are struggling badly due to lack of resourcing in key areas such as staffing, infrastructure, acute bed capacity and community care. The major group of patients affected are those on hospital corridors waiting for 4-24 hours or more for an acute hospital bed. Others secondarily affected also include mental health patients, the critically ill and also children to a lesser extent. In addition an increasing proportion are those awaiting delayed elective surgical care who are now presenting to EDs with secondary complications.

Staffing levels of nursing and medical staff within Emergency Depts and the wider acute care systems in England ( as well as the rest of the UK & Ireland) often continue to be stretched on a backdrop of a chronic workforce crisis. Many parts of the emergency care system do not operate

effectively in the evenings or over weekends and bank holidays. At present emergency care system performance in England is at the lowest level since records began in 2004. Safety for patients is increasingly challenged in such departments on a regular basis. This is occurring in the mildest winter, with low levels of other seasonal factors such as flu and norovirus.

### COLLABORATION

If we are to move forward well then we must find ways through building consensus to collaborate well. Testing and evaluation of new proposals of quality standards in this highly complex field will therefore require a careful collaborative framework in order to maintain safety and also to produce objective meaningful results on this backdrop.

Testing should demonstrate links to improved outcomes. The metrics used to determine success or failure of testing should be carefully thought out. Any testing or indeed premature roll out of revised policy in this important area that destabilizes existing systems or further compromises safety, we believe will risk significant unintended consequences.

I will be working hard in the coming weeks and months to work with senior colleagues in other Colleges, the RCN and indeed with NHSE/I to do those 3 things – sharing expertise on the complexity of what we are trying to achieve, building consensus and ensuring we collaborate well to build strong frameworks for the measurement of a powerful set of quality standards in emergency care.

### AND FINALLY...

The introduction of the 4hr ECS in 2004 produced a new cultural paradigm which is woven into the very fabric of modern day emergency care systems in the NHS. We shall be advocating strongly that any revision to that metric should and will rightly retain the very best of what it achieved and address some of its limitations. You will know that we had 'Quality Indicators' as one of the 10 strands of work within the ***RCEM Vision 2020.*** This is our chance to get this right for the next decade for the Long Term Plan and we will knock at every door till it is delivered well by applying those key principles.

Have a good month.

**Dr Taj Hassan**
**President, RCEM**

# Being a RCP Chief Registrar

I knew I wanted something different out of my final year of training.

I heard about the Chief Registrar scheme from reading about the Royal College of Physicians' 'Future Hospital' programme. I have long found it useful to read about the plans of other specialties and training bodies, as I think the best ideas often crop up in other domains. I was impressed by its goals of bridging the gap between junior doctors and senior management, learning about quality improvement and leadership.

As an emergency medicine trainee there are many unknowns about consultant work, despite the Royal College of Emergency Medicine's efforts to change this with the management portfolio. How do you change something you feel could be improved? How do you implement a great idea taken from elsewhere in your own department?

The scheme seemed an ideal way to start to answer these questions and gain insight into the inner workings of an acute Trust, away from the emergency department. In addition, the RCP's education faculty appeared to have a great deal of quality improvement expertise, which would be a help in completing my only outstanding component of the final emergency medicine (FRCEM) exams.

I suggested the scheme to a department lead who had been a previous educational supervisor and before I knew it, a job had been advertised. I applied, was shortlisted and interviewed and got appointed! I separately applied for approval of an out of programme experience (OOPE) through my Training Programme Director and Head of School. It was important for me to get prospective College approval for the 50% clinical time, to avoid delaying my certificate of completion of training for a whole year.

I am now more than halfway through my Chief Registrar time. My typical Chief Registrar week involves planning time around my projects and getting involved in site and whole Trust issues - as well as clinical shifts. I was able to agree a bespoke rota with the clinical director's approval, as I felt it important for me to have some clinical time every week. I am mentored by a senior consultant from outside emergency medicine, who has been very supportive.

I have worked on instituting Greatix/Learning From Excellence in the department. I set up an electronic form, which can be completed on computer or mobile phone and so is available to all staff. The goal is to encourage them to submit examples of great care given, to be fed back to staff involved and shared for wider learning. I have analysed the themes under the Care Quality Commission's five domains. I have observed that, as staff use the form more frequently, they find it easier to notice great work performed by colleagues, and so discussing the submissions has started to become part of monthly clinical governance.

I chair the monthly Junior Doctors' forum for the site. Senior management attend to hear concerns from junior doctors and work together proactively to deal with issues raised. This has given me invaluable practice at the difficult skill of chairing a meeting with different stakeholder groups, as well as the opportunity to work with the Medical Director, Guardian of Safe Working and staff from human resources and medical education. The forum also enables cross-specialty working with other junior doctor colleagues.

I shadowed the Trust Chief Medical Officer at the weekly executive board meeting, allowing me to observe how it is chaired and run, and how decisions are made. This experience improved my understanding of how the Trust functions - something trainees are rarely exposed to.

Another great opportunity has been to become an advisor on a piece of policy research at The King's Fund, around inequalities BAME staff face in the NHS, an issue which affects both staff wellbeing and the care we give to patients.

I think we need more jobs like this, and an increased practical focus on leadership within EM training. A Chief Registrar will be an asset to your department if you think training and inspiring the next generation of emergency medicine leaders, getting our specialty a better seat at the top table, and upskilling your department in quality improvement, is your responsibility. I would highly recommend reading the RCP's guide to recruitment, which does now require that Trusts fund the high-quality teaching, provided by the RCP (10 days across 12 months) as well as for the trainee in role themselves.

I would encourage EM trainees to apply for these ST4+ roles, and consultants to create opportunities like this. I have listed the skills I feel I have improved, compared to when I started the role - all of them are vital for my future consultant career. With the College's forthcoming EM leaders' programme, there is increasing recognition of the evidence underpinning the requirement for these skills, and the need for systematic training of our future consultants - all trainees need them!

**negotiation // chairing // promoting values // delegation // observation // self-insight // influence // reflection // summarising and giving others a platform**

**Chris Odedun**
**ST6 in emergency medicine**

# Bullying in the Emergency Department – stopping the vicious cycle

Bullying is a major problem in the NHS. In the 2018 NHS England staff survey[1], over 19% reported at least one incident of bullying, harassment or abuse in the last 12 months – an increase from 2017's figure. Whether you regard this as an increase in bullying, or an increase in the reporting of bullying, the fact remains that bullying by colleagues is a problem that seems entrenched in the NHS.

If you are an Emergency Medicine (EM) trainee, your experience is even worse. In the 2018 EMTA (Emergency Medicine Trainee Association) survey[2] which ran from December 2018 to February 2019, in the previous four weeks, over 23% reported having felt undermined, 5% felt harassed and 9% felt bullied.

Why is this happening to EM trainees? One reason is its position as a diagnostic practice, where referral to, and interactions with, other specialties are part of the job. For trainees in EM it is not just a question of possibly(!) being bullied by your senior colleagues (reported across the board by specialties) but also by a colleague from another specialty. This isn't just the lazy trope of the arrogant consultant surgeon; it goes far beyond that. We know trainees regularly report that their authority and skills are questioned and undermined by colleagues in other specialties.

Another reason is that working conditions in EM often coincide with factors that drive bullying and harassment. There are many reasons why bullying and harassment occur in the workplace, usually because of underlying problems such as: poor job design and work relationships, the existence of a particular culture, an over-competitive environment and a rigid style of management. All these can exist within the NHS. The GMC National training survey 2018[3] reported that 74% of EM doctors reported the intensity of their workload as heavy or very heavy and 46% felt short of sleep on a weekly basis followed only by those in surgery. This is a healthy breeding ground for a bullying culture to thrive and an inability for those on the receiving end to take positive action against the perpetrators.

### WHAT ARE BULLYING AND HARASSMENT?

Bullying, harassment and victimisation are often linked or used as interchangeable terms, but they are different things in law. There is no legal definition of bullying – it can be subjective. ACAS[4] defines workplace bullying as "offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the person being bullied".

The concept of "harassment" is defined in the Equality Act 2010[5]. This specifically amounts to unwanted conduct relating to a protected characteristic (which include: age, sex, race and disability) that has the purpose or effect of violating a person's dignity or creating an intimidating, humiliating or offensive environment for that person. A one-off incident can be sufficient to amount to harassment.

Employees can also bring a claim under the Protection from Harassment Act 1997[6]. The legislation was originally introduced to bring stalkers to justice. Bringing a claim under this act does not require the behaviour to be targeted at protected characteristics. In Majrowski v Guy's & St Thomas's NHS Trust[7], Mr Majrowski, a clinical audit co-ordinator, was criticised excessively by his manager who was rude and abusive to him in front of other staff. Under this act the employee only needs to show they are suffering from anxiety and distress and the employer should have foreseen this would happen as a result of the behaviour.

### A TIME FOR CHANGE?

Change is happening but for an institution the size of the NHS the pace is frustratingly slow. Whilst change must be driven from above, for change to happen quickly it must come from the "shop floor" and it must happen now. Each Emergency Department (ED) will want to tackle this issue in a different way, but team leaders must be willing to accept that bullying and undermining are more than likely taking place within their ED. Some suggestions include:

- tell your colleagues from other specialties you are implementing a zero-tolerance policy;
- put a list on the wall of what you won't tolerate from your colleagues;
- challenge a colleague who regularly undermines you to spend a day in the ED working with you;
- don't be a bystander, report any bullying and undermining you witness to your team leader and/or Freedom to speak up guardian;
- team leaders decide how to deal with persistent offenders – talk to other department heads and agree how to raise this with the trust board; and
- team leaders take a weekly 'pulse check' of all members of staff.

## WHAT ARE THE STAKES?

The issue is fundamental for both patient safety and for the future of the specialty itself. Time and again 'poor' culture has proved to be a patient safety issue, as highlighted in the Francis Review[8] (which explored raising concerns within the NHS culture) and more recently in the Kennedy Review[9] into the breast surgeon Ian Paterson's surgical practice. This revealed that a hierarchical and oppressive culture made it difficult for colleagues to raise concerns about senior colleagues.

From the perspective of the specialty itself, we know anecdotally that trainees are leaving because of their experience of bullying and harassment. If this is not addressed, it will create conditions of greater overstretch in EM, which will catalyse a vicious cycle of increasing stress, bullying and departures.

As doctors on the frontline, EM specialists regularly feature on our media coping with the demands of increasing numbers of patients and "winter pressures" that are no longer just seasonal. The specialty is therefore in a highly visible position: exposed, but also influential if it makes progress on this issue.

The MeToo and the TimesUp movements were started by individuals who spoke out. This is within your gift. You will do more than saving lives: you may save your specialty and change medicine and wider society for the better.

## REFERENCES


1. https://www.england.nhs.uk/2019/02/nhs-publishes-latest-nhs-staff-survey-results/
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**Jayne Hidderley,**
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# Being Heard

Media attention gives an opportunity for an organisation under the spotlight to reaffirm its core values, and also to show that it can be flexible to the challenges of a changing world. Medical Colleges sadly have little power in the real world, but they can have a lot of influence. The people in power do listen to the Colleges, but action may not follow if they don't like what they hear.

The 95% 4 hour target has served our specialty well for many years and has been responsible for a transformation of the way Emergency Medicine is seen both by the public and the NHS as a whole. However there must be questions as to whether the target has a future as public services face increasing austerity. In reality achievement of the Emergency Access target has been increasingly challenging for some time. A target which most units cannot meet serves little purpose, and Commissioners of hospital services have begun to assume almost without discussion that their local unit will miss the 95% yet again and by a wide margin. This is an unhelpful situation. We all know that the target could be achieved once again if sufficient resources were made available both within acute Trusts and in the community, but this is unlikely to happen. The NHS struggles to meet the cancer treatment targets, which have just as much clinical relevance as our 4 hour target. Mental health has never had the investment that was promised. UK life expectancy is static or declining, due in part to underinvestment in public health, primary care and community services. Alcohol consumption and obesity are increasing with little sign of political will for effective action. Can we persuade the wider public that our target is more important than any of these?

Some will remember that before we had the 4 hour target, Emergency Departments had just one clinical target – the 20 minute thrombolysis target for patients with a STEMI. Most departments eventually met or nearly met this target, which undoubtedly helped cardiac patients, but did little for the average ED patient, or for the department as a whole. Targets focussed on individual clinical problems certainly serve a purpose but do little to improve the overall system.

It is surely inconceivable that we shall return to the days when there were no targets and a retreat to, say, an 85% 4 hour target would look too much like political failure. The challenge is to devise a target that is simple, measurable and relevant to the wellbeing of the majority of emergency patients. It should be achievable and affordable, and the effort to achieve it should bring resources to the Emergency Care pathway. It is not easy to do, and it is hard to imagine that anything could have the elegant simplicity of the 4 hour target. But it is better if any new target is drawn up by people who understand the needs of the emergency patient, and who understand how Emergency Departments work.