

The Royal College of
Emergency Medicine

RCEM Workforce Recommendations 2018



Consultant Staffing in Emergency Departments in the UK

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Foreword



Delivering consistent, safe, high quality emergency care in the modern-day Emergency Department (ED) is a constant challenge. Ensuring that ill and injured patients are cared for and supervised by adequate numbers of clinicians with appropriate training, skills and judgement in Emergency Medicine (EM) makes it far more likely that that level of care can be delivered. The previous model, with patients being cared for by junior staff alone, is being steadily transformed as senior staff become ever more present and available.

This position paper defines for the first time in one document the standards we believe EDs should aim for in the future in terms of the numbers of senior Consultant staff and how the intensity of that work is recognised, so that they have time to rest, recover and recuperate adequately.

Discussions with policymakers, commissioners and providers have focused on the importance of training adequate numbers of Emergency Physicians (EP) who are able to work with and supervise a multidisciplinary ED clinical workforce. In England, there has been agreement in this area as part of the wider *RCEM Vision2020* and with the launch of *Securing the future ED workforce* launched in October 2017. In the devolved nations, similar discussions remain ongoing and we hope that they will lead to equally successful outcomes in the near future as part of their *RCEM Vision2020* approach. Work is ongoing to help implement the many strands of the strategy and a suite of related documents will steadily emerge in the coming year.

This document is related to the wider strategy. We believe it is amongst the most important that the College has published in recent years. I am grateful to Dr Ed Smith and his colleagues on the RCEM Service Design and Configuration Committee (SDCC) for having brought together a comprehensive, coherent and potentially far-reaching set of recommendations that will have a significantly positive impact in the medium and long term. The position paper has also had input from the Fellows of the Council of the College and is, therefore, strongly representative of what we all believe as a College is the right way forward for EDs to be staffed in the United Kingdom (UK) at a senior level.

At the heart of this publication lie 3 key principles:

1. An ED must have a model of delivery that ensures an adequate '*depth and breadth*' of EP senior decision makers (SDM) to lead, manage and treat an increasingly complex workload. The College has with these recommendations provided greater clarity on the numbers of EPs that Executive Boards of hospital trusts and policymakers should aim to achieve in the coming years as more clinical staff are trained. It applies detailed calculations from a range of previous work.
2. The ED is well-recognised as having amongst the most intense working environment for SDMs in a healthcare system. If poorly structured, this heightens the risk of clinician mental illness and subsequent 'burnout'. This is

not only bad for the individual and their families but also for the country and the taxpayer that has spent large quantities of money training EPs. Medical Directors and Executive Boards of hospital trusts must ensure that they adhere to good practice to mitigate these risks with good job planning so that EPs are able to work sustainably and have long fulfilling careers. Annualised job planning with clear compensatory recognition, especially of the intense periods of out of hours working, must allow time for the human body to rest, recover and recuperate. This becomes even more important in the older EP. Employers must have this as a high priority when developing workforce plans for the ED. For the first time, the College provides explicit guidance in this area.

3. The value of having enough EPs on duty concurrently at busy times of the day (depth of cover) and over a 16- or 24-hour period (breadth of cover) is recognised as being vital. Casemix and demand will dictate the model that is right for a system to be safe and sustainable. The expert view of the College is that such an approach will prove to be cost-effective and better 'value for money' in the context of better assured decision-making in order to maximise the likelihood of delivery of timely clinical care and safer practice. Properly designed rotas will allow a greater proportion of patients to be cared for directly, be reviewed by or have their cases discussed with trained EPs.

I strongly recommend this paper to be essential reading for all policymakers, commissioners and Executive Boards of hospital trusts as they plan for a robust Consultant workforce for their ED now and into the next decade. I hope that close collaboration, planning and action will follow soon after.

A strong, sustainable, trained Consultant EM workforce will provide the essential central pillar for a safer, more consistent quality of care for our patients when they present to us in an emergency.

A handwritten signature in black ink, consisting of a large circular loop on the left and several vertical lines extending upwards from the center, followed by a horizontal line extending to the right and a diagonal line extending downwards and to the right.

Dr Taj Hassan
President, The Royal College of Emergency Medicine
September 2018

Summary

- 1** Consultants¹ in EM enhance safety, quality and efficiency of care. They add senior expert 'breadth and depth' to the delivery of the ED service and, as such, cannot be replaced by other staff groups.
- 2** Greater availability of Consultants in EM will allow dedicated roles to be assured to include Command and Control/Emergency Physician in Charge (EPIC), Resuscitation and Clinical Decision Unit (CDU)/Ambulatory Emergency Care (AEC), as well as direct clinical care, support of initial assessment processes and supervision of junior staff. These are essential to the functioning of the department and the service, especially during busy periods. These many roles, linked to demand, require at least 16 hours/day cover at Consultant or SDM level.
- 3** Development of the Consultant workforce *must* occur with sustainability as a central principle, in recognition of the high- pressure environment within which they work and the resultant higher risks of mental illness and 'career burnout'. The College has made recommendations based upon existing systems and their practices that allow time within annualised rotas to rest, recover and recuperate especially from out-of-hours and night time working.
- 4** A combination of Consultant and non-Consultant SDMs must be present in sufficient numbers in all roles for all medium and large EDs. The exact number of Whole Time Equivalent (WTE) Consultants required will depend on the complexity of service delivered. A ratio of one Consultant to every 3600-4000 ED attendances is required for most departments. Very large EDs and Major Trauma Centres (MTCs) will require greater numbers of Consultants
- 5** We have defined the model of senior care delivery and supervision in EDs that will need to evolve and be delivered. The College will work closely with the governments, policymakers, commissioners and regulators to ensure that we can describe funding that can be identified in the medium- and long-term planning for the NHS over the next decade.

¹ Throughout this document the term 'Consultant' includes specialty doctors and associate specialists.

Context

The relentless increase in demand for ED services has been followed, but not matched, by a growth in the numbers of Consultants in EM. In 2016-17 there were 15,262,758 attendances at type 1 EDs in England¹. In October 2017 there were 1719 EM Consultants working in England, resulting in a ratio of 8879 ED attendances per Consultant. The comparable figures for the devolved nations are listed in Table 1, below.

Table 1 – Estimated number of patients per Consultant/year

	Annual ED attendances 2016-17	Total number of Consultants (WTE)	Estimated number of patients per Consultant/year
England	15,262,758	1719	8,879
Scotland	1,627,412	220.6	7,300
Wales	1,003,710	67	15,000
Northern Ireland	797,666	68.3	11,700

Although the EM Consultant workforce has grown over recent years (6.6% per year 2012-2016)², this has not kept pace with the demand and complexity of work required to be delivered. Worse still, approximately 26% of advertised Consultant posts remain unfilled³. In 2016-17, the NHS in England spent £2.94 billion on locum and agency staff, 16% of which (£470 million) was spent in EM⁴.

Over the last decade, a number of RCEM documents have been produced (available on the [RCEM website](#)) that describe in detail ways in which ED staffing requirements can be calculated^{5,6,7,8,9,10}. The purpose of this document is to, for the first time, build upon these calculations, incorporate current working practices and describe future requirements for ED senior staffing in medium and large emergency care systems. This allows for a clear definition of the ways in which these SDMs can perform to contribute to safe and effective patient care. The staffing requirements for smaller EDs and remote and rural emergency care systems will be described separately.

Why invest in Consultants in Emergency Medicine?

The value of Consultant-delivered care has long been recognised. Many studies have provided evidence that patients experience increased morbidity and mortality when there is a delay in involvement of a Consultant in their care¹¹. In addition, as part of their non-clinical roles, EM Consultants make essential contributions to the education and training, clinical governance, quality improvement work, development and delivery of the emergency care service within which they work. Dedicated time for clinical supervision on the shop floor is a vital component of the Consultant role, particularly given the increasing multidisciplinary nature of the EM workforce.

Consultants improve safety, quality and efficiency of clinical care through:

- Enhanced clinical decision making, especially by leading the resuscitation of critically ill and injured patients in the ED.
- Improved supervision of junior members of the medical workforce by either direct review of cases or discussion on areas of concern. This ensures that patients are provided with the most efficient, effective diagnostic and therapeutic pathways if they need to be admitted.
- Ensuring that those patients who can be managed by AEC pathways, either by a linked ED run CDU model or working collaboratively with in-hospital colleagues. This enhances 'gatekeeping' of the in-hospital bedbase, maximises safety and optimises the patient experience.
- Reducing numbers of serious incidents and complaints through robust quality improvement cycles.
- Improved access to an SDM to support decisions around patient flow, e.g. contact with Primary Care, streaming and inpatient clinical teams¹².
- Delivering on the expectation of patients to be seen by an appropriately qualified clinician.
- Improving the efficiency of use of resources and reducing overall cost of care by delivering the correct care from the outset.
- Consultant-delivered care, which reduces the likelihood of clinical negligence claims. 40% of claims are related to failure or delay in patient diagnosis or treatment and new clinical negligence claims doubled from 5,300 to 10,600 between 2006-07 and 2016-17. During 2016-17, 13% of the claims agreed by NHS resolution related to EM and it is estimated that EM accounted for £87 million in damages and £54 million in costs in that year.

Calculating the contribution that a Consultant makes in terms of a 'value for money' investment of service delivery is, therefore, complex. The College will produce separate guidance on the principles of what defines productivity of a Consultant EP in late 2018.

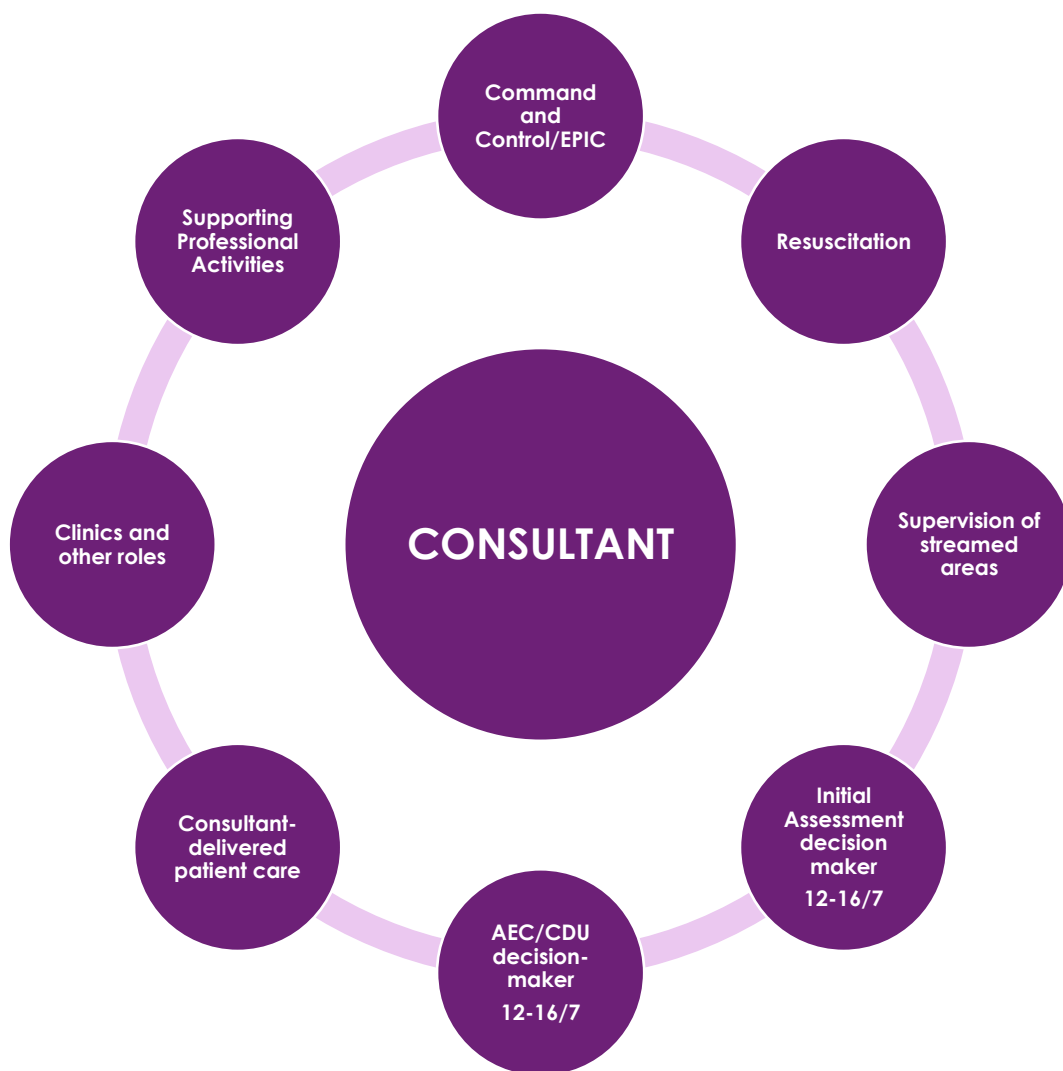
The old simplified approach of numbers of 'patients seen' directly by a Consultant per year is outdated.

Functions of a Consultant in Emergency Medicine

Consultants in EM are fully trained practitioners who deliver high quality clinical care to undifferentiated patients presenting to the ED. They typically hold an FRC EM (Fellow of the Royal College of Emergency Medicine) qualification (or equivalent), which provides assurance to their employer regarding the quality and consistency of the care and leadership that they bring to the service.

They add value to a number of highly specific and defined roles, and it is useful to think of Consultants contributing to each of these components of the service when calculating the number of individuals required to deliver safe, effective ED care 24/7. Consultants function as SDMs in EM and as such are able to formulate the definitive plan of care for the next stage in each patient journey.

Figure 1 - Specific departmental clinical roles that Consultants deliver



Command and Control/Emergency Physician in Charge

Pressures on EDs and emergency care systems in terms of demand, complexity of casemix and the challenges that exist in terms of crowding, exit block and patient flow mandate the presence of an SDM in this role. Best practice is for this role to be filled by an EM Consultant for at least 16 hours a day (08:00–00:00) in all medium and large systems.

In modern EM, this role can be demanding and stressful even at times of non-peak demand and consideration must be given in all EDs to supporting those colleagues who regularly perform this role. Effective performance in this domain is vital to the effective running of the ED, supporting the wider service and enabling the entire team to execute their response to the clinical pressures faced at any one time.

Resuscitation

Consultants in EM coordinate and lead the delivery of high-quality care in the Resuscitation Room to deal with the most critically ill and injured patients in an ED. In larger systems, particularly those with a Major Trauma Centre (MTC) function, this will require dedicated on-site Consultant presence for a minimum of 16 hours a day and, increasingly, this is moving towards a 24/7 model. In most average systems, it is important to create 'depth and breadth' of coverage at busy times.

Supervision of specific streamed areas within the ED

Streaming of patients into specific parts of an ED or service (e.g. Majors, Paediatric ED and Minors) requires senior supervision of the multidisciplinary junior clinical staff to help deliver patient care (as well as education and training) in that clinical area. This requirement will typically be present for the hours during which the streamed service is open to patients. Streaming of patients in this way and appropriate senior cover for these areas ensures consistent effectiveness and efficiency.

Assessment and treatment of ED patients/initial assessment processes

EDs commonly employ an initial assessment process supported by SDMs. These include Consultants and other SDMs supporting experienced nursing staff and other allied health professionals. Nomenclature around these processes is variable (e.g. Rapid Assessment and Treatment (RAT), or Senior Doctor Triage (SDT)). Where there has been a local decision to operate such a process, it will require dedicated senior staff to deliver it during the period of its operation (typically 12-16 hours/day).

These initial assessment models will vary and though Consultants must ensure support and that they are running smoothly, delivery commonly will occur with support of experienced nursing staff and other clinicians on the senior tier. Consultant time will be tailored in these supervisory roles to support sustainability and role modelling for other staff groups.

Clinical Decision Unit/Ambulatory Emergency Care

It is recommended that all hospitals have a facility that enables same-day emergency care in a non-inpatient setting¹². Many EDs have CDUs and/or ED-

delivered AEC units that provide this service. To provide this effectively, both these units require access to SDMs for the times during which they are open. Although CDUs may open 24 hours, AEC is usually limited by access to key diagnostics and, therefore, more typically open 12 hours/day. Thus, EM Consultant cover for these functions would typically be 12-16 hours per day.

Consultant-delivered direct patient care

Depending on the number of senior staff working at any one time on shift, especially at times of 'surge activity', Consultants will be able to see, assess and manage patients directly themselves. This will help to maintain processing flow within the ED but will be heavily dependent upon the resourcing and functions within their other roles that will take priority according to clinical need.

Soft tissue clinics and other roles

In addition, Consultants in EM have a range of other clinically related roles, including shopfloor clinical governance, supporting the review of abnormal X-ray and blood results to ensure patient safety, embedding change linked to quality improvement projects and creating wider sustainability within the clinical workforce. These will depend on local circumstance and be more difficult to define in terms of exact time commitments but are an essential component of wider clinical related activity.

Many departments will also run a range of soft tissue clinics and related services dependent upon local expertise and system need. These will have clearly defined 'direct clinical care' activity described.

Supporting Professional Activities

Consultants in EM have a host of complex SPA activities for which they should be provided with dedicated time within their job plans. These include teaching, quality improvement, managerial activities, research and leadership roles as well as external duties. This aspect of consultant work is described in separate RCEM publications. Best practice of 3 SPAs as occurs in Wales is recommended. A minimum of 2.5 SPAs is considered acceptable in job planning as a minimum to allow time for the full range of activities and to also help achieve sustainability for the long term.

Creating sustainable working practices

Why this is important?

There is now clear evidence that the intensity of working in highly pressurised healthcare environments is significantly associated with an adverse impact on the health and wellbeing of clinical staff. The ED setting is amongst the most intense of these environments and numerous studies confirm EPs as being amongst those at highest risk of mental ill health, compassion fatigue and 'career burnout'^{13,14}. This is worsened in situations where crowding in EDs becomes a recurrent phenomenon due to wider system failures.

Such working environments not only heighten risk to patients but also reduce the attractiveness for the next generation of EPs. National EM surveys have demonstrated the importance of consideration of working conditions in order to maintain and develop the senior workforce¹⁵. This is also thought to be a factor in the rise in emigration of trainees and trained EM staff, which is further worsening the situation.

What is being done to guide improvement?

The College provides expert guidance to governments in the UK on system design to minimise crowding and to improve safer practice in EDs. In addition, the Sustainable Working Practices Committee has produced a range of guidance to assist policymakers, Executive Boards of hospital trusts and Clinical Directors of EM to influence EM system job planning and wellbeing strategies. Further work will also be published in late 2018 and 2019.

The British Medical Association and NHS Employers have been in protracted negotiations to agree a new Consultant contract for a number of years. In the meantime, individual Trusts and systems have found pragmatic solutions to create stability and to protect their ED workforce, which broadly fit with guidance and advice provided by the College in this area¹⁶. The strategic agreement in England in 2017 identified this as an important area that needed to be addressed in order to maximise retention amongst trained staff². The College continues to profile these solutions. A number of recommendations are set out below based upon experience within systems in recent years and agreement by expert groups at the College.

Recommendations for ensuring sustainability of Consultant careers

The following set of recommendations are intended to be an essential part of a multifaceted strategy to support trained EM staff to achieve sustainable, fulfilling and productive careers. The guidance is intended to help advise employers and policymakers until formal contract negotiations can be completed at some stage in the future.

The key principles are to allow hospitals and Trust Executive Boards to:

- Maximise safe working practices for EM Consultants working a significant part of their time out of hours to allow more proportionate time off so that they

have time to rest, recover and recuperate from the intensity of the working environment.

- Actively support the development of portfolio and less than full time (LTFT) working careers, where appropriate.
- Develop job plans for the older EP, so that they can continue to have a better balance to their clinical and non-clinical work. Part of these proposals should allow 'opting out' of onerous on call and night time clinical duties.

System design recommendations for ensuring sustainability of Consultant careers in EM

- Job planning
 - DCC/SPA split of 7.5/2.5 (Consultants in Wales have a DCC/SPA split of 7/3, which is considered best practice) with annualised rostering
 - Alteration over time to a greater emphasis on SPA time (e.g. EM Consultants at 55 moving to a 6/4 DCC/SPA split and by age 60 plus to a 5/5 or equivalent DCC/SPA split)
- Recognition to reflect high intensity working practices
 - Appropriate attention to risk of longer shifts, fatigue, sleep deprivation
 - Appropriate recognition to reflect working in high intensity and anti-social out of hours periods – suggested minimum to reduce risk of harm to staff: 2 hours per PA after 19:00 and 1.5 hours per PA at night, post 23:00
 - Discontinuation of late shifts/night shifts/on-calls from age 55
- Greater opportunities for portfolio careers and less than full time working
- Enhanced study leave allowance and paid sabbaticals, especially in fragile systems
- Funded wellbeing strategies in every ED

DCC – Direct Clinical Care
SPA – Supporting Professional Activities

Emergency Department size and senior staffing ratios

It is not possible to describe a “one size fits all” approach to ED Consultant staffing. Effective staffing is a function of capacity, capability, sustainable working and resilience. Insufficient staff numbers deliver a vicious spiral of longer waits, crowding, compromises to safe practice, reduction in the quality of care and poor experience of patients and staff. This leads to an inability to recruit and retain staff, a reduction in system efficiency, an increase in staffing costs (increased locum staff numbers) and system costs (serious incidents, complaints and litigation). Larger systems require more staff, and for more hours, across the full range of professional groups.

For the purposes of describing senior staffing numbers required, the size of systems is defined in terms of annual new patient attendances to an ED, as shown in Table 2, below.

Table 2 – Size of systems and new patient attendances

Size of ED	New patient attendances
Small ED	less than 60,000 attendances (may be urban)
Remote and Rural ED	typically less than 60,000 attendances (may be much lower attendances, e.g. some EDs in Scotland)
Medium-sized ED	60,000–100,000 attendances per annum
Large ED	greater than 100,000 attendances per annum
Very Large ED	greater than 150,000 attendances
Major Trauma Centre	Usually either a large or very large ED

The number of new patient ED attendances per WTE Consultant are shown in Table 3, below.

Table 3 – New patient ED attendances per WTE Consultant

	Annual ED attendances 2016-17	Total number of Consultants (WTE)	Estimated number of new patient ED attendances per Consultant/year
England	15,262,758	1719	8,879
Scotland	1,627,412	220.6	7,300
Wales	1,003,710	67	15,000
Northern Ireland	797,666	68.3	11,700

The College has defined for the first time that this ratio should be **1 WTE Consultant to between 3,600-4,000 new attendances**, depending upon complexity of workload and associated clinical services for which an ED is responsible. The complexity of care delivery by senior staff during such periods will be addressed separately.

Table 2, below, lists recommended Consultant and other non-Consultant SDM staffing numbers for each department defined by the numbers of annual

attendances. Previous RCEM guidance has described the tiered approach to understanding medical staffing in EDs⁶.

RCEM classifies clinical staffing into five tiers, with an increasing autonomy of practice from tier one (F1 doctors, trainee practitioners) to tier five (EM Consultants with FRCEM).

SDMs are made up of staff from tiers four and five. Although not all hold FRCEM, they are able to make more key decisions regarding investigations, treatment and disposal at the point of first contact with the patient⁶.

The guidance does not apply directly to specialist EDs (e.g. pure Paediatric EDs) but it is reasonable to interpret the Consultant numbers listed here to deliver comparable functions in other types of department. These numbers should be considered as minimum staffing and there is an assumption that they are not designed to mitigate for other parts of a challenged system (manifest as exit block and crowding). The Consultant/SDM numbers required within a functional system to maintain that front door functionality is shown in Table 4 and Table 5, below.

Table 4 – Recommended minimum senior staff modelling for mixed EDs

Attendances	Day Shift	Evening Shift	Night Shift
60,000-100,000/year	Consultant roles: EPIC 1 Resus 1 DCC and supervision (may include Initial Assessment processes) 1-2 CDU/AEC 1	Consultant roles: EPIC 1 Resus 1 DCC and supervision 1 - 2 CDU/AEC 1	Consultant on call: 1 EPIC SDM: 1
	Other (non-FRCEM) SDM 2-4 (including SAS and ST4-6)	Other (non-FRCEM) SDM 2-4 (including SAS and ST4-6 – see notes below)	Other (non-FRCEM) SDM 2-4 (including SAS and ST4-6)
100,000/year+	Consultant roles: EPIC 1 Resus 1-2 DCC and supervision 1-3 CDU/AEC/Other areas 1 per area	Consultant roles: EPIC 1 Resus 1-2 DCC and supervision 1-3 CDU/AEC/Other areas 1 per area	Consultant on call (if not on site in EPIC role): 1 EPIC (or other SDM): 1
	Other (non-FRCEM) SDM 4-6 (including SAS and ST4-6)	Other (non-FRCEM) SDM 4-6 (including SAS and ST4-6)	Other (non-FRCEM) SDM 4-6 (including SAS and ST4-6)
Major Trauma Centre	As for >100,000 with additional Major Trauma Consultant(s) as needed	As for >100,000 with additional Major Trauma Consultant(s) as needed	As for > 100,000 with additional Major Trauma Consultant(s) on duty or on-call

In broad terms, this allows the numbers of Consultants and other SDMs to be calculated within ED systems. The calculations take into consideration numbers of new patient attendances, complexity, co-located services, rota design and sustainability for senior staff.

Table 5 – Numbers of Consultants and Minimum WTE SDMs

Size of Department (attendances/year)	WTE Consultant numbers	WTE SDMs (minimum)
Medium	18-25	30
Large	25-36	42
Very Large	34-48	60

Notes on Table 4 and Table 5:

- Overnight minimum Consultant cover is one individual (with additional for Major Trauma Centres). Other SDM roles overnight are likely to be provided by non-Consultant grade staff, the exact number of which will be dictated by local demand and departmental geography and structure.
- There is clearly a difficulty in ensuring adequate SDM cover at weekends without making the frequency of weekend working unsustainable in terms of recruitment and retention. Trusts (England) and other employers will need to consider on a local basis how to provide the additional SDM cover at weekends. This might involve the use of voluntary bank/locum shifts for those seniors willing to work additional weekends, or local job planning arrangements to agree a higher frequency of weekends under locally negotiated terms, and with attention to sustainability. For permanently employed SDMs a baseline weekend working frequency would be reasonably set at 1 in 8, prior to the implementation of local agreements as described. The same dilemmas apply to antisocial working during the week. Increased out of hours working should not require Consultants to increase their annualised commitment.
- Senior staffing requirements for Smaller and Remote and Rural systems, which have particular challenges, will be addressed separately.
- The numbers listed apply to mixed EDs. However, the principles around calculation of staffing requirements are similar in single specialty EDs (e.g. Paediatric EDs).
- The numbers required for Very Large EDs are not listed as they will require a bespoke solution depending on how the workload is organised. Typically, very large EDs will require more Consultant staffing for the various streamed areas and the overall numbers of Consultants required will be proportionately greater.
- The numbers listed are those that are required in a **functional** system and are not those required to mitigate for a failing system that is experiencing ED crowding/exit block (greater numbers required).

- Full **night shift** working for Consultants is desirable in terms of the delivery of high-quality patient care (for all the reasons discussed in this guidance). However, it is only supported where sufficient numbers allow, typically in large and very large systems, with a strong focus on sustainability of the role.
- The nature of modern EM work requires the presence of a large number of Consultant level SDMs working within the ED. Systems will also need to consider appropriate supporting strategies from colleagues in other specialties to help maintain system flow, especially out of hours.

Next steps

This strategy paper has defined the model of senior care delivery and supervision in EDs that will need to evolve and be delivered.

In order to meet the standards of safety, consistent quality in emergency care and sustainable working practices for Consultants working in these intense environments, systems will need to be well-planned for the future.

The College will work closely with governments, policymakers, commissioners and regulators to ensure that we can describe funding that can be identified in the medium- and long-term planning for the NHS over the next decade.

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Appendix 1 – Abbreviations and terminology

Abbreviation	Term
CDU	Clinical Decision Unit
DCC	Direct Clinical Care
ED	Emergency Department
EM	Emergency Medicine
EP	Emergency Physician
EPIC	Emergency Physician in Charge
FRCEM	Fellow of the Royal College of Emergency Medicine
PA	Programmed activities
RAT	Rapid Assessment and Treatment
SAS	Staff Grade, Associate Specialist and Specialty Doctors
SDCC	Service Design and Configuration Committee
SDM	Senior Decision Maker
SDT	Senior Doctor Triage
SPA	Supporting Professional Activities
WTE	Whole Time Equivalent

Term	Definition
Ambulatory emergency care	The provision of same day emergency care for patients being considered for emergency admission ¹⁷
Burnout	Depersonalisation, emotional exhaustion and dissociation ¹⁶
Clinical Decision Unit	A dedicated area within the ED for patients awaiting further tests and investigations or for mobility/physiotherapist assessments ¹⁸
Consultant	Specialist in EM holding an FRC EM qualification. Throughout this document the term 'Consultant' includes specialty doctors and associate specialists.
Major Trauma Centre	A specialist hospital with an ED, responsible for the care of the most severely injured patients involved in major trauma, providing 24/7 emergency access to Consultant-delivered care for a wide range of specialist clinical services and expertise ¹⁹
Medical Director	Medical leadership role with statutory position on Executive Boards of hospital trusts as an executive member ²⁰
Resuscitation Room	A dedicated place to treat patients suffering life-threatening illness or injury and require direct monitoring and immediate life/limb saving interventions ²¹
Senior Decision Maker	Clinician who can establish a diagnosis, define a care plan and discharge a patient without routine reference to a more senior clinician ²²
Staff Grade, Associate Specialist and Specialty Doctors	Staff Grade, Associate Specialist and Specialty Doctors have at least four years postgraduate experience, two of which are in their chosen specialty ²³
Executive Boards of hospital trusts	Accountable for setting strategic direction, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the local community ²⁴

Appendix 2 - Authorship and acknowledgements

This strategy paper was authored by Dr Ed Smith and the SDCC.

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