**Emergency Medicine Taskforce**

**Interim Report**

**Executive Summary**

**Background**

In recent years, the poor recruitment at ST4 in Emergency Medicine (EM) has raised concerns within the specialty and the medical profession. The specialty in 2011 and 2012 has achieved a lower than 50% fill rate into higher training. Fewer trainees are opting to choose EM for higher specialty training due to concerns over the intensity and nature of the work, unsociable hours, working conditions and the sustainability of such a career to the age of 68.

The Emergency Medicine Taskforce was established by the Department of Health in September 2011. This is its interim report. The Taskforce in fulfilling its Terms of Reference has explored many aspects of medical education and training, which may be contributing to the problems that the specialty is currently facing.

Fill rates, trainee numbers and deanery data has been collected, expert evidence and opinion has been sought to establish the key factors effecting Emergency Medicine. Using this data and evidence the Taskforce has developed a number of recommendations focusing on medical education, training and service provision in order to improve the recruitment and retention in the specialty.

**Commissioning**

It is essential that commissioners seek advice from those who understand the urgent and emergency care landscape and the population served.

**Workforce**

Poor fill rates have lead to a decline in the number of higher trainees and thus the supply of future Consultants. The Taskforce group have looked at ways in which to increase fill rates for Emergency Medicine posts at ST4, whilst simultaneously identifying ways to enhance the desirability of the specialty.

The College of Emergency Medicine (CEM) has recommended a minimum of 10 whole time equivalent EM Consultants for each Emergency Department. This number is designed to provide up to 16 hours a day EM Consultant presence 7 days a week. Increased EM Consultant numbers will ensure improved work/life balance prospects for the trainees, enhanced protected training time and better supervision.

In recent years, there has been an increase of non-medical practitioners undertaking a role in the ED. These practitioners work with and compliment the senior medical workforce, interacting closely with Emergency Medicine Consultants. Many of these roles have been developed in UK hospitals.
Innovative developments in skill mix and roles will continue to play a major part in the delivery of urgent and emergency care. The Taskforce will look to highlight best practice and encourage dissemination to the wider health economy.

**The Training Programme**

To improve recruitment rates in Emergency Medicine more flexibility is needed in the way core training is configured and delivered. The specialty is currently considering the entry requirements for core training and recognising transferable competences of trainees currently in other specialties.

CEM also wishes to explore the parallel running of a run-through training programme.

**Reconfiguration**

Reconfiguration is a complex agenda and involves an understanding of professional views, patient safety, public access and the political dynamic. Given the pressures on primary care and EM services to meet unscheduled demand this may be a consideration for the future.

**Market facing pay / terms and conditions**

It is impracticable to pursue market facing pay and changes to terms and conditions at this current time as this would simply drive up current costs without fundamentally addressing the problem. In the longer term this area may well need to be reconsidered to make the specialty a more popular career choice.

**Conclusion**

The report should be used by Health Education England (HEE) as a basis for further discussions as to how best to address the workforce issues that the report highlights at a national and LETB level; recognising that each LETB area may need different aspects of the solutions that the Taskforce have identified.

However, there is an urgency to this and the Taskforce believes that measures will need implementing in the next months if we are to avoid increasing problems. The Taskforce would also wish to emphasise that urgent work is needed across the spectrum of emergency and acute care specialties (so not just EM) to address the service pressures. Developing an attractive and sustainable career in Emergency Medicine and those other specialties that have a large emergency component is the major and urgent challenge.
Department of Health (DH) officials and members of the College of Emergency Medicine (CEM) established the Emergency Medicine Taskforce in September 2011 to address workforce issues in Emergency Medicine. The group has considered
these issues and made recommendations on the future clinician staffing of Emergency Departments (ED) with the aim of ensuring patients within EDs receive high quality care that is consistent, responsive, safe and effective as well as being value for money. Regular updates of these recommendations were provided to the Medical Programme Board.

1. Introduction and principles

The specialty of Emergency Medicine is currently facing critical workforce shortages at ST4 and Consultant level in many areas in England. This problem is sufficient enough to potentially threaten the reliable delivery of urgent and emergency care services.

Waiting for a natural solution to the problem is no longer an option and EDs in partnership with the medical training and education system will have to actively seek alternative staffing and training solutions in order to meet service delivery and public expectation.

Fundamental changes in training support and supervision, working conditions and long-term career pathways are needed to ensure that Emergency Medicine is made attractive and sustainable to trainees in the future.

Additional pressures on acute medicine departments and General Practice could result in increasing pressures on the ED and the wider service in some trusts.

This is an interim report from the Emergency Medicine Taskforce Group.

The principle underpinning the work of the group is that patient safety is paramount and the current situation in which much of the care within the ED setting is invariably delivered by relatively junior doctors in training is no longer tenable or acceptable. All patients attending the Emergency Department should be reviewed by a suitably trained and experienced clinician1.

The issues that prompted this initiative were:

- Concerns over patient safety.
- Desire to optimise quality and effectiveness of care in Emergency Departments (EDs).
- Inadequate Emergency Medicine Consultant numbers.
- Trainee recruitment difficulties and attrition.
- Difficulty in staffing ED rotas at higher specialty trainee, SAS rota and senior level particularly overnight.
- F2 and other junior doctors inadequately supervised in EDs.
- Staff grade doctor recruitment difficulties and attrition.
- Overnight closure of EDs.
- Significant and increasing expenditure on locums and agency staff.
- Emerging roles for non-medical staff that appear to lack national standardisation around preparation.

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An opportunity to develop a collegiate response to meet the increasing demands placed on EDs.

Urgent and Emergency Care describes the provision of all unscheduled care, whether, in primary care or hospital based. The future model of care will determine the workforce needs. Workforce planning aims to create the capacity required for the known or predicted demand. This is the main aim of this document. It does however mention policy and service design issues, which may be able to influence demand, either by decreasing it or redirecting it. The present fragmented system across emergency and urgent care leads to duplication and poor use of its workforce. If every patient could see the appropriate clinician first; then the quality of care would be improved. An emergency and urgent care system that is truly designed around patients and the staff delivering the care, will address demand and capacity issues, variability and sustainability problems because it would become an attractive specialist area to in which to work. In addition, whilst it is undesirable for staff to be overstretched it is equally undesirable for staff to be underutilised and thus the model by which care is provided is highly relevant but is not addressed in this predominantly workforce-focused paper. The group recognises the era of tight financial constraints and thus the limitations for any additional investment in workforce. However, this must be balanced against the wider healthcare system’s commitment to patient safety, public expectation and the negative publicity surrounding the consequences of inadequate ED staffing. A permanent, fully trained and experienced senior ED clinical workforce will deliver the care that the public expect and deserve.

ED clinical staffing needs to reflect the high risk profile of many ED patients, of all age groups, presenting in large numbers with undifferentiated conditions with the consequent potential for significant mortality and morbidity. This care needs to be provided 24 hours/day, 7 days/week.

In England the year on year increase in ED attendances, both in terms of number and complexity, combined with the expanding role of EM in both diagnosis and treatment, has not been matched by increases in the ED workforce, particularly at a senior level. As a result, there is frequently a mismatch between demand and ED expertise, particularly overnight and at weekends.

Current ED senior staffing compares unfavourably with international models in North America and Australasia. The risks associated with inadequate senior EM staffing have been dramatically demonstrated in Mid-Staffordshire NHS Trust, and elsewhere.

A major contributory factor to the current workforce landscape has been the flawed assumption that emergency care demand can be managed downward. Although initiatives such as long-term condition surveillance, 111, NHS Pathways, Urgent Care centres and the Directory of Services are welcome and have been shown to have local impact on patient flows, this has not resulted in an overall reduction of unscheduled care ED attendance (for example, the Urgent Care Centres for Birmingham and Solihull area had 250,000 attendances per year, only 4% of which result in referral to secondary care, N Chauhan, personal communication). It should, therefore, be reasonable to anticipate a continuing rise in ED demand, as the population ages and public awareness of the importance of chest pain, stroke and infection initiatives, for example, increases. The present urgent and emergency care system is inconsistent and is often commissioned and planned as individual components within the whole patient journey.
There is an enormous amount of variation in how this care is delivered, which often results in patients being confused with regard to which part of the system is most appropriate to meet their need. As a consequence, patient outcomes are not optimised, care is fragmented and staff are left feeling demoralised. More recently, ‘whole system’ and ‘team’ working are being encouraged which have benefits for workforce planning and for the quality of care being delivered, but the implementation of such arrangements is inconsistent, and is dependent upon individuals rather than systems.

Current financial challenges mandate an evidence based approach to the delivery of emergency care. The evidence suggests that care delivered by more experienced clinicians is safer, has better outcomes and is highly cost effective.

2. Landscape

1. The model of care recommended by the College of Emergency Medicine (CEM) is for Consultant presence 16 hours per day, seven days per week. This requires 10 Whole Time Equivalent (WTE) Consultants per ED, compared to the current average of 4.5 WTEs.

2. The Centre for Workforce Intelligence (CfWI) predicts it will take until 2020 to secure sufficient numbers of consultants. This is based on maintaining the number of training posts at current levels and ensuring 100% fill rates for such posts and programmes. However, this is unlikely to occur given current attrition rates which will inevitably lead to a significant revision towards 2030.

3. For core training, recruitment is to the Acute Care Common Stem (ACCS), of which EM is one constituent specialty. In 2011, 96% of the 192 posts were filled— but retention in ED training is poor. For example, many ACCS trainees migrate to another specialty rather than progressing to ST4 (EM). In 2012, 94% of posts were filled.

4. For ST4 (first year of higher training) in 2011 there were 135 posts vacant in England but only 45 (41%) were filled. In 2012, there were 196 posts vacant in England and 86 (44%) were filled.

5. Based on the GMC Trainee Survey there were 169 CT3 trainees in post on the 30 April 2012. Of these trainees, only 84 applied to the national EM recruitment ST4 recruitment round. 92% (77) were considered appointable and were offered a post, with 85% (71) accepting a post.

6. Recruiting doctors from overseas represents a possible short-term solution but will not provide longer-term recruitment and retention solutions given there were significant immigration obstacles to this recruitment option during 2011-12. This route is now open and there is still significant scope for the UK to recruit non-UK/EEA doctors into EM posts in 2012. In practice, despite intensive recruitment efforts, this initiative has proved disappointing. It may be that the issues of quality of support and supervision of trainees are impacting on overseas recruitment.
3. Consensus views of the Taskforce group.

3.1 The benefits of an EM Consultant present service are well described.

3.2 Sub-optimal recruitment and retention and poor progression through training in EM may be related to:

   A. The difficult conditions under which Emergency Medicine is currently practiced with its high decision density, relentless target pressures, overcrowding and with junior doctors competence stretched by the challenging case load.
   B. Perception of poor work/life balance in comparison with other specialisms and peers.
   C. Deficiencies in training and supervision, in part related to inadequate consultant and senior clinician numbers.
   D. The training assessment burden and sequencing of training.
   E. Uncertainty as to how a future career in EM will develop and be sustainable.

3.3 Maximising the potential of the wider workforce is important

   A. General Practitioners have a crucial role in delivering urgent care, but the number of GPs who take on this role is less than was anticipated.
   B. Development of Advanced Clinical Practitioners (ACP) and Physician Assistants/Associates\(^2\) as an increasingly important part of the future ED team would be valuable in providing a stable, consistent, ‘mid-level practitioner’ workforce.
   C. Roles and career development of SASG and specialty doctors working in Emergency Departments need addressing. This group need the opportunity to develop and maximise their potential.

3.4 Commissioning needs to facilitate these changes and encourage whole system working

   A. In principle the reconfiguration agenda for EDs is supported. This will demand careful triangulation between the expectations of the public, the responsibility of the profession to ensure safe care and the political dimension.
   B. Reconfiguration of ED services overlaps considerably with other aspects of commissioning and wider configuration and provision of urgent/emergency care.

4. Commissioning of services

Clinical commissioning groups (CCGs) will work under a statutory duty to seek advice in commissioning services from a broad range of professionals, including those who are well placed to understand the urgent and emergency care needs of local populations. They will also be able to access advice from clinical senates and networks.

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\(^2\)Terminology for this role, also know as a Physician Assistant in the USA, is under debate and the term Physician Associate has now been accepted by the profession in the UK; Physician Associate (PA) will therefore be used from this point on in this document.
The clinical senates will bring together doctors, nurses and other professionals to give expert advice, which we anticipate that clinical commissioning groups will follow, on how to make patient care fit together seamlessly in each area of the country. Clinical senates will provide advice and support on a range of issues, and from a variety of health care perspectives, including public health and adult and child social care experts, as well as allied health professionals. Health and wellbeing boards will provide an opportunity to ensure join up between health, social care and services that have an impact on health.

The framework in the Act for ensuring the competence of commissioners, in securing continuous improvement and ensuring the promotion of integration, apply particularly to emergency and urgent care services. Commissioners will need to use expert advice from senates and networks and from other sources to determine the best approach to commissioning.

CCGs must (under 14V of the NHS Act 2006, as inserted by Clause 25), obtain advice appropriate for enabling them effectively to discharge their functions from persons who (taken together) have a broad range of professional expertise in:

(a) the prevention, diagnosis or treatment of illness; and
(b) the protection or improvement of public health.

CCGs can include emergency care or unscheduled care specialists in their governing bodies or committees. The Department of Health does not want to require this specifically, but there is nothing to prevent it. CCGs should ensure EM Consultant input occurs to provide an informed contribution to this crucial area of commissioning.

For CCGs to make the best informed decisions the involvement of those central to the delivery of urgent and emergency care should be integral to commissioning. The local lead for Emergency care is such a person.

4.1 Definitions of service

The delivery of a coherent 24/7 urgent and emergency care service aims to provide the highest quality of patient care. This will be facilitated by developing a system in which people can easily identify the right place for their care. The evidence indicates that many patients and healthcare professionals currently find the existing nomenclature and arrangements for urgent and emergency care services confusing. They struggle to understand which services are provided at which facilities at what time and where they should go to access the most appropriate service for them. Over the years, the picture has become more confused, and more layers of complexity have been added, and so work is under way to simplify this and make the system more consistent and more intuitive to navigate.

The new NHS 111 system should support the development of a simpler system and people will be encouraged to use this before attending a face-to-face facility, unless they have a life threatening condition in which case they will use 999. Following engagement with the public and the NHS, as well as various other stakeholders, the plan is for the NHS Commissioning Board to issue guidance on a simpler system. The ultimate aim is to produce an evidence-based categorisation of services that will improve patients' ability to access the right service first time. To this end, discussions
with external stakeholders and NHS colleagues continue and we expect further progress to be made in the second half of this year.

5. Workforce

The future core ED workforce will, therefore, be a hybrid team of suitably trained and experienced decision-making clinicians including:

- EM Consultants
- EM Higher Specialty Trainees – ST4 and above
- Consultants and higher trainees in acute medicine and other acute specialties including trauma and orthopaedics, paediatrics and psychiatry. This group can make an important contribution to patient care by their earlier involvement in the patient journey.
- EM Specialty Doctors (SAS grade)
- General Practitioners
- Advanced Clinical Practitioners (from various nursing and AHP backgrounds)
- Physicians Associates
- Emergency Nurse Practitioners

6. EM Consultants

The role of the EM Consultant is multi-faceted and involves:

- Direct patient care, particularly the most ill and complex cases
- Supervision and teaching of other clinicians at all levels, and supervision of others in their supervision and teaching roles
- Leadership including interacting with management, senior clinicians of other departments and the public

The demands on an EM Consultant are relentless, with a constant stream of decision making for high-risk patients presenting with critical illness, serious injury or with the potential for high morbidity and mortality, generally overlaid with additional Departmental management responsibilities.

In order to ensure patient safety, this decision dense activity is only safely sustainable for a limited number of hours. This is important when considering the total number of Emergency Medicine Consultants required in an ED, accepting that these Consultants will be working a shift pattern.

The College of Emergency Medicine has recommended a minimum of 10 whole time equivalent EM Consultants for each ED. This number is designed to provide up to 16 hours a day EM Consultant presence 7 days a week. Increased EM Consultant numbers will ensure improved work/life balance prospects for the trainees, enhanced protected training time and better supervision as well as an improvement in mortality and morbidity rates in and out of hours (OOHs).

Work is also being done to identify how ED Consultants may continue to work with a greater age given the likelihood that changes to NHS pensions. This may necessitate ED Consultants working in this high-pressured and relentless environment well beyond the age of 60. In the interest of patient safety, the intensity and unsocial
nature of EM mean that there should be the option to reduce the proportion of unsocial working as clinicians get older and this needs to be reflected in workforce planning.

7. EM Trainees

Emergency Medicine is a highly attractive specialty for junior doctors throughout the world. Internationally, EM residencies rank amongst the top few specialties attracting junior doctors of the highest calibre in large numbers.

While EM is still viewed in the UK as an interesting specialty, trainees experiencing the current workload in ED, and witnessing the unsocial hours of their consultants, are leaving the specialty to pursue careers other specialties; usually anaesthetics or general practice. There are also significant problems with EM trainee recruitment at the more senior levels, and with progression from core to higher training.


The main points arising from this survey were:

- A desire for greater Consultant supervision.
- Greater emphasis on education and training compared to service provision.
- Concerns over the current work/life balance in Emergency Medicine.

The trainees' perception of their future in the specialty is judged problematic, as are the issues with the existing training programme.

Currently there are vacancies at ST4 in EM with fewer applicants applying than there are posts to fill. As well as the reasons described above, some of the difficulties in filling these posts have arisen from the current entry requirements being rigid. Currently applicants eligible for entry into ST4 need to have all the competences and experience that they would have acquired within an EM core training programme. They must also have passed the Membership examination of the CEM (MCEM). Doctors with some experience of the specialties comprising core training in EM often find it difficult to gain the additional experience needed for ST4 entry from outside a designated EM training programme. Doctors from other specialties are not encouraged to change specialty into EM since there is currently no agreement in place for transferable competences that might reduce the duration of the training programme to CCT. This means that all trainees applying for core EM training from another training programme must apply at CT1 level. The consequence of these factors is that approximately 30% of core trainees are opting to go into alternative specialties, such as Anaesthetics.

8. The Training Programme

To improve recruitment in Emergency Medicine more flexibility is needed in the way core training in EM is configured and in the entry requirements for higher specialty training. This is most easily addressed by reverting to, or running a parallel, Run-through training programme (see Fig 1.)
CEM also wishes to explore ways of recognising transferable competences of trainees currently in other specialities in order to increase the pool of trainees eligible to apply for HST posts.

A trainee with some previous experience in the specialties comprising core EM training will be allowed to enter at a level higher than CT1 and, through targeted training, will gain missing competences later in the programme. Unlike the current core training programme, the actual length of time spent in each specialty area and the order in which the experience is gained, will be flexible, depending on the previous experience of the trainee. A review of the curriculum, person specifications, funding and assessment matrix will be required.

Progression through training needs to be improved: in particular, trainees in core training are failing to pass the MCEM within the three year ACCS programme. One of the reasons for this arises out of the current sequence in which experience is gained during the ACCS programme. Current trainees complete only 6 months of EM in the first two years of the programme. One part of the solution could be a reorganisation of the EM Core Training programme. A proposal to alter the current sequence of training has been considered in which the third year of EM training, (Paediatric EM and Musculo-skeletal competences) is moved to Year 1, with ACCS (EM, AM, Anaesthetics and ICM) being completed in years 2-3.

**Fig 1. Emergency Medicine Run through Programme**
9. SAS and Specialty Doctors

This group comprises doctors currently working under various titles including staff grade, Trust doctors, associate specialists and specialty doctors.

In the past, this group of doctors has been the backbone of many EDs providing high quality safe care throughout the 24-hour period 7 days a week.

Unfortunately, this contribution to emergency care has not always been valued or supported. Many of these doctors report working predominantly unsocial hours, have job plans with little or no provision for CPD and feel unsupported both within their department and in their organisation. As a result, there has been an increasing trend for these highly experienced doctors to leave EM, particularly into General Practice where there are opportunities for an increased salary and little unsocial hours working.

In turn, this has led to a great difficulty in populating SAS rotas, particularly overnight and at weekends. This has led to a vast expenditure on locum doctors of variable quality and/or very junior doctors being largely unsupervised in EDs, particularly overnight and for extended periods at weekends.

A recent survey of the College of Emergency Medicine FASSGEM group identified the following factors leading to attrition:

- Non-sustainable rotas with high frequency of out of hours work
- Poor morale within the department or perceived lack of respect
- Poor working environment with high stress levels
- Poor pay and conditions
- A perceived inequality with higher specialty trainees

This group need the opportunity to maximise their potential. As well as CPD, the option for further training and development is important, so that these doctors have a sense of continued development and are able to make greater contributions to clinical care. A clear sense of career pathway and the opportunity to pursue the CESR route would enhance the working lives of this important group.

10. General Practitioners

General Practitioners could have a crucial role in delivering urgent and emergency care. In principle, GPs could be invited to consider the following options:

- Ensuring prompt access to community Urgent Care for as much of the seven-day period each week as possible, including some limited access available in the evenings and at weekends. There is evidence that improved access both in hours and out of hours is linked to decreased ED attendances.
- High quality chronic disease management including individualised plans for acute episodes can prevent hospital attendance and admission.
- GPs should provide Primary Care expertise in a facility co-located with the Emergency Department or fully integrated in to ED.
- In the ED, facilitating discharge of patients back to community facilities.
• Encourage those GPs who wish to develop Emergency Care skills as a special interest, with skills and competences as agreed by the RCGP and College of Emergency Medicine.

General Practitioner engagement is crucial. However, many locations are having difficulties in recruiting because of an increasing tendency for individuals to limit out of hours work and significant pressures on the GP workforce.

11. Emergency Department Nursing

It was not considered to be within the remit of this group to consider emergency nursing, except where those with a nursing qualification take on an autonomous enhanced role as outlined below. However, the group did identify the relatively high turnover of staff in this general group and an increasing dependence on agency staff in many EDs.

12. Mid-level non-doctor clinicians

It is increasingly clear that there are many practitioners undertaking a role in the ED but who are not themselves doctors. Such roles have been developed in many UK hospitals and of course also world-wide. They have the potential to provide a hugely important ‘ballast’ of professional continuity within the ED, reducing the turmoil resulting from the rapid turnover of junior doctors in training. If substantial numbers are employed, the continuity and quality of care would be improved. In addition, the quality of education for juniors could enhance, allowing them to focus on their learning needs (‘deliberate learning by doing’) rather than only the needs of the service (‘serendipitous learning while doing’). Such clinicians also bring a great deal of experience to their role since they tend to stay in place for some years (e.g. UK Advanced Clinical Practitioners (ACPs) and US Physician Associates typically stay in a single specialty for over 8 years3). Such mid-level clinicians may be drawn from nurses (e.g. ENPs), other practitioners (e.g. ACPs) or could be new to the clinical world (e.g. PAs).

Fig 2. shows the ‘flow’ of junior doctors at various stages of training as they ‘pass through’ the core ‘medical’ workforce: most direct care is delivered by junior doctors, SASG and Specialty doctors and, increasingly, non-medical clinicians and the diagram demonstrates the delivery of care as well as the role of the junior doctors, and the supervision delivered for those in training by the permanent members of the workforce, including senior specialty trainees, SAS doctors and consultants.

13. Emergency Nurse Practitioners

During the past 10-15 years, the role of Emergency Nurse Practitioners in emergency/urgent care has developed and matured. Most EDs now have an ENP service and ENPs tend to be the mainstay work force in Minor Injury Units, Urgent Care Centres and Walk in Centres. In many EDs this contribution has been predominantly in providing high quality safe care for patients presenting with less serious injury or illness. There is a good evidence base that those with appropriate training do provide a very safe and effective minor injuries service. Unfortunately, training and degree of autonomy have been variable. However, the move to an all graduate nursing profession in 2013 has been an impetus for nurses particularly ENPs to achieve graduate status particularly in the sphere of emergency nurse practicioning.

The Taskforce feels there needs to be a consistent definition of what an ENP is as well as their scope of practice and training requirements. There need to be mechanisms developed so skills are transferable between NHS organisations.

13.1 Consultant Nurses

The role and numbers of Consultant Nurses in EDs has increased, there are now in excess of 50 nurses employed in this role throughout the UK. While the role has 4 specific core functions including clinical practice, there are variations in role and scope of these posts in terms of advanced clinical practice. Future Consultant Nurses are likely to be drawn from current ACPs who possess an advanced clinical focus that will
enable them to work at an intermediate tier and beyond. This group of staff are well placed to manage the increasing body of ACPs and ENPs within many EDs. They will obviously work closely with Emergency Medical Consultants who will have overall responsibility for the service and will contribute to greater consistency in terms of clinician workforce planning.

### 13.2 Advanced Clinical Practitioners

In recent years, Advanced Clinical Practitioners (ACPs) have developed skills and competencies in providing care for more seriously ill and injured ED patients. They come from a variety of backgrounds. The most effective schemes train them to see the whole range of patients presenting to the ED. There has been a proliferation of this type of role in an unknown number of EDs across England. The high volume high-risk nature of undifferentiated patients presenting to the ED mandates absolute certainty with regard to the skills and competences of any clinicians working in all areas of the ED as it does for doctors.

It is crucial that development of the ACP model is underpinned by the following:

- An emergency care workforce profile
- A national curriculum
- Nationally agreed standardised assessments
- Standardised assessments and competence across disciplines working at this level of practice
- Defined role and scope of role and lines of accountability
- Nationally agreed indemnity for the role
- Nationally agreed remuneration for the role

Representatives of RCN, FEN, Emergency Consultant Nurse Association (ENCA), College of Emergency Medicine and Department of Health are currently exploring these issues. The curriculum and assessments developed by the College of Emergency Medicine provide a proven template with some transferable commonality to the ACP agenda.

It is crucial, however, the group developing the ACP model explore the role and scope of such practitioners, which will be applicable to the generality of EDs.

The general principle should be that ACPs work with and complement the senior medical workforce, interacting closely with the Emergency Medicine Consultant.

Where individuals have greater experience or wish to enhance their core ACP skills, then specific additional training maybe arranged. This would ensure that those ACPs who so wish are allowed to fulfill their potential, whilst ensuring that the greater body of ACPs provide high quality safe care within their scope of practice.

ACPs should therefore be regarded as a crucial part of the ED clinical team of the future.

Further work should be undertaken to develop the ACP role, this includes:
• Develop a nationally applicable curriculum, competences and assessment framework.
• Achieve consistency with regard to the clinical role.
• Describe the boundaries of such practice in the generality of Emergency Departments.
• Define the likely timescale for a widespread implementation.
• Undertake piloting to define the evidence base for this initiative.
• Develop an evidence base for the role.

To develop an effective ECP will take three years of training and then a period of two years of mentorship, building on a previous background of specialist skills in nursing or an AHP.

14. Physician Associates (PAs)

The situation regarding Physician Associates (PAs) is analogous to that of ACPs described above.

The role of PAs in the ED has been impressively developed in North America, for example a typical ED staffing, such as at Johns Hopkins, involves approximately 12 PAs, 3 FY1/2s equivalents, 5 specialty trainees and 8-9 consultants. (Personal communication, T Ritsema, PA-C, Assistant Professor, George Washington University.)

The optimal contribution of PAs to the ED is by working under the supervision of a senior EM doctor undertaking a range of activities contributing directly to patient care. This model provides a defined scope of practice with an invaluable contribution to the overall provision of patient care. The senior EM doctor benefits from being able to allow the PA to practice within their skills and competences, thus freeing up the EM doctor to care for other patients.

PAs are currently working in a number of UK EDs (City Hospital, Birmingham; Dudley Group of hospitals; Northwick Park; Leicester Royal Infirmary; Kingston Hospital; Mid Staffordshire; Hairmyres Hospital (Lanarkshire); Derby Royal Infirmary will advertise posts shortly.

PA training programmes last 2 years and the Taskforce identified that University-based programmes can be established and a new cohort of students recruited within a very tight timeframe of less than a year. Programmes follow a national curriculum and graduates have to pass a national assessment. PAs are expected to join a managed voluntary register, and to undertake re-accreditation every 6 years (as per the US model for PAs and indeed doctors). Thus, PAs development is one of the workforce measures that could be introduced most quickly.

The Taskforce identified that there is no current defined responsibility within DH, or elsewhere, to support the further development of PA training programmes within England despite increasing evidence that PAs can provide a high quality contribution to patient care, and mounting support from doctors working in a number of specialties including EM, physician specialties, mental health, family medicine and surgery. The Taskforce recommends that Health Education England looks actively at promoting this new pluri-potential health professional discipline.
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<th>EM Professional</th>
<th>Implementation Time</th>
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<td>ENPs</td>
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<tr>
<td>PAs</td>
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<tr>
<td>Consultants</td>
<td>5-12 years</td>
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15. Reconfiguration

It is recognised that having an increased number of specialists in one location allows more patients to be seen by senior clinicians earlier in their care. It also gives those clinicians more exposure to serious illness and hence improves their competences and abilities; this underlies the rationale for hospital reconfiguration.

Given the ED workforce shortages and the current era of tight financial constraints, the potential opportunities provided by reconfiguration demand consideration.

There is a view, given the pressures on both primary care and EM services to meet unscheduled demand, that the system should consider reconfiguration in the form of integrated emergency or unscheduled care services working across primary and secondary care, for which doctors (from EM and GP backgrounds) and other clinicians would be trained to the same standard and accredited. The key to this model would not just be the accredited clinicians, but even more crucially the development of community and social resources, which would provide alternative options for care other than acute hospital admission, access to rapid specialist assessment when necessary.

Decisions regarding the reconfiguration agenda are complex and involve triangulation of the views of the profession regarding safety, of the public regarding access and the political dynamic but there is a clear urgency if services for patients are to be maintained.

16. Market Facing Pay / Terms and Condition

Market facing pay and adjustments to terms and conditions can, in certain circumstances, improve recruitment and retention in unpopular working environments (specialty and/or geography). However, market facing pay in the current circumstances, of significant and sustained workforce undersupply, will simply drive up costs without fundamentally addressing the problem of maintaining comprehensive service provision.

In the longer term, this area may well need to re-considered as it could be part of a package that would make EM a more popular career choice for a number of professional groups, and in particular doctors. There is some experience of the positive impact this can have from Australia.
17. Summary of Recommendations of group

1. An increase in Emergency Medicine Consultant numbers to ensure a consultant presence for 16 hours a day, 7 days/week in all Emergency Departments and 24 hours a day, 7 days/week in larger departments or Major Trauma Centres.

2. Work with the CfWI to explore workforce modelling in EM.

3. EM trainee numbers should be carefully calibrated to support continued Consultant expansion.

4. Early exposure to the EM component within ACCS core training to improve early experience and improve MCEM pass rates.

5. Develop alternative routes into EM training for trainees currently in other specialty programmes.

6. Explore the recognition of transferable competences of trainees currently in other specialities to increase the pool of trainees eligible to apply for EM training at a level higher than CT1.

7. Support Associate Specialist and Staff Grade Doctors (Specialty Doctors) in their roles to ensure retention and increase work satisfaction. Measures to achieve this should include:
   - Job planning to avoid unsocial hours’ predominance and enhance support for CPD.
   - The College of Emergency Medicine will look to ways of supporting the development of this group using the College curriculum and assessment systems.

8. GPs could be invited to consider the following options:
   - Ensuring prompt access to community Urgent Care for as much of the 24 hour period each day as possible, improving access available in the evenings and at weekends.
   - GPs could provide Primary Care expertise in a facility co-located with the ED.
   - GPs could work with the ED team to facilitate discharge of patients back to community facilities.
   - Those GPs who wish to develop Emergency Care skills as a special interest should be encouraged to acquire skills and competences as agreed by the RCGP and CEM.

9. Expand training of clinical nurse specialists and PAs, and define their roles. It is clear that the day-to-day delivery of ED care will require significant expansion of the non-medical clinical workforce. No formal estimates have been performed but given current issues re: delivering care, the Taskforce recommends that there is a need for at least 10 such higher specialty trainee and SAS rota clinicians per ED. To ensure consistency, development of the roles of each of these groups should be underpinned by:
• A national curriculum for ED-specific competencies
• National Standards for skills and competencies
• National Assessment framework

And the working group also recommends that the College supports such developments.

10. There is a real urgency about the ED workforce crisis, and these recommendations need to be enacted urgently. For PAs, core generalist training takes two years, and universities need up to a year to initiate programmes. Thus, a recommendation to use PAs within ED needs to be made quickly so that new graduates will be available from summer 2014, and can then undertake post-graduate training and provide a significant impact on the ED workforce by say mid-2015. In addition, many PAs taking a generalist PA course will not enter ED, thus significant numbers of PA courses need to be instituted as soon as possible. Lastly, PAs are not statutorily registered and thus cannot prescribe or order x-rays, both of which are clearly significant barriers to their effective implementation. Registration with HPC would solve this problem quickly.
18. Actions underway:

1. CEM and GMC are working together to develop a Run-through training programme and facilitated entry into EM training.

2. Work with ACCS colleagues in anaesthesia and acute medicine to consider re-ordering the training programme to provide earlier experience in the main specialty.

3. Training and assessment review and development of alternative training and assessment system that is now ready for consideration by the GMC.

4. CEM and DH colleagues working with colleagues in advanced nursing and PAs to support development of curricula and assessment systems.

5. Research and piloting to demonstrate effectiveness and provide the evidence base for clinical and cost considerations of recommendations.

6. East Midlands Deanery/LETB held a half-day symposium in July 2012 to look into the issues faced by the specialty in the area. The symposium brought together stakeholders to share information and solutions that were being implemented to address recruitment, retention and progression of a multi-professional workforce in the specialty.

7. The issue of provision of a workforce to deliver Urgent and Emergency Care is the focus of the Academy (7/7 working group) and the RCP (Future Hospital Commission).

8. DH survey of the Emergency Department workforce.

9. CEM Dashboard exercise which includes staffing, training and commissioning.
References


2. Guidance and competencies for the provision of services using practitioners with special interests – Urgent and Emergency Care RCGP 2008.

3. The Benefits of Consultant Delivered Care: Academy of Medical Royal Colleges January 2012.


Appendix 1

**Emergency Medicine Taskforce Membership:**

Prof. David Sowden - (Chair) Director of Medical Education (England), METP, DH
John Heyworth – Immediate Past President, CEM
Patrick Mitchell - Director of National Programmes, METP, DH
Joanne Marvell – Specialty Recruitment Manager, METP, DH
Alison Carr – Senior Clinical Advisor, METP, DH
Mike Clancy - President, CEM
Helen Cugnoni - ACCS lead for Emergency Medicine
Andrew Fraser – Policy Support Officer, Urgent and Emergency Care, DH
Prof. Matthew Cooke – National Clinical Director, Urgent and Emergency Care, DH
Colin Holburn – Consultant in Emergency Medicine, fellow of CEM
Prof. Robert Crouch, Consultant Nurse, University Hospital Southampton NHS Foundation Trust
Jim Parle – Professor of Primary Care, Physician Assistant Course Director, University of Birmingham
Gary Swann - Consultant Nurse, Emergency Care Directorate (HEFT)
Tim Yates - JDC Representative, BMA Junior Doctors Committee
Peter Chessum - Advanced Clinical Practitioner, Heart of England NHS Foundation Trust
Agnelo Fernandes - Representative, RCGP
Alison Graham - Chair, Scottish Association of Medical Directors
Mike Jones - Vice President, RCP, Edinburgh
Prof. Moira Livingston - Commissioning Director, CfWI
Barry Lewis - Chair, COGPED
Don MacKechnie - Representative, CEM
Bill McMillan - Head of Medical Pay and Workforce, NHS Employers
Prof. Gillian Needham - Postgraduate Dean, NES
Trish O’Conner - Emergency Medicine Consultant, Hairmyres Hospital
Emma O’Donnell - Senior Policy Manager, DH
Sarah Parsons - Medical Workforce Manager, NHS Employers
Chris Roseveare - President, Society for Acute Medicine
Caroline Shaw - Chair, FASSGEM (EM)
Garry Swann - Consultant Nurse, RCN
Stephen Timmons - Lay Representative, CEM
Chet Trivedy - Representative, CEM
India Peach – Project Support Officer, METP, DH

Previous chair
Patricia Hamilton – Former Director of Medical Education England, Department of Health