Royal College of Emergency Medicine

January 2024

Acute Insight Series

The impact of staff burnout and how to improve retention

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Executive Summary

Emergency departments (EDs) across the UK are facing crisis level pressures that are bearing a significant burden on patient care and staff wellbeing. Many services within the NHS are struggling to deliver optimum care in the context of chronic under funding, lack of sustained investment and the after-effects of a multi-wave pandemic. Emergency Care (EC) is no exception; even prior to the pandemic, EC work environments were reported to be the most intense and high-pressured, with clinical staff expressing highest level of burnout in comparison to other specialties. Workforce retention has been at crisis level for over a decade and is now deepening, with little progress made despite targeted initiatives. The safe delivery of EC is now under serious threat.

Over the past few years, several important factors have been identified as key contributors to the strain and pressure EC is currently under. This has included crowding, bed shortages, and workforce strain. While these issues are undoubtedly vital targets for change, it is also important to consider how staff wellbeing and burnout contribute to the systemic pressures within EC.

EDs are dynamic, stimulating and high-pressured environments that play an essential role in the health and wellbeing of the nation; however, they rely on wellbeing of the staff to function well, which we know directly affects standards of care for patients.

In this report we will draw from up-to-date evidence and our previous acute insight series reports to examine the issue of burnout in the EC workforce and how addressing this core problem is key to maintaining both standards of practice and workforce retention. The capacity of our emergency healthcare workforce is currently compromised beyond what is safe. To deliver adequate care consistently, within the context of high demand, whilst beyond capacity and on an unrelenting basis, is simply unrealistic and can only result in poor outcomes for patients and staff alike. Action is needed to address these issues urgently.

Acknowledgements:

We would like to thank the following for the authoring and research:

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- *Professor Edd Carlton, Professor for the Royal College of Emergency Medicine, University of Bristol, North Bristol NHS Trust*

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The Emergency Care Working Environment

Working in Emergency Care (EC) can be physically, mentally, and emotionally challenging. As standard practice, the ED working environment is stimulating yet tough, operating 24 hours a day 7 days a week, consistently time-pressured and unpredictable in nature.[1] EC has been repeatedly identified as the workplace with the highest intensity of labour across specialties,[2] and it is this level of intense working environment which is recognised as one of the leading factors in job dissatisfaction, staff attrition, and career burnout.[3,4] EC doctors also report higher 'need for recovery' than any other profession,[5] and EC nurses report highest rates of burnout.[6] This paints a picture of an over-stretched workforce working relentlessly in a high-pressured environment. This is neither healthy nor sustainable. Yet it is also the fast paced, intellectually demanding nature of the work that positions EC as one of the most rewarding and stimulating specialties to work; these difficulties arise in a specialty that is well-regarded and valued by those who work within it.

However, the landscape of EC has changed over recent years, with Emergency Departments (EDs) often understaffed and under-resourced, a problem that has been exacerbated by the COVID-19 pandemic.[7] Problems such as exit block and lengthy ambulance queues serve to magnify pressure on an already stretched workforce who are limited by beds and flow through the department. These well documented problems make EC less attractive to both new staff[8] as well as making it unnecessarily stressful and unsustainable for those who are already working in EDs. Other workplace stressors that compromise wellbeing and performance in the EC workplace include poorly functioning IT systems, inadequate or no access to rest spaces and hot food, lack of autonomy over working patterns, and poor leadership,[9,10,11] with many prioritising these concerns over understaffing and crowding. Working in 'unsustainable' environments where workload is high, performance is compromised and staff are working with permanently unmet basic needs, is linked to poor job satisfaction and loss of staff from the specialty.[3,4,9]

[1] RCEM. Creating successful, satisfying and sustainable careers in Emergency Medicine. Available here.
[2] GMC (2019) National training surveys 2019: Initial findings report. Available here.
[3] GMC (2021) Completing the picture survey. Available here.
[4] HEE (2017) RePAIR: Reducing pre-registration attrition and improving retention. Available here.
[5] Cottey L, Roberts T, Graham B, Horner D, Stevens KN, Enki D, Lyttle MD, Latour J et al. (2020) Need for recovery amongst emergency physicians in the UK and Ireland: a cross-sectional survey. BMJ open;10(11):e041485.
[6] Adriaenssens J, De Gucht V, Maes S (2015) Determinants and prevalence of burnout in emergency nurses: a systematic review of 25 years of research. International journal of nursing studies;52(2):649-61.
[7] RCEM (2020) Retain, Recruit, Recover: Our call for action to improve the urgent & emergency care system. Available here.
[8] HEE (2013) Emergency Medicine: Background to HEE proposals to address workforce shortages. Available here.
[9] Daniels J, Ingram J, Pease A, Wainwright E, Beckett K, Iyadurai L, et al. (2021) The COVID-19 Clinician Cohort (CoCCo) Study: Empirically grounded recommendations for forward-facing psychological care of frontline doctors. International Journal of Environmental Research and Public Health;18(18):9675.
[10] Daniels J, Robinson E, Jenkinson E & Carlton, E. (2024) Psychologically Informed Practice & Policy(PIPP) recommendations. Available here.
[11] Daniels J, Robinson E, Jenkinson E & Carlton, E. (2024) Perceived barriers and opportunities to improve working conditions and staff retention in Emergency Departments: a qualitative study. *Emergency Medicine Journal*, Epub ahead of print: [8 Jan 2024]. https://doi.org/10.1136/emermed-2023-213189

We recognise that the pandemic has also sustained a significant impact on the mental health of those working in EC in recent years,[9,12,13] with research reflecting that the multi-wave pandemic served to compound existing stressors at work.

While rates of mental health problems across the workforce during the full force of the pandemic were alarming, these problems were not new. More recent reports suggest that the mental health of the workforce is further deteriorating, with 47% of NHS staff reporting feeling unwell because of work-related stress in the previous twelve months.[14] The impact of this long-term will be far reaching. The workforce is struggling, and we are now at crisis point.

Retention in EC has been identified as a priority area for at least a decade;[15,16] key organisations have set out initiatives and targeted plans, such as the NHS Long Term Plan National Retention Programme,[17] the NHS People Plan,[18] The Royal College of Nurses retention campaign,[19,20] and the RCEM CARES campaign, which included retention as a key aim. More recently, NHS England & Department for Health's Long-Term Workforce plan included key steps to improve retention in the healthcare service. However, staff attrition continues to escalate. While there are emerging longer-term plans to train more staff, this does not solve the known problems faced by current staff which underpin their intention to leave, such as the compromised wellbeing in the context of increasing pressure on clinical staff to perform despite this unsustainable workload.

As discussed in our earlier Acute Insight briefing on Crowding, poor patient flow through the ED and inadequate staffing are key factors that increase higher workload. The consequences of this are unavoidable breaches in standard clinical processes, such as longer wait times for triage and assessment and patients waiting on beds in corridors, leading to inadequate care and medical errors. The impact on the patient is direct, however the indirect impact on EC staff is the intense personal burden of working in ways that feel morally unacceptable and risk harm, both in the context of a lack of appropriate support. This contributes to burnout and staff attrition, with the resulting low staff ratios further contributing to the high-pressure work environment that further compromises patient care and staff wellbeing.

[12] Harris S, Jenkinson E, Carlton E, Roberts T, Daniels J (2021) "It's Been Ugly": A large-scale qualitative study into the difficulties frontline doctors faced across two waves of the COVID-19 pandemic. International Journal of Environmental Research and Public Health;18(24):13067.
[13] Roberts T, Daniels J, Hulme W, Hirst R, Horner D, Lyttle MD, et al. (2021) Psychological distress during the acceleration phase of the COVID-19 pandemic: a survey of doctors practising in emergency medicine, anaesthesia and intensive care medicine in the UK and Ireland. Emergency Medicine Journal;38(6):450–9.
[14] IPPO (2022). NHS Staff Wellbeing: why investing in organisational and management practices makes business sense. Available here.
[15] Oliver D (2015) David Oliver: Stop blaming patients for emergency visits. BMJ;351:h6119–9.
[16] Hughes G (2013) The emergency medicine taskforce: an interim report. Emergency Medicine Journal;30(5):348–8.
[17] NHS (2019) The NHS Long Term Plan. Available here.
[18] NHS (2020) WE ARE THE NHS: People Plan 2020/21 - action for us all. Available here.
[19] RCN (2023) Healthy workplace, healthy you. Available here.
[20] RCN (2018) Rest, Rehydrate, Refuel. Available here.

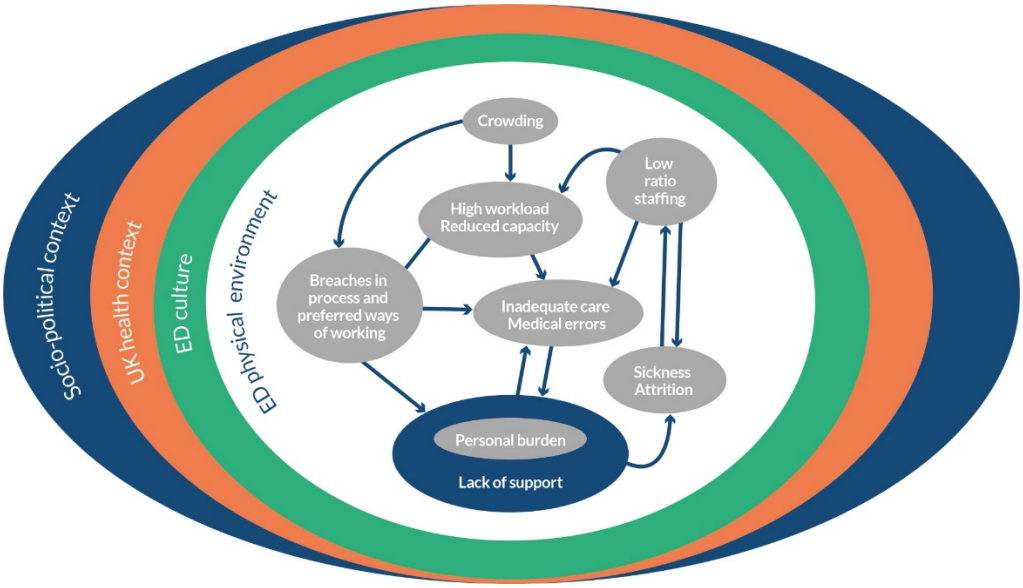

Figure 1. The systemic impact of staff high workload and the delivery of inadequate care

These multiple factors and how they interact serve to maintain the cyclical systemic pressure within the EC working environment. The solution must be multi-level and take account of the complexity of these problems and the specific nature of the environment in which they occur; a busy emergency department where the nature of the work is naturally intense, fast paced and historically overstretched.

The personal and economic burden cost of burnout

'Burnout', a state of physical and emotional exhaustion resulting from long-term stress in an occupational role, is common amongst the healthcare workforce. Burnout is linked to absenteeism, intention to leave, low job satisfaction, substance abuse, poor health[21] and adverse outcomes for patients.[22] One-third of UK doctors report burnout, with the highest levels were seen in EC,[23,24] where up to 80% of doctors[25] and around 60% of nurses are affected.[26] These worryingly high rates reflect that the majority of the workforce in EC are severely compromised on a day-to-day level. Burnout develops gradually, with many performing at much lower levels without recognition of the impact on productivity and wellbeing. Symptoms include feeling excessively tired, a negative outlook towards work, a sense of overwhelm and physical health problems. When comparing medical specialties, burnout and low job satisfaction is the most problematic in those working in EC and intensive care.[22] We know that key factors associated with burnout include volume and intensity of workload, control and autonomy, recognition, respect and civility, and lack of support. These

[21] Goldberg R, Boss RW, Chan L, Goldberg J, Mallon WK, Moradzadeh D, Goodman EA, McConkie ML (1996) Burnout and its correlates in emergency physicians: four years' experience with a wellness booth. Academic Emergency Medicine;3(12):1156-64.
[22] Hodkinson A, Zhou A, Johnson J, et al. (2022) Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis. BMJ;378:e070442.
[23] McKinley N, McCain RS, Convie L, Clarke M, Dempster M, Campbell WJ, et al. (2020) Resilience, burnout and coping mechanisms in UK doctors: a cross-sectional study. BMJ Open;10(1):e031765.
[24] Arora M, Asha S, Chinnappa J, Diwan AD (2013) Review article: Burnout in emergency medicine physicians. Emergency Medicine Australasia;25(6):491–5
[25] Boutou A, Pitsiou G, Sourla E, Kioumis I (2019) Burnout syndrome among emergency medicine physicians: an update on its prevalence and risk factors. European Review for Medical and Pharmacological Sciences;23(20):9058–65.
[26] Chor WPD, Ng WM, Cheng L, et al. (2021) Burnout amongst emergency healthcare workers during the COVID-19 pandemic: A multi-center study. Am J Emerg Med;46:700-702.

are all problems commonly reported in EC work settings[9,10,11,12]. Alongside high rates for need for recovery[5] and mental health difficulties in the workforce[13], EC has become a high-risk specialty to work in. This will not change without intervention.

Poor mental health and wellbeing costs the NHS an estimated £12.1 billion a year (estimated cost of presenteeism £6.07 billion, staff absence £3.79 billion, and cost of the use of bank/agency staff £2.24 billion). Data from NHS Employers[27] indicate that savings of 4,000 Whole-Time Equivalent working days can be made through reductions in sickness, by improving staff wellbeing. In one example, this translated to £301,015 savings in sickness absence costs.[28] By tackling poor mental health and wellbeing and reducing staff losses, the NHS could save up to £1 billion under some of the scenarios modelled.[14]

Burnout and medical errors

Burnout is associated with the increased risk of medical errors[22], leading to increased risk of patient morbidity and mortality as well as higher health care costs.[29] In the UK, medical errors are estimated to cost the NHS over £1billion in litigation costs and £2billion in additional bed days annually.[29] The most common medical errors include medication and diagnostic errors, with national estimates of more than 237 million medication errors happening each year in England. The avoidable consequences of these errors cost the NHS roughly £98 million (2.9% of UK NHS) and contributing to 1708 deaths yearly.[30]

EC is particularly vulnerable to medical errors due to the commonly complex, critical and time-sensitive decisions that make up the work of the EC clinician,[31] decisions which have the potential to bear long-term consequences. Data reflects that medical errors are common in the ED, with 11% of all medical liabilities taking place in EDs.[32] The top four categories of clinical claims reported by volume this year were obstetrics, emergency medicine, orthopaedic surgery and general surgery. Taken together, this suggests that ED patients are being exposed to risks of harm and/or death[33,34] on a regular basis. Evidence points to the pivotal role of job strain, fatigue, high workload and poor wellbeing as the greatest predictors of poor patient safety and medical errors.[35] However, burnout in clinicians has been repeatedly recognised as the key factor associated with increased risk of medical errors,[36] and, as identified, rates of burnout are high in EC so the risk is further magnified.

[27] NHS Employers (2019) Improving performance by improving staff wellbeing: North Bristol NHS Trust. Available here.
[28] NHS Employers (2021) NHS health and wellbeing strategic overview. Available here.
[29] O'Connor DB, Hall LH, Johnson J (2020) Job strain, burnout, wellbeing and patient safety in healthcare professionals. Connecting Healthcare Worker Well-Being, Patient Safety and Organisational Change;11–23.
[30] Elliott RA, Camacho E, Jankovic D, Sculpher MJ, Faria R (2021) Economic analysis of the prevalence and clinical and economic burden of medication error in England. BMJ Quality & Safety;30(2):bmjqs-2019-010206.
[31] Schenkel S. (2000) Promoting patient safety and preventing medical error in Emergency Departments. Academic Emergency Medicine;7(11):1204–22.
[32] Hughes G (2013) The emergency medicine taskforce: an interim report. Emergency Medicine Journal;30(5):348–8.
[33] Källberg AS, Göransson KE, Östergren J, Florin J, Ehrenberg A (2013) Medical errors and complaints in emergency department care in Sweden as reported by care providers, healthcare staff, and patients – a national review. European Journal of Emergency Medicine;20(1):33–8.
[34] Nunez S (2006) Unscheduled returns to the emergency department: an outcome of medical errors? Quality and Safety in Health Care;15(2):102–8.
[35] Hall LH, Johnson J, Watt I, Tsipa A, O'Connor DB (2016) Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. PLoS One;11(7):e0159015.
[36] Stehman C, Testo Z, Gershaw R, Kellogg A (2019) Burnout, Drop Out, Suicide: Physician Loss in Emergency Medicine, Part I. Western Journal of Emergency Medicine ;20(3):485–94.

In addition to the direct impact on patients, medical errors can also be a source of great distress for the clinician responsible, with common consequences including burnout and depression[36,37], continuing the vicious cycle between burnout and compromised care.[38] Those associated with medical errors are often already displaying varying degrees of burnout, which are directly attributed to extended work hours and heavy workloads.[39] The lack of societal understanding given to medical errors has also become a source of stress[36] both to the individual and their wider team, a further factor associated with both burnout and staff attrition.

The pressures of working within EC such as high patient volumes, slow flow through the department, the physical environment and nature of the work itself, serve to elevate the risk of both staff burnout and standards of clinical care to a degree that is unsafe and costly. Burnout is undoubtedly a symptom of a poorly functioning system that detrimentally affects staff wellbeing and patient outcomes and needs to be addressed.

The impact of burnout on staff retention and attrition

As outlined, workplace wellbeing and burnout are known to be closely linked to staff retention, both as a key contributor to staff leaving the profession and also as a consequence of the increased demands on staff during the staffing crisis.[40,41] Clinicians in EC are exposed to sometimes quite extreme or prolonged occupational stressors as a matter of routine; both those that are naturally part of the job, such as critical nature of the clinical work, but also the added pressures that are the consequence of an under-resourced poorly functioning system. We know that this affects staff morale, increases the likelihood poorer outcomes for patients,[42] reduces job satisfaction,[22,43] and ultimately increases intent to leave the profession,[21,44] keeping that vicious cycle going. Clinicians experiencing burnout are also three times more likely to have serious intentions to leave their jobs.

While the clearest direct impact on the workforce is staff exiting the profession or specialty, the significant shifts in recent years towards staff reducing hours, changing careers, or retiring early[2] also have a tangible effect with important resource implications. These changes in working practices are a sign of unsustainable working in the EC, and also an opportunity for workforce development that could offer solutions to these problems through workforce redesign.

The impact of burnout on the sustainability of the workforce is unequivocal and the evidence is overwhelming. The current poor working conditions in the ED are fertile ground for the proliferation of burnout and loss of staff. Yet despite the known knock-on effects of low staff ratios on workload, wellbeing and patient care, information is not collected on workforce

[37] Fatima S, Soria S, Esteban-Cruciani N (2021) Medical errors during training: how do residents cope?: a descriptive study. BMC Medical Education;21(1).
[38] Schwappach DL, Boluarte TA (2009) The emotional impact of medical error involvement on physicians: a call for leadership and organisational accountability. Swiss Med Wkly;139(1-2):9-15.
[39] Aala A, Tabrizi J, Ranjbar F, Shams Vahdati S, Mohammadi N (2014) Frequency of burnout, sleepiness and depression in Emergency Medicine residents with medical rrrors in the Emergency Department. Advances in Bioscience and Clinical Medicine;2:58-63.
[40] Rondeau KV, Francescutti LH (2005) Emergency Department overcrowding: The impact of resource scarcity on physician job satisfaction. Journal of Healthcare Management;50(5):327–41.
[41] GMC (2019) Caring for doctors, caring for people. Available here.
[42] Crowe RP, Bower JK, Cash RE, Panchal AR, Rodriguez SA, Olivo-Marston SE (2018) Association of burnout with workforce-reducing factors among EMS professionals. Prehosp Emerg Care;22(2):229-236.
[43] Schneider A, Weigl M (2018) Associations between psychosocial work factors and provider mental well-being in emergency departments: A systematic review. PLoS One;13(6):e0197375.
[44] Jiang H, Ma L, Gao C, Li T, Huang L, Huang W (2017) Satisfaction, burnout and intention to stay of emergency nurses in Shanghai. Emergency Medicine Journal;34(7):448-453.

attrition in EC at a local or Government level. Without this, targeted interventions and policy development are more difficult, particularly given the unique circumstances of the EC working environment and the necessity to tailor to the unique demands of EC working. While NHS digital and other non-NHS platforms collate data on workforce, none of the data gathered is sufficiently granular to gain a greater understanding of staff loss or the reasons associated with workforce attrition. In order to take steps towards resolving one of the most pivotal problems maintaining the systemic pressures in the ED, we must first be able to quantify and understand it, which we currently do not.

The consequences of inadequate staffing

We know that inadequate staffing levels impact patient care and staff wellbeing. Currently, there is a shortfall of over 2000 consultants in EDs,[7] with many more in nursing and other roles. These are concerning numbers which serve to highlight the inevitable impact on patient care. Where RCEM recommends that safe staffing should be based on a ratio of at least one WTE consultant for every 4000 annual attendances,[45] current staffing is substantially below this (see table 1). This suggests that the ED is operating at levels where medical errors and compromised care is practically unavoidable.

Low staff ratios are a significant challenge for EC, placing avoidable, unnecessary pressure on the workforce. This is particularly problematic due to the nature of the clinical work and reliance on a full staff compliment and importantly, the necessary specific skills mix. Low patient-to-clinician ratios are associated with poorer patient care measured by longer waiting times, number of patients leaving without being seen and patient satisfaction,[46] staff wellbeing[47] and productivity,[48] again highlighting the cyclical relationship between patient wellbeing, staff wellbeing and retention: lower staff ratios lead to higher workloads thereby reducing quality of care,[46,49] increasing medical errors,[35] harming staff wellbeing,[47] and inevitably leading to increased staff sickness and intention to leave,[48,50,51,52,53,54] further compounding the issue.

Safe staffing levels within the ED are vital to the delivery of efficient and adequate care, particularly when facing chronic crowding issues. Understaffing is a key contributor to the increasing pressure on an already stretched workforce[55]. Low staff ratios and staff attrition is now considered the major challenge to ensuring the continuity of essential health and of high

[45] RCEM (2019) Consultant Staffing in Emergency Departments in the UK. Available here.
[46] Kanavaki AM, Lightfoot CJ, Palmer J, Wilkinson TJ, Smith AC, Jones CR (2021) Kidney care during COVID-19 in the UK: Perspectives of healthcare professionals on impacts on care quality and staff well-being. International Journal of Environmental Research and Public Health;19(1):188.
[47] Hofmeyer A, Taylor R, Kennedy K (2020) Fostering compassion and reducing burnout: How can health system leaders respond in the Covid-19 pandemic and beyond? Nurse Education Today;104502.
[48] Teoh KRH, Kinman G, Hassard J (2020) The relationship between healthcare staff wellbeing and patient care: It's not that simple. Integrating the Organization of Health Services, Worker Wellbeing and Quality of Care;221–44.
[49] Jones S, Moulton C, Swift S, Molyneux P, Black S, Mason N, et al. (2022) Association between delays to patient admission from the emergency department and all-cause 30-day mortality. Emergency Medicine Journal;39(3).
[50] Chen Y, Wu H, Kuo F, Koh D, Guo YL, Shiao JS (2022) Hospital factors that predict intention of health care workers to leave their job during the COVID -19 pandemic. Journal of Nursing Scholarship;54(5).
[51] Hämmig O (2018) Explaining burnout and the intention to leave the profession among health professionals – a cross-sectional study in a hospital setting in Switzerland. BMC Health Services Research;18(1).
[52] Moloney W, Boxall P, Parsons M, Cheung G (2017) Factors predicting Registered Nurses' intentions to leave their organization and profession: A job demands-resources framework. Journal of Advanced Nursing;74(4):864–75.
[53] Norkiene I, Jovarauskaite L, Kvedaraite M, Uppal E, Phull MK, Chander H, et al. (2021) "Should I Stay, or Should I Go?" Psychological Distress Predicts Career Change Ideation among Intensive Care Staff in Lithuania and the UK Amid COVID-19 Pandemic. International Journal of Environmental Research and Public Health;18(5):2660.
[54] HSE (2022). Work-related stress, anxiety or depression statistics in Great Britain, 2022. Available here.
[55] RCEM (2019) RCEM CARES: The Next Phase. Available here.

standards of care[56] with low staffing considered to be the primary influencing factor in the efficient delivery of care in the ED, over and above patient volume.[57] Low staff ratios are also related to poor job dissatisfaction[40] and emotional exhaustion,[58] with staff feeling unable to deliver high level quality care to their patients under what they consider unsafe circumstances.[59]

Increased staffing levels represent a key target for intervention, due to the positive knock-on effects with respect to workload and wellbeing, and this is a key focus in the Long Term Workplan. However, it is also crucial that we consider staff *already* working within the ED environment and how we retain them, as this represents not only a more cost effective and timely intervention than re-training, but it also sends the message to our staff on the frontline that they are important and that they are valued.

Facing forward…

The silent burnout epidemic in EC has resulted from working in an unremitting, high-intensity and chronically over-stretched environment, which poses a serious threat to safe and effective healthcare delivery. Burnout is not simply a staff wellbeing issue, the effects are far reaching and bear a personal and economic burden to patients, staff teams and the workforce as a whole. As is stands, the workforce is significantly depleted in terms of numbers and wellbeing. With fewer staff, the workload is higher, and the consequence is burnout, further eroding the workforce. This vicious cycle will continue to worsen without action.

We know that intervention is most effective at an organisational level when it comes to staff wellbeing and retention, however organisational change cannot happen without the support of Governmental policy. For this reason, we call for action on two levels.

Firstly, we call upon governments and national policymakers to commit to resolving the key systemic problems that are contributing to workload pressures, such as crowding, flow and the current level of staff attrition. Specifically:

1. **Increased bed availability** to match demand more closely, in order to improve flow through the ED, reducing ambulance waiting times and pressure on EC staff. This means keeping bed occupancy levels below 85%.
2. **Increased investment in health and social care services** to tackle exit block, protecting the most vulnerable of our ED patients and ensuring a safe pathway out of the ED and to communities.
3. **Increased investment in the workforce** through recruitment and retention: financial support for the recruitment of consultant posts, driven by the safe staffing ratios reflecting expected standards in a Western developed nation.

[56] Nacer H, McKee M (2022) WHO offers a prescription for tackling the health workforce crisis, but will the UK take the medicine? BMJ;o2567.
[57] Anderson DE, Pimentel L, Golden BL, Wasil E, Jon Mark Hirshon (2016) Drivers of ED efficiency: a statistical and cluster analysis of volume, staffing, and operations. American Journal of Emergency Medicine;34(2):155–61.
[58] Sheward L, Hunt NT J, Hagen S, Macleod M, Ball J (2005) The relationship between UK hospital nurse staffing and emotional exhaustion and job dissatisfaction. Journal of Nursing Management ;13(1):51–60.
[59] Wolf LA, Perhats C, Delao AM, Clark PR, Moon MD (2017) On the Threshold of Safety: A Qualitative Exploration of Nurses' Perceptions of Factors Involved in Safe Staffing Levels in Emergency Departments. Journal of Emergency Nursing;43(2):150–7.

4. **Mandate collection of EM workforce attrition data**: professional bodies require high quality granular data on attrition and retention at a national level in order to develop policies and intervention that can understand and feasibly address retention.

Secondly, we call upon Government to provide financial investment and updated guidance to mandate the implementation of NHS and professional guidance on workforce wellbeing in local NHS Trusts. This should include implementation of the RCEM commissioned recommendations for wellbeing and retention for the EC workforce:[10,11]

The following are aimed at the NHSE and Trusts as employers:

1. Create an environment to thrive in.

- **Access to healthy hot food** should be available to all staff at all times during shift working, including out of hours, whether this is access to a canteen or through provision of means to purchase and heat food. This is a basic need for the workforce to function effectively.
- **Protected study time** is vital for staff to continuing professional developed to ensure each staff member can work safely. This should be a mandatory within training contracts and/or annual job planning and appraisal. This needs to be rolled across all NHS Trusts.
- **Access to adequate rest spaces** should be provided. A comfortable place to rest and decompress is vital for all staff, especially those on extended hours shifts, and is an important part of safe working.
- **Influence and autonomy** over working patterns are key to workforce wellbeing and engagement. Self-rostering should be introduced to allow staff to gain balance and autonomy in their working lives. Investment in is needed to reduce barriers to access, such as specialised software or training.
- **A department that is well-resourced and fit-for-purpose** should include efficient IT facilities, personal protective equipment, staff only spaces (including toilets), protected spaces for writing clinical notes, all as a minimum. All departments should take inventory of the resources required to support a fully functioning team and be supported to escalate need for safe working practices.

2. Cultivating a better culture

- **A proactive approach to wellbeing.** This includes support to rest and take annual leave entitlements; appointment of wellbeing champions; adopting positive feedback/praise as part of a normal culture; ‘Warm handovers’ ensuring staff in need arrive at where they need to be, whatever the problem.
- **Civility and respect.** Supporting and expecting staff to address incivility and adhere to up-to-date policies in relation to bullying, harassment and issues of inclusion, asking the question whether staff are subject to harassment or bullying as a matter of course. A clear written/visual description of the lines of accountability from shop floor clinician to chief executive should form part of trust and local induction material.
- **Regular review of need.** Regular planned formal and informal discussions or reviews of educational needs, personal needs and circumstances, at a frequency acceptable to those involved is vital. This should also form part of an appraisal that is tailored to the individual, completed with dedicated time, space and interest in the interviewee, but should not be restricted to an annual check in.

- **Variety in role.** This is particularly important for those experiencing burnout or who have been working in the same role for extended periods. This should include a review of engagement with current role and consideration of short-term or long-term secondments, day-to-day rotations, opportunities for skill development.
- **Work to destigmatise mental health.** Information on mental health should be places around the place of work, with mental health check ins forming part of every post-incident debriefing, appraisal and formal review. Those in leadership positions are vital in creating a 'psychological safe' space where work is often difficult and stressful, and distress is a normal response to abnormal experiences.

3. Access to psychological wellbeing

- **A tailored pathway of care** is vital for staff to access the care they need when they need it. All trusts should offer a multilevel approach which is tailored to need, offers choice, and is clearly and easily accessible to all. Services should not be developed exclusively for those struggling with mental health, but for staff who are in need of any kind of signposting or support (see CoCCo study[9] and PiPP[10] report for models of staff support).
- **Staff support services** should offer:
    - Information about services available to staff. This should be accessible and visible throughout trusts, including how, why and where to access staff support.
    - Signposting to other services such as occupational health
    - Proactive/preventative training and consultancy to cultivate high-functioning teams that are well equipped to manage challenges as they arise.
    - Interventions that are responsive to need, from bespoke team training to leadership consultation, individual structured therapy to informal drop-ins.
    - Different formats and modes of evidence-based support and interventions
- **Wellbeing leads** should be appointed across each department and service. This should include not only leading on wellbeing initiatives, but also quality improvement and cultural change. This role should be valued as a vital agent of change.

4. Leadership

Leadership is also pivotal to organisational and cultural change. Training for leadership should be mandated in the NHS and begin early to ensure stronger leadership development and better outcomes. It should be integral to medical and nursing training. A formal programme of leadership training should also be mandatory for all appoint to their first leadership role. At a local NHS Trust level, those in leadership positions should be provided with:

- An NHS local induction that includes mapping lines of accountability, escalation routes and support pathways
- A compassionate inclusive leadership training package, with protected time to both attend the training and complete necessary tasks and requirements.
- Leadership specific mentorship or coaching programme to support continued development
- •Access to consultation services with the local NHS staff support services. Clear role description on appointment, defining workload, protected time and responsibilities. This should be at trust level and supported by RCEM.

- Training focussed on recognising signs of poor wellbeing in staff, including next steps and available pathways to psychological care.

These are simple steps that will benefit the mental health and wellbeing of the workforce, which will benefit retention of the workforce. However, action is needed on the part of the Government to support health leaders at all levels to action and implement change.

We urge health leaders to urgently respond to the repeated calls to action in regard to mental health and wellbeing of the workforce and take a moral responsibility through direct investment and leadership for change. Without targeted and channelled action, we are knowingly and willingly placing our dedicated staff and most vulnerable patients at risk, promising more significant and far-reaching problems in the longer term. The time to act is now.