Royal College of Emergency Medicine

Service Design and Configuration Committee

Medical Workforce Guidelines for Remote, Rural and Smaller Emergency Departments

March 2023

Summary of Guidelines

1. **Smaller, remote and rural Emergency Departments face particular challenges with respect to staffing medical workforce roles. This can be contributed to by factors such as difficulty in recruitment, sustainability of training and overall lower numbers of staff.**
2. **Supporting the development of the senior workforce with respect to the provision of Specialist, Associate Specialist and CESR roles is likely to assist recruitment and retention.**
3. **A rota of a minimum of 12 whole time equivalent consultants (or equivalent) is recommended for sustainability of the workforce.**
4. **A maximum frequency of 1 in 8 weekends is recommended for consultants.**
5. **Rotational trainees should be supported through their training experience when working in the ED.**
6. **Advanced Clinical Practitioners are likely to be able to make a very positive contribution to training and service provision in the small, remote and rural ED**

Scope

This guidance is designed to assist Members and Fellows planning and delivering services from smaller Emergency Departments (EDs), especially those located in rural locations and those situated remotely with respect to other services. It describes a suite of potential staffing and organisational solutions for services that define themselves in this way.

Reason for development

In 2018 the Royal College of Emergency Medicine (RCEM) published guidance on Consultant Staffing in Emergency Departments[1]. Smaller emergency departments (described at that time as those with attendances of less than 60,000 patients per year) were excluded from the overall staffing guidance. ED pressures have continued to grow over time and the attendances at those UK departments that consider themselves as small have increased. Defining small, remote or rural based on a number of annual attendances has become more challenging as a result. Some smaller hospital EDs are located at some distance from their nearest neighbour, whereas others are located geographically closer to other departments but may suffer from similar challenges with regards to staffing recruitment and retention, paucity of additional on-site services etc.
As a rule of thumb smaller EDs should be considered as those that receive up to 70000 attendances annually.

This guidance recognises that although each department will face a unique set of challenges, it is possible to group these into underlying themes in terms of describing the potential solutions and support that may be needed for each department and service to thrive.

Definitions

- **Small(er) ED: 70000 attendances/year or less (All types)**
- **Remote ED: Minimum 30 miles/ 45 minutes travel time from nearest ED**
- **Rural: Serving a non-urban population (not city-based)**
- **Coastal: ED serving a population located within 10 miles of the sea**

More than one of the above may apply to a single ED

Contents

Introduction

In 2014 smaller hospitals in the NHS in England were defined as those with an operating revenue of less than £300million per annum[2]. Over the last few decades there has been a move towards delivering care in larger hospitals. The argument supporting this reconfiguration of services has been that centralisation and specialisation of acute hospital services provides better care for patients. Whilst this is correct for certain very specialised services with smaller overall numbers of patients, smaller hospitals provide care for almost half the population of patients in hospitals in England. The needs of the smaller acute hospital were recognised in the 2019 NHS long term plan[3].

The smaller hospital, and the smaller ED, is not a phenomenon that is unique to the UK. In comparison with other countries with geographically more widely-distributed population, our smaller hospitals are comparatively large. In the United States for instance, rural Critical Access Hospitals are defined as having 25 beds or less[4]. In Australia, the smaller hospital is well-established and minimum standards for remote and rural hospitals are set by the Australian College of Rural and Remote Medicine[5].

Smaller hospitals, particularly those that are remote, rural and/or coastal in location often face ongoing existential challenges. National standards of care that have been developed with respect to services in their larger urban contemporaries are often difficult to deliver, and this can lead to Care Quality Commission (CQC) ratings that can be inferior to others[6]. All acute hospital trusts in England that were rated outstanding by the CQC were larger than an average Trust. Smaller hospitals often service communities that are relatively deprived, often with an older population that have a greater need to access acute healthcare services than elsewhere. These hospitals are often in locations that have difficulty attracting sufficient workforce in primary care which exacerbates the established challenges.

Hospitals with smaller EDs will almost inevitably have higher staffing costs (when measured against activity), bringing into question their “sustainability”. Staffing in line with best practice guidance, such as the RCEM Consultant workforce recommendations 2018, is a challenge for all Emergency Departments. The situation in remote rural or coastal departments is often much worse. There are many reasons for staffing challenges faced in smaller, remote and rural departments. These include:

- Difficulty in attracting staff to departments whose staffing is already inadequate (which delivers a vicious circle of worsening staffing)
- Potential unattractiveness of less diverse communities for some staff
- Potential limitations of spouse/partner employment in rural areas
- Reputational difficulties on the back of CQC and other inspections
- More remote localities inevitably have more limited options in terms of community and family facilities (such as schooling) and have higher travel times from more populated localities

In his 2021 annual report, the Chief Medical Officer highlighted the inequalities experienced in terms of healthcare in our coastal communities, many of which are served by comparatively smaller hospitals[7]. His report included a number pf recommendations focussed on strategy, research and workforce development.

Despite these challenges, a number of very positive factors exist that have attracted staff who work in smaller, remote rural and coastal hospitals to those locations. Often colleagues who practice Emergency Medicine in smaller departments value the camaraderie of a smaller unit and the sense of close reliance on each other within the department and the hospital. This supports the development and maintenance of close working relationships. Many individuals will be energised by the comparatively straightforward ability to deliver improvements in patient care that working in a smaller department provides.

Lifestyle factors can also feature prominently in terms of decisions to work and live in more remote and rural locations. Immediately accessible outdoor facilities are often better (walking, cycling, and aquatic sports for instance) and often house and land prices and the general cost of living can be much more reasonable in such locations.

Workforce

As with all healthcare services, the key determinant of the success or otherwise of the provision of a high-quality service is the quality and quantity of the workforce available to deliver it. A shortage of workforce is often self-perpetuating in that it makes it increasingly hard to attract additional colleagues to join a team that they feel is under-resourced from the point of their arrival.

A particular challenge for senior staff working in Emergency Medicine is that there are a large number of non-direct clinical care tasks that are required to be delivered for all departments, irrespective of the size of the department. The list is extensive and can include recruitment of new colleagues, managing the daily clinical governance tasks (complaints, incidents, litigation responses etc.) and the complex interface with all inpatient specialties, as well as primary care and the ambulance service. These roles are on top of the delivery of direct clinical care and in a smaller department there are simply lower numbers of colleagues that are available to perform all these essential tasks.

The RCEM Consultant Workforce Recommendations 2018 describes the myriad of roles that Consultants now undertake within Emergency Medicine and provides a formula for the calculation of the number of whole time equivalent (WTE) consultants required to ensure that all these roles are delivered on a daily basis. It also describes the challenge of delivering sustainability within the consultant and senior staffing workforce. It emphasises the importance of colleagues being able to expand their portfolio over time and ensure that the increasingly intensive clinical work is augmented by other aspects of the role that bring meaning and motivation to the job. This will inevitably mean different things to different people, but it is critical that any departmental workforce plan reflects the importance of sustainability in recruiting and retaining an effective team. A smaller departmental workforce must also be able to demonstrate such sustainability.

Workforce roles in a smaller department

The requirement for direct clinical care of Emergency Department patients continues 24 hours a day, 7 days a week. The provision of consultant delivered care to these patients represents the highest quality of care delivery to our patients. At present this remains an aspirational goal for most EDs. A combination of the need to deliver sustainable rosters for all our staff, and the implementation practicalities of the consultant and other senior staff contracts, as well as the recruitment challenges that many department face, make consultant delivered care for all patients unachievable at present.

The objective remains the delivery of high quality care with supervision and oversight by senior Emergency Medicine staff. The concept of the Senior Decision Maker (SDM) is key to calculating the number of staff required to provide a service.

Senior Decision Makers

Senior decision makers are medical staff, or credentialed Advanced Clinical Practitioners (ACPs) that are sufficiently experienced to make safe and effective decisions regarding the care of every patient. This would apply to a decision to admit or transfer the patient to the care of a specialty, or to safely discharge the patient with, or without, follow up.

Staff members in the role of a consultant would be expected to have oversight of the service at any one time, either by a physical presence within the department or via availability on the phone and to attend the department within a reasonable time frame if required.

Smaller departments may have proportionally larger numbers of medical staff that have provided a senior decision maker role for a longer time and will have a detailed understanding of the local context in which healthcare is delivered. As such it is recommended that such individuals are supported and developed to progress into a consultant (or consultant equivalent) role to support the existing senior team in the ED.

CESR programmes

One way in which individuals can be developed is by them engaging in a Certificate for Eligibility for Specialist Registration (CESR) process[8]. Such a process ensures that colleagues employed as Specialty Doctors within a service can progress to a consultant role, once they have demonstrated training and experience equivalent to that of an FRCEM consultant on the specialist register. CESR programmes can be hugely beneficial for colleagues who wish to progress in terms of skills and experience but may find a conventional rotational training scheme doesn't suit their requirements.

Running an effective CESR programme can be positive in terms of recruiting and retaining staff. It is important to note the resource implications however, as it usually requires the recruitment of greater numbers of specialty doctors than your department would need (on paper) in order to ensure rotation out of the department into the other disciplines so experience and expertise is gained. Again, this "workforce premium" can be disproportionately challenging for smaller departments.

Associate Specialist and Specialist Grades

In keeping with CESR qualified colleagues, a challenged senior rota in a smaller department can be supported and enriched by colleagues working as an Associate Specialist (AS) or in the newer Specialist role.

Although the AS role was discontinued several years ago at the time of creation of the Specialty Doctor role, it had been reinstated by some Foundation Trusts in England to provide continued career progression for specific individuals who fulfilled the local requirements for such a role. RCEM has previously supported such a role[9]. More recently a new grade, designated Specialist, has been created to augment the senior staffing options available[10].

Consultant and Consultant Equivalent Recommendations

It is difficult to be completely proscriptive regarding the number of individual consultants (or equivalent), however it is recommended that smaller EDs have a minimum of 12 WTE individuals in these roles. Although it is likely that the requirement for covering different parts of the department will be less than in larger departments, the requirement to provide a sustainable roster as well as the need to deliver on all the ancillary roles of the senior workforce mean that 12 represents a reasonable minimum number.

Weekend working

The need to cover weekends on all Emergency department rosters, but especially senior staffing rosters, presents a real challenge. This challenge is exacerbated in smaller departments because of the paucity of senior staff. Many colleagues value time off at weekends with respect to family activities and responsibilities. Recruitment and retention to smaller departments will not be assisted by more onerous rosters (in terms of frequency of on-call) for these departments.

It may be reasonable, however, to consider different working patterns for senior staff in smaller, remote and rural departments. A department that sees 100 patients a day will require different staffing levels at all grades than one that sees 400 patients a day. With the exception of a very limited number of very small remote departments, the traditional “weekend on call” with Friday to Monday clinical cover provided by the same senior doctor is unlikely to be sustainable given the increasing intensity of Emergency Department clinical activity.

Weekend Working Consultant (and Equivalent) recommendations

Assuming there is a minimum of one consultant on the shop floor (or on call) at any one time, the recommended maximum frequency of working is one weekend in eight. This is aligned to the workforce recommendations for larger departments[1].

Consultant/Consultant Equivalent Workforce Guidelines Summary

- **Minimum of 12 whole time equivalent Consultants per ED**
- **Maximum frequency of 1 in 8 weekends**
- **Consider (and invest in) CESR, Associate Specialist and Specialist roles**

Non-consultant grade workforce recommendations for small, remote and rural departments

Specialty trainees

The presence of Specialty Trainees at any level in an Emergency Department delivers a positive experience for staff of all grades and disciplines. It is also argued that rotation of specialty trainees to train in smaller, remote and rural departments is very likely to deliver a different and positive experience for the trainee. Quoted benefits for trainees in working in smaller departments often include learning a greater degree of autonomy in clinical decision making, and being exposed to management and leadership development opportunities that may be less easily accessible in larger departments. Trainees often return to departments where they have worked previously as consultants, so more trainees in smaller departments is likely to result in a greater number of senior staff in those departments over time as well.

The big challenge with delivering training in a smaller department is usually the relative lack of senior medical staff to provide day to day supervision to trainees. This can lead to trainee dissatisfaction with their experience and it has resulted in Specialty Trainees being withdrawn from some smaller departments. RCEM would advocate the use of creative solutions to avoid this occurring wherever possible (eg use of technology to ensure links with other trainees/trainers elsewhere in the region, support with accommodation/travel etc).

Specialty trainee rotation from larger centres should be supported – local training authorities should work with smaller EDs to ensure that training posts are not lost from smaller EDs and expanded where possible

Specialty Doctors

Specialty doctors (non-training grade staff usually working at middle grade level) are often the mainstay of the Senior Decision Maker cadre within smaller EDs. This group of medical staff must be viewed with the importance that they deserve. As permanent members of the medical team it is important to view them with the same perspective on recruitment and retention that would be used for other permanent senior staff.

For some Specialty Doctors an opportunity to engage with a CESR programme will be strongly attractive. For others, work-life balance considerations, or portfolio careers, may be to the fore. As with other staff groups, having an appropriate overall number of whole time equivalent positions is critical for delivery of a sustainable roster.

Ensure the Specialty Doctor rota is sustainable and tailors for individual requirements – e.g. an annualised roster allows for overseas doctors to travel to see family (although the risk of this is all leave is used up in one or two blocks potentially leading to exhaustion at other times).

Doctors in Training

Doctors in training (at all levels and from a broad range of specialties) will benefit from experience in Emergency Medicine irrespective of the size or characteristics of the specific department. The number of individuals required to populate a rota will be determined by the size of the department and the contractual arrangements of the particular grade of doctor. It is also the case that a well delivered training scheme in a smaller, remote or rural department can be instrumental in supporting recruitment of other medical staff to the area, in particular GPs, and that this will have significant benefits for the community as a whole.

Advanced Clinical Practitioners (ACPs)

ACPs are senior clinicians that have undergone training to Masters level in acute and emergency care. Usually from a senior nurse, paramedic or physiotherapist background, their contribution to delivery of the service is viewed as invaluable in departments that have invested in them as a workforce. Key learning points from experience of this workforce group to date include:

- The presence of an ACP role within the department will motivate some senior clinical staff to remain working in Emergency Care rather than moving into a managerial role to further their career
- Experience from some remote and rural EDs suggests that “growing your own” represents a more successful model of developing the team rather than advertising jobs for those qualified elsewhere (although both may work)
- There appears to be an advantage in training a number of ACPs together rather than a small number at a time – this mitigates against the inevitable attrition rate as well as giving peer support to the trainee cohort
- The challenge of training a number at once is the impact on the trainers (usually senior ED medical staff) which can be difficult in resource challenged environments

Consider investing in an ACP workforce to augment and support the junior medical workforce. ACP remuneration is contentious as they are paid as agenda for change staff rather than on medical pay-scales. This may make them theoretically cheaper in respect of filling junior doctor workforce gaps however it can lead to a “them and us” perception that is unhelpful, and it is suggested that local pay arrangements for covering rota gaps that are equitable are developed.

RCEM has an established system of credentialing for ACPs to facilitate progression of skills and experience[11].

Physician Associates

Physician associates may also contribute to a blended workforce within smaller EDs however it is noted that there are aspects of their current registration arrangements that mean that they are not able to yet engage with all aspects of patient care.

Non- Consultant Workforce Recommendations Summary

- **The presence of Specialty trainees in smaller departments should be supported**
- **Specialty doctor rotas must be sustainable (frequency and intensity)**
- **ACPs provide a valuable contribution to the workforce**

Smaller remote and rural Emergency Departments – Service Delivery Considerations

The way in which other services delivered locally can support the smaller Emergency Department can influence the sustainability of and the quality of care provided in such departments.

Many different models of care exist and there is an inevitable variation around the UK, driven by local service availability as well as specific policy decisions.

Some specific innovations designed to support smaller EDs could include:

- Linking up EDs within a specific Trust or region to be operated under the auspices of one managerial team. There would be an expectation for the larger department to support the smaller. This would be predominantly around staffing but would also include organisational support.
- Consideration of smaller EDs receiving more than their currently allocated resource of trainees to ensure that there is a pipeline of potential future employees in greater numbers than has historically been the case.
- External investment in high quality accommodation for rotational trainees to avoid the need for travel post shift where that would be detrimental to their health and wellbeing.
- Consideration of night closure – this isn't necessarily the best way to proceed for remote and/or rural departments but may be an option for smaller departments that are less distance from other larger centres.
- Encourage the supporting services on site (Urgent Treatment Centre, Inpatient specialties) to engage with the clinical care of the presenting patients to manage the cohort more equitably

Conclusion

Whilst the environment for delivery of emergency medicine continues to be difficult in all settings nationally, smaller rural remote and/or coastal Emergency Departments experience particular challenges in delivering safe emergency care. Smaller EDs provide an essential service to their catchment (and visitor) populations which are often relatively deprived in socioeconomic terms, and may also have limited transport options to access healthcare elsewhere.

Recruitment, retention and support of all grades of medical staff is vital for sustaining healthcare delivery in these EDs, and there is an argument for proportionally greater resourcing in an attempt to offset the greater financial and human costs of delivering such services.

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Dr Ed Smith, Chair of the RCEM Service Design and Configuration Committee with input from the committee

Acknowledgements

RCEM Remote and Rural Special Interest Group

Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None

Disclaimers

RCEM recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Research Recommendations

There is a paucity of research regarding the factors that can support delivery of healthcare in remote and rural settings.

Recommendations for further research could include:

- Assessment and improvement of trainee experience in remote and rural EDs including understanding what is needed to encourage trainees to work in smaller hospitals
- Consideration of evolution of models of care to support the ED in resource challenged environments (within the hospital and in primary care)

Key words for search

Medical workforce

Emergency Department

Remote

Rural

Small

RCEM
Royal College
of Emergency
Medicine

Excellence in Emergency Care