Royal College *of* Emergency Medicine

May 2023

Executive Summary

The NHS, particularly emergency care, is experiencing its most difficult period in recent history. Performance has been declining over a number of years reaching a record-breaking low this winter.[1] Policymakers are often inclined to address such issues with short-term solutions that may temporarily keep the system afloat. While these solutions can be drawn up quickly, they are not cost-effective in the long run and never seek to address the issue at its core.

In the words of the NHS Long Term Plan, policymakers should be “ambitious but realistic” about their approach. Yet, what is currently expected of emergency department staff is far from realistic. At present emergency medicine (EM) consultants see almost double the number of annual attendances that is considered safe.[2] Furthermore, many of these patients present with more complex clinical conditions and may require a longer length of stay in the emergency department. The burden of care hours per member of staff is exacerbated by a widespread lack of EM workforce.

This report found that:

- Emergency medicine trainee doctors make up 45% of the total emergency medicine workforce. Without a detailed plan to replenish and grow this cohort of the workforce, there is great risk to service provision, namely during out of hours, night and weekend shifts, and poor consequences for patient safety.

- 29% of our emergency medicine consultant members in England are over 50. As consultants approach this age, they may consider reducing their working hours. Furthermore, with a third of the workforce approaching retirement age at the same time, we may witness a mass exodus of experienced senior clinicians.

- There should be one whole-time equivalent consultant for every 4,000 annual attendances. At present, this ratio stands at 1:7052. This is further exacerbated by extreme long waits that are now commonplace in emergency departments.

- 2019 and 2022 saw a comparable number of attendances (0.15% difference), yet the number of care-hours per whole-time equivalent emergency medicine consultant and nurse respectively, almost doubled within this time frame.

Unsurprisingly, the working conditions are making it difficult to retain staff in the specialty: retention of the staff we *do* have is of great concern. Burnout and low morale plague the specialty incentivising senior staff to retire early.

This explainer found that in 15 years’ time, there will still be a shortfall of 600 WTE consultants in England. Planning and implementation must begin now if we are to sustainably secure the workforce of the future, and ensure emergency departments continue to be there for anyone and everyone at their time of need.

[1] https://rcem.ac.uk/data-statistics/

[2] Table 1. WTE Consultant numbers and Annual Attendances (Type 1)

Recommendation

The Government must act now to achieve safe staffing levels in EDs and plan for the long term. The expansion of emergency medicine training places is needed to ensure patients are treated by staff who receive high quality training. To achieve this there must be **an expansion of a minimum of 120 emergency medicine training places from 2024 continued for 6 years.** This must also include an accompanying increase in Allied Health Professionals, SAS doctors, Emergency Nurses, and include the faculty to train them.

Introduction

NHS England is one of the largest employers in the world, with over 1.5 million members of staff.[3] From porters to managers, physiotherapists to neurosurgeons, these people do their very best to ensure the healthcare needs of the UK population are met by keeping the cogs of this vast system turning. Simply put – without its workforce there is no NHS. Despite this, the NHS continues to be severely understaffed, placing additional strain on existing staff and inadvertently impacting patient safety. One such area where this is acutely experienced is within our emergency departments (EDs).

The emergency care system operates 24 hours a day, seven days a week, contributing to the already-intense type of work that presents itself to EDs. A lack of sufficient workforce poses a plethora of risks, not least to the patient. 2022 saw record-breaking worst performance against every metric and ED staff frequently find themselves trying to bridge the gap between the quality care patients deserve and an under-resourced, underfunded system.

To explore this further, this explainer will touch upon workforce trends over time, analysing how the comparatively young specialty of emergency medicine and its diverse workforce has adapted to changes in not just size, but type of demand it sees. Moreover, we will look ahead and discuss the future of emergency care based on current and anticipated staffing needs. Emergency medicine workforce issues are rife throughout all the UK and as such, should be a policy priority for the respective governments in each nation. However, this explainer will predominantly delve into how these issues manifest within the English context. To explore workforce pressures afflicting Scotland and Wales, you can refer to our census reports here and here.

What is Emergency Medicine?

Emergency Medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis, and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. EM was not recognised as a specialty until 2005 in the UK. This occurred when The British Association for Emergency Medicine (BAEM), formerly the UK's Casualty Surgeons Association, merged with the Faculty of Accident and Emergency Medicine (FAEM), to become the College of Emergency Medicine, later gaining its Royal title in 2015.

While the recognition of EM as a distinct specialty is relatively recent, the importance of emergency care has been acknowledged in some capacity for hundreds of years, most notably in the field of battlefield medicine. Emergency Medicine's long history of flexibility in the face of changing demand and crisis, is uniquely one of its strengths. Yet, it is this very adaptability which has seen the normalization of workforce pressures within an ill-designed and poorly funded system.

Despite the difficulties, emergency medicine continues to be an area for which people show a keen interest. The Royal College of Emergency Medicine (RCEM) represents a growing membership of almost 11,000 in the UK and around the world.

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[3] https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers

How do we know we don't have enough staff?

At the crux of workforce planning should be patient safety. This means ensuring there are enough members of staff trained in emergency medicine to take on and oversee the care of attendances to the emergency department. Skill mix and departmental needs will vary to some degree, and the exact number of Whole Time Equivalent (WTE) Consultants required will depend on the complexity of service delivered. RCEM recommends that safe staffing should, on average, be based on a ratio of at least one WTE consultant for every 4000 annual attendances.[4]

Table 1. WTE Consultant numbers and Annual Attendances (Type 1)

Year	WTE Consultants	Annual Attendances	WTE Consultant: Annual Attendance ratio
2013	1340	14219878	1:10609
2014	1457	14672118	1:10068
2015	1514	14597703	1:9640
2016	1591	15406915	1:9682
2017	1682	15338481	1:9120
2018	1803	15436835	1:8562
2019	1925	16185686	1:8409
2020	2046	12856098	1:6283
2021	2196	15271416	1:6953
2022	2299	16210573	1:7052

Table 1 outlines staffing numbers reported by NHS Digital and annual attendances over the last decade. Despite a larger average growth in workforce, staffing numbers are insufficient to meet demand, with the most recent figures showing that there are nearly double the number of annual attendances per consultant than should be. In fact, if growth in both staff and demand were to continue the same trajectory, the RCEM safe staffing recommendation would not be met until 2041. Even so, this is on the generous assumption that retention and recruitment issues do not worsen and that uptake of less than full time working stagnates, both scenarios unlikely, and are topics that will be discussed later in the document. RCEM data show that 29% of emergency medicine consultant members in England are over 50. This will inevitably have consequences on WTE workforce numbers, as consultants approach this age, they may consider reducing their working hours. Furthermore, with a third of the workforce approaching retirement age at the same time, we may witness a mass exodus of experienced senior clinicians.

How accurate are the data?

It is important to mention that at present, the workforce figures published by NHS Digital are the best publicly available data. NHS Digital source their numbers from the HR pay system, NHS Electronic Staff Records (ESR), which likely paints a misleading picture. The NHS Digital whole-time equivalent figure is based on the proportion of time staff work in a role. For instance, a doctor on a typical job plan of 10 programmed activities (programmed activities are blocks of time, in

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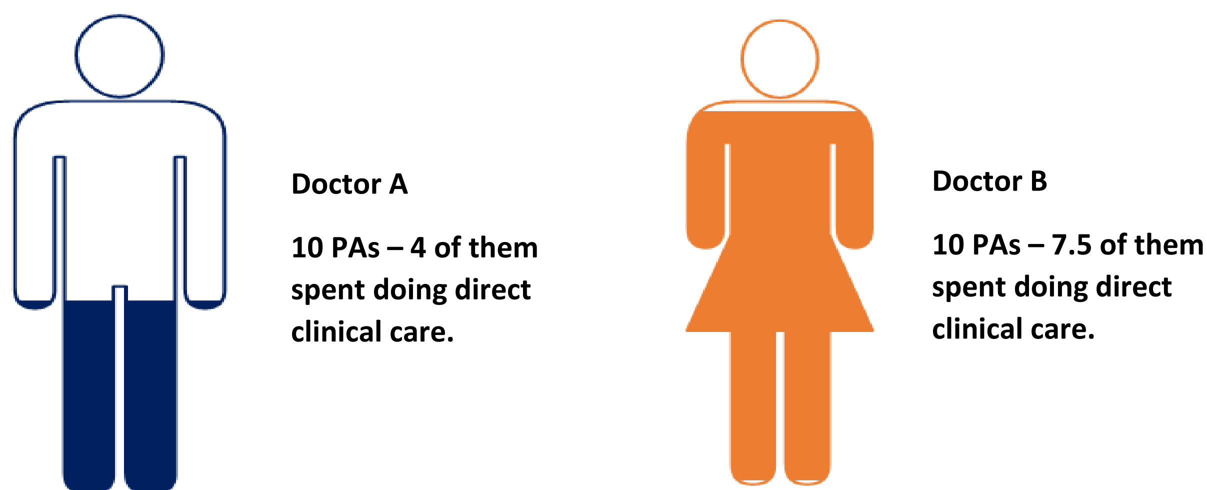
[4] https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Consultant_Workforce_Document_Feb_2019.pdf

which contractual duties are performed) equal to 37.5 hours a week, would be counted as one WTE, and a doctor working around 19 hours would be 0.5 WTE. Normally 7.5 programmed activities (PAs) will be assigned to patient-facing direct clinical care work (DCC) with the remaining 2.5 PAs spent doing supporting professional activities (SPA). However, the proportion of PAs dedicated to doing direct clinical care work in Emergency Medicine can actually vary greatly between two members of staff.

Diagram 1. Demonstration of the distribution of Programmed Activities



Take the two doctors illustrated above. In this scenario, both are on a typical job plan of 10 PAs, but their work is different, so they have a different number of DCCs with the remaining time covering other activities that are vital to the wider NHS such as teaching and training. Nonetheless, they will be indistinguishable on the ESR and recorded as one WTE each. In essence, ESR tells us how much an individual is working, but not what they're working on. Therefore, the amount of ED work activity of these two members of staff will be very different, despite no allusion to this in the data. It is likely that this effect is more pronounced for the older consultants many of whom will have mixed portfolios of working, which will result in less time in the ED. The result is a WTE figure that likely suggests more staff presence in the emergency department than is true.

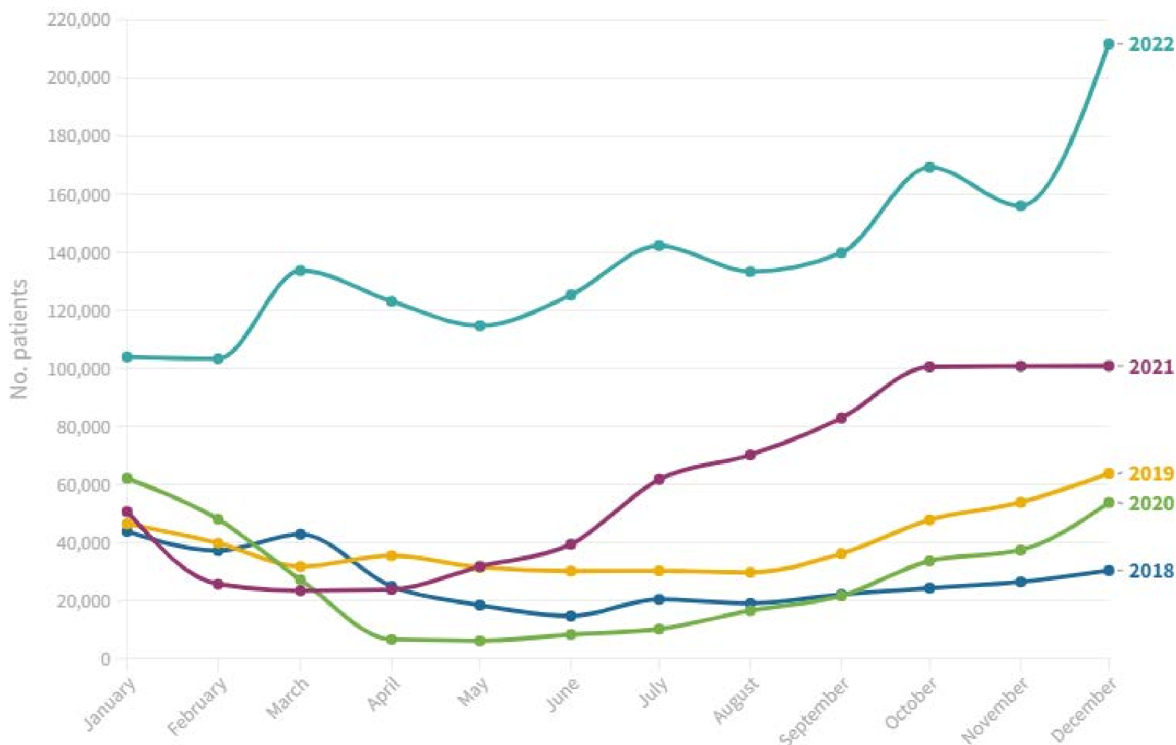
Change in demand

Another factor to consider is the change in the type of patient demand that is presenting itself to EDs. While there has been an incremental growth in attendances, the health needs of patients admitted to hospitals are also becoming more complex: NHS England recently reported that over the last five to seven years the percentage of patients attending an ED with more than three long-term conditions has risen from 10% to 30%.[5] This trend is set to continue with two-thirds of adults aged over 65 expected to be living with multiple health conditions (multi-morbidity) by 2035. 17% would be living with four or more diseases, double the number in 2015. One-third of these people

[5] https://committees.parliament.uk/oralevidence/11545/pdf/

would have a mental illness like dementia or depression and increased life expectancy by around three years for both men and women mean people will spend longer living with multi-morbidity.[6] A general trend of the population living longer in poorer health will inevitably have an impact on the healthcare system, particularly emergency care. Compounding this issue is the increase in long waits in emergency departments due to pressures in other parts of the system.

Graph 1.



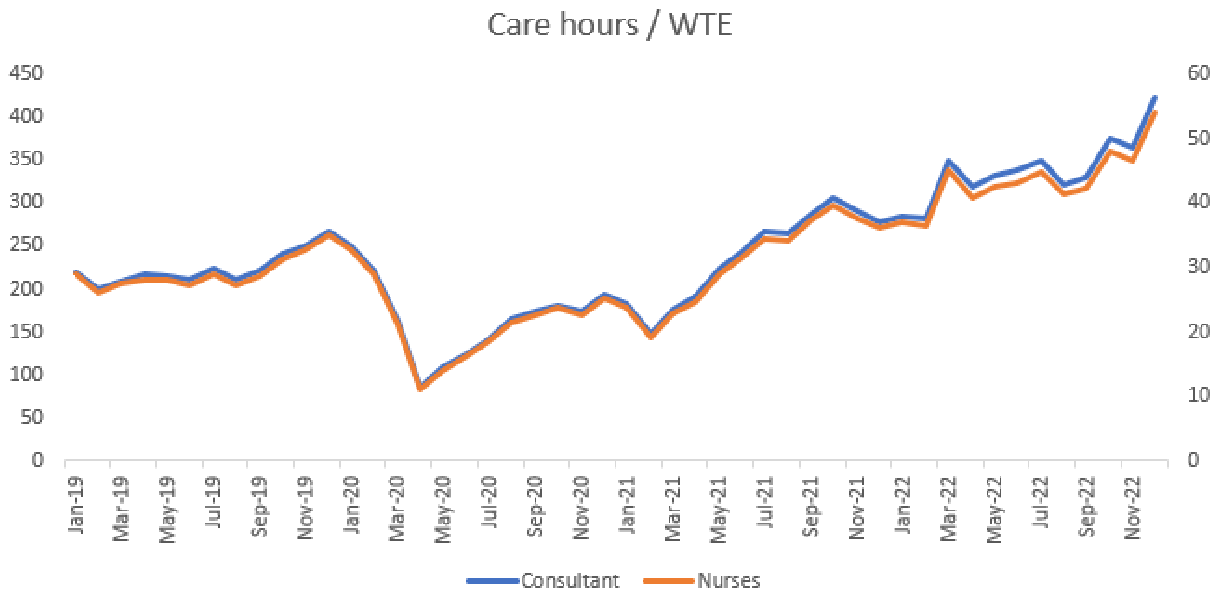
The number of patients staying in an ED for 12 hours or more from their time of arrival is particularly indicative of the strain EDs are under. There is rarely, if ever, a clinical justification for a patient to stay in an ED for more than 12 hours, yet in 2022 this was the case for 1,656,206 patients.[7] A significant proportion of these patients would have been awaiting admission to an inpatient ward after being processed and receiving any initial treatment they need in the emergency department. Consistent high bed occupancy rates frequently mean that patients are unable to move on from the ED and into a bed in a timely manner. As a result, overcrowding occurs in the department, with patients waiting and being cared for in clinically inappropriate areas, such as corridors and even cupboards converted into cubicles. This is inhumane and stressful both for the patients and staff. Aside from the impact this has on staff wellbeing and

[6] Multi-morbidity predicted to increase in the UK over the next 20 years (nihr.ac.uk)

[7] https://rcem.ac.uk/datastatistics/#:~:text=58.0%25%20of%20patients%20were%20admitted,since%20April%202020%20(10.9%25).

morale, the increase in the number of care-hours staff are responsible for exacerbates the pressure the workforce is under.

Graph 2.



Graph 2 demonstrates the total time spent in a department by patients, divided by the number of WTE consultants and nurses respectively. Even though attendances in 2019 (16,185,686) and 2022 (16,210,573) were comparable, the number of care hours almost doubled. Increase in care hours illustrates why the job is feeling increasingly more difficult, intense, and unsustainable despite a marginal change in demand. Staff may be seeing similar numbers of patients, but those patients are sicker, and are staying longer.

Less than full time working

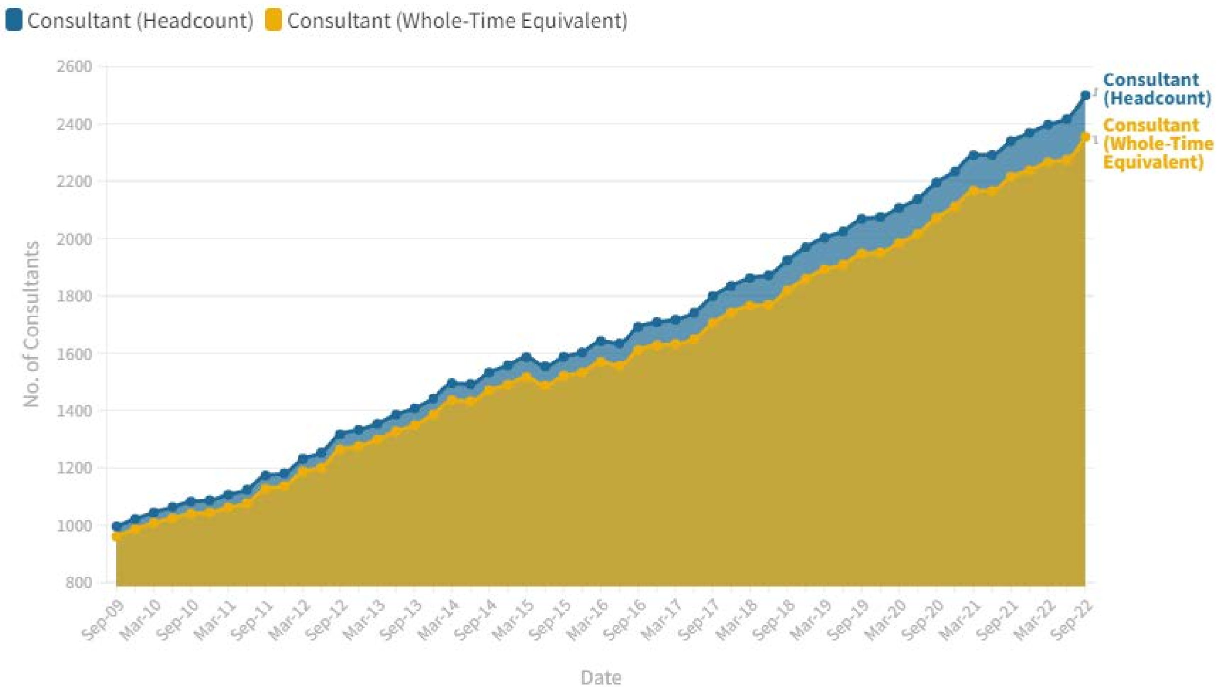
It is due to this intensity of the work that less than full time working (LTFT) is increasing in emergency medicine as it offers staff the opportunity to remain in the job with appropriate time for rest and recovery. For many, working LTFT is the only way to have a sustainable career in EM. By looking at the number of consultants as a headcount in comparison to the WTE figure, we can get an idea of the proportion of the total potential workforce lost due to LTFT working. As Graph 3 demonstrates, LTFT working has increased overtime, with the headcount and WTE figures slowly diverging. In 2009 the number of WTE consultants was 96.5% of the total potential consultant workforce, in 2022, this fell to 94.2%.[8] Although this is just a 2.3 percentage point difference, the increase in LTFT working since 2009 represents a loss of 57 WTE consultants from today's workforce. That is enough to staff three medium-sized departments and safely see an additional 228,000 patients per year.[9] This does not mean we should be discouraging staff to

[8] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

[9] https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Consultant_Workforce_Document_Feb_2019.pdf

work LTFT, but rather policymakers must seriously consider its impact on workforce planning and projections for the future.

Graph 3.



Additionally, the specialty registrar cohort, who are in the pipeline to be the consultants of the future, have undergone one of the largest uptakes of LTFT working. Therefore, is important to consider what the working patterns of our future consultant workforce will look like. Furthermore, the option to complete EM training LTFT (of which 24% do) will have implications on how quickly we replenish consultants leaving the specialty. A significant proportion of those completing EM training LTFT will be doing so towards the end of the training programme, meaning that there is least department presence from those with the most experience. Finally, when trainees go LTFT they still occupy a training number, every time someone decides to go LTFT, they are not replaced, and so staffing shortages and "underrecruiting" are inadvertently built into the framework of recruiting. It must be noted that these WTE and headcount figures have been acquired from NHS Digital workforce statistics, which, as outlined previously in the document, should be considered with caution.

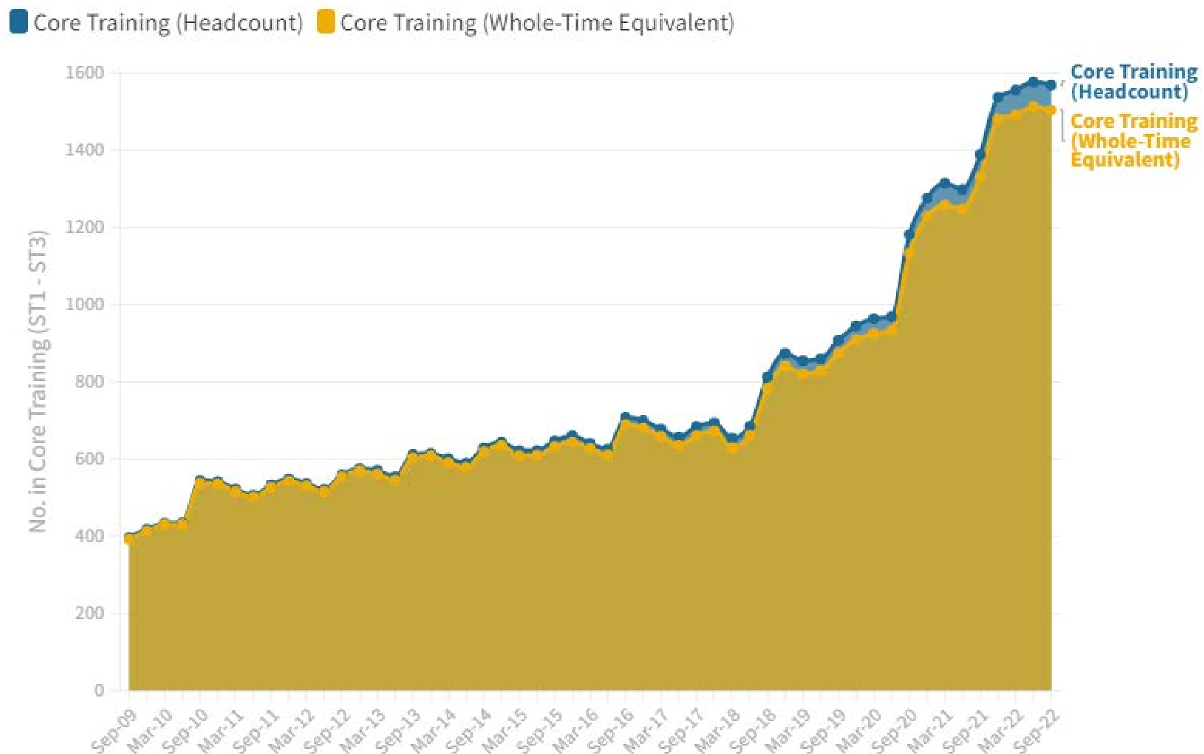
Emergency Medicine Training

Among the range of skill mix present in the emergency department, the most popular and predictable career route is that of post graduate doctors in training. The emergency medicine training programme (ST1-ST6) takes six years, although in reality, due to less than full time working and out of programme training, it can take seven or eight years. During this time, doctors in training must achieve the Acute Care Common Stem (ACCS) and complete core training which takes three years. The first two years of core training are spent rotating through Emergency

Medicine, Acute Internal Medicine (AIM), Anaesthetics and Intensive Care Medicine (ICM). The third year is spent in Emergency Medicine to ensure the trainee meets the minimum requirements for ST4 level. Trainees will then enter Higher Specialty Training (HST) for the subsequent three years (ST4 - ST6). Trainees at this level assume the EM Specialty Registrar posts and work their way to become a consultant. We know that a percentage of trainees will drop out of the programme, with this most commonly occurring during core training, but the exact proportion is unknown.

Graph 4 displays ST1 – ST3 numbers for each quarter going back to 2009. It demonstrates a steeper increase in WTE core training numbers beginning in 2018, with 2019 seeing an 11% increase in those at ST1 – ST3. The largest increase took place between 2020 and 2021 which saw those in core training increase by 26%.

Graph 4.



This is somewhat anomalous when compared to historic growth which averages out to a 4.5% increase in core training numbers each year. The recent uptick may be explained by a few reasons. Firstly, in 2017 RCEM worked with Health Education England (HEE) to increase the National Training numbers, with the continued 75 additional posts in ACCS trainees in Emergency Medicine and HST. This uplift can be seen in the numbers of those in Core Training from 2018 onwards. We can anticipate a plateau in growth as the agreed expansion plan takes effect by August 2024, which is 6 years from the original year 1 of expansion in 2018.

An additional factor is the approval of the Defined Route of Entry into Emergency Medicine (DRE-EM) programme as a formal entry route into Emergency Medicine specialty training which began in 2014. DRE-EM enables entry at ST3 for those who have successfully completed two years of a UK core surgical training programme, or a minimum of 24 months in any ACCS specialties. In DRE-EM the ST3 'year' will normally last for 18-24 months depending on the competencies each trainee still requires for entry to ST4, creating a bulge in the core training numbers at ST3. This entry into EM specialty training has more recently been populated by international medical graduates (IMGs) who have previous relevant experience and want to transition into the EM training programme in the UK. The recruitment of IMGs is often proposed by NHS England when talking about the workforce crisis, as a means to plug the gap, at least in the short term. However, any push for international recruitment must be ethical and considered. We must be cognisant of the fact that IMGs have often come from very different structures to the NHS, requiring time to bed in, and may well need shadowing with intensive supervision placing additional responsibilities on existing staff that are already time pressured.

It's important to be aware of how time-pressure and the strain emergency care is under impacts trainees. Aside from the operational pressures impacting trainees' ability to deliver the quality care they'd like to, it also has an adverse effect on their experience of the training programme, as EM training relies on our senior colleagues in EM to have resources, time, and energy to teach. It is not uncommon for SPA time to become deprioritised, and while HEE have made recommendations to ensure sufficient trainer time, the issue persists. There is evidence that ringfencing Education Development Time (EDT) has proved challenging especially during the COVID-19 pandemic.

The GMC national training survey of 2022 showed EM trainers reporting significantly more negative responses for workload, supportive environment, resources for trainers and trainer development.[10] Furthermore, the current workforce structure whereby they provide a significant portion of service provision out of hours is unsustainable both in terms of providing meaningful training for EM doctors without a high risk of burnout and also in terms of adequate service provision with the numbers of EM trainees simply unable to meet service demand. Doctors in training make up 45% of the total EM workforce and therefore play an integral part in the running of the service. Importantly, the ability to train in a capacity that adds value to the career of an individual is a factor in whether they decide to remain in the specialty. Expanding the workforce will not only provide relief in terms of easing the clinical workload but will also have a positive impact on the quality of training and teaching.

The Multidisciplinary Team

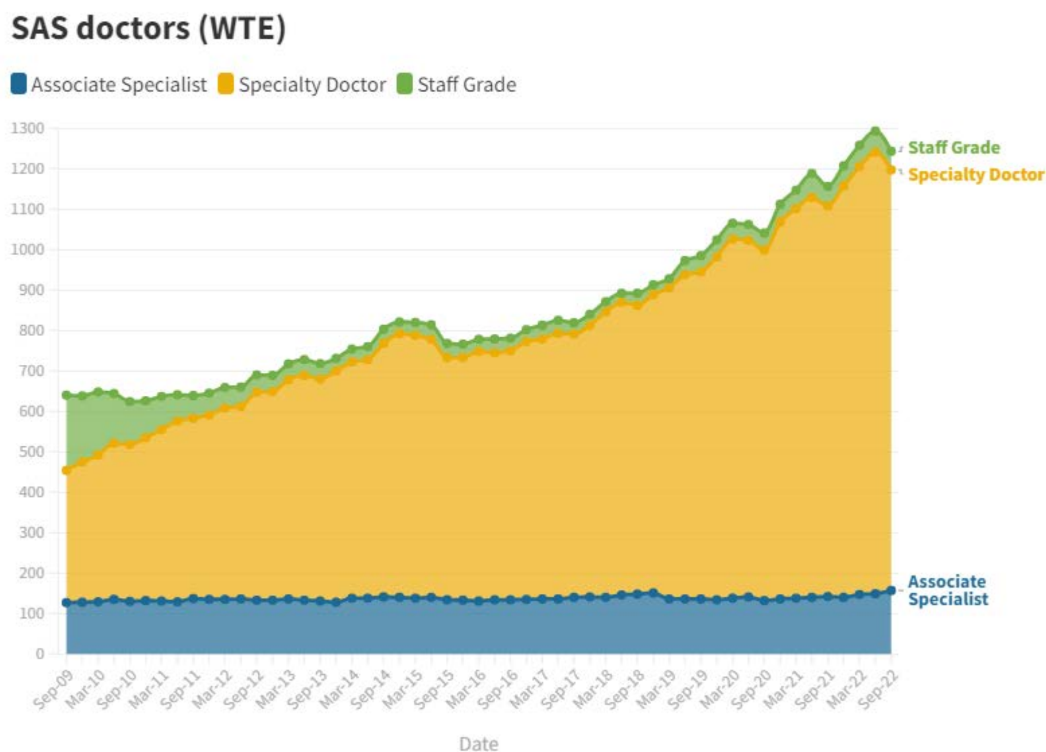
Emergency medicine staffing and workforce planning is often spoken about in a binary fashion: trainees and consultants. Yet, the emergency department team is comprised of a plethora of roles with wide ranging experiences, skill mix, and responsibilities. Furthermore, the evolving character of today's workforce, including the demand for less than full time working patterns, creates an appetite for alternative career pathways. One such route is taken by staff, associate specialist, and specialty (SAS) doctors. Making up 13% of the EM workforce, SAS doctors generally take up substantive posts and can operate at a trainee-like level, to senior-decision maker (SDM) level. While they do not undertake the EM training programme, some trusts have created local "CESR

[10] https://www.gmc-uk.org/education/how-we-quality-assure-medical-education-and-training/evidence-data-and-intelligence/national-training-surveys

training" programmes for trust and SAS Doctors, but this is very much under control/discretion of the local employing trust/department. It is a lengthy and difficult process that does not always end in a consultant post. This is often the route into the specialty for IMGs.

Graph 5 displays SAS doctor numbers since 2009. The growth has been in the Specialty Doctor title with Associate Specialist remaining stable over time. An ED must have a model of delivery that ensures an adequate depth and breadth of SDMs to lead, manage and treat an increasingly complex workload, and without SAS doctors this simply would not be possible. There is no predictable succession pathway for career grade staff, and so no guarantee that this staff group will continue to consistently replenish itself. Therefore, in the instance that career grade numbers decrease, there must be a sufficient number of Certificate of Completion Training (CCT) holders to ensure that there is adequate seniority and experience within the department.

Graph 5.



Another cohort of doctors that form a substantial proportion of the ED team are Locally Employed Doctors (LEDs). This group of staff are employed by trusts on local terms and conditions and are usually non-permanent posts and do not have nationally agreed terms and conditions unlike SAS doctors. Furthermore, there is also no nationally recognised career or pay progression thresholds for these posts, but while the trust is under no obligation to provide training it can be agreed in their job plan and is important for patient safety. LEDs job titles can range from trust doctors, clinical fellows, and senior clinical fellows.

The final prominent group working in emergency departments, and the backbone by which much institutional knowledge is retained are the allied health professionals and nursing staff. These include Emergency Nurse Practitioners (ENP), Advance Nurse Practitioners (ANP), Advanced Clinical Practitioners (ACP), and Physician Associates (PA).

Health Education England (HEE 2016) defines Advanced Clinical Practitioners as "professionals from a range of backgrounds including nursing, pharmacy, paramedic, and occupational therapy. ACPs hold Master's level education, as well as having skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients". ACPs tend to have long term careers within their areas of clinical practice and so offer consistency and continuity in care that is absent from the rotational nature of medical workforce training. In turn, such an experienced, stable core workforce can enhance the educational opportunities and training for all trainees that may rotate through such an environment. Advanced clinical practice is central to helping transform service delivery and better meet local health needs by providing enhanced capacity, capability, and efficiency. It's also important to note that ACP training is now considered in most regions to be an apprenticeship model of training, reliant on the same senior faculty to deliver training for trainees, SAS doctors, LEDs, medical students and ENPs.

The regulation around Physician Associates is due to undergo change. This could have an impact on the way in which this role is defined, regulated, and how PAs operate within the ED. Consequently, we may witness a change in the number of PAs employed by EDs. While some units currently have PAs, the maturation of this role, and the introduction of prescribing rights for example, could prove to add even more support to the EM team and a more structured framework for those keen to pursue this career pathway. All members of such multidisciplinary teams bring different, complementary skills, knowledge, and attributes which when brought together, deliver enhancements in patient care and experience.

Retention

Expansion of the emergency medicine workforce is paramount for patient safety, but it is somewhat futile without a concurrent focus on retention. Whether it be changing specialties, going to work abroad, or leaving medicine all together, there are a range of reasons why attrition is such a prevalent issue in EM. The Psychologically Informed Policy and Practice (PIPP) Project report published in October 2022 identified four key themes related to retention: untenable working environments; a culture of blame and negativity; striving for support and the pivotal importance of leadership. Staff reported that the immense work pressure associated with crowding, poor staff ratio and their working environment were having a negative impact their ability to perform effectively. This resulted in a significant personal burden, affecting how they felt about their jobs and their ability to care for patients, with many staff considering leaving their jobs for these reasons.[11] In other words, operational pressures, and staff dissatisfaction appear to be intrinsically linked.

In recent times we have seen this result in the hemorrhaging of nursing staff in particular. This presents a serious issue as more experienced clinicians provide higher quality and more cost-effective care. Retaining them in the specialty is vital, both to preserve institutional memory and to ensure continuity in the delivery of care. A study found that burnout and poorer job satisfaction was greatest in hospital settings, physicians aged 31-50 years, and those working in emergency medicine and intensive care. In addition, the association between burnout and patient safety incidents was greatest in physicians aged 20-30 years, and people working in emergency

[11] https://rcem.ac.uk/wp-content/uploads/2023/01/PiPP_Project_Key_Study_Recommendations_V2.pdf

medicine. Most worryingly clinicians suffering burnout are twice as likely to be involved in patient safety incidents.[12]

Another barrier to retention and a driving reason why senior staff may have been choosing to retire early, was the rules around pension taxation. From 2016 a person's annual allowance is tapered (reduced) if their threshold income (taxed) and adjusted income (total including pension contributions) are above set amounts. Although these rules applied across all schemes, the higher salaries and nature of many doctors' work (for example, consultants taking on additional work often at short notice to cover service pressures) meant there was a larger impact on the NHS particularly on experienced staff. The RCEM Scottish Census report revealed that 65% of EDs confirmed consultants had declined locum work to cover rota gaps due to pension considerations/penalties, and it was likely to be a similar picture in England. The consequence was two-fold, senior staff were refusing extra shifts to cover rota gaps due to the fear of the tax penalty which would essentially result in them paying to work. Secondly, it may have incentivized important senior staff to retire early and leave the specialty altogether. However, pension tax changes announced in the 2023 budget have seen the end of punitive taxation rules for doctors. This will hopefully have a significant impact on retention and dissuade doctors who are approaching the end of their career from retiring early. More detail about retention, burnout, and attrition will follow in an upcoming explainer that will further explore the solutions to this salient issue.

Locums and spend

As a result of these culminating issues, as well as insufficient workforce provision, there is a heavy use of locum staff in EM. A locum is a person who temporarily fills vacant shifts in the ED in order to mitigate rota gaps. In 2022, NHS Benchmarking data showed that 25% of reporting Trusts spent more than a third of their consultant pay budget on locums, with five Trusts spending more than half the budget on locums. [13] Some locums are internal, where an existing member of staff essentially helps out to fill gaps, however the majority of locums are provided by commercial companies and is a relatively expensive way to deal with persistent workforce shortages.

While filling these vacant roles is certainly a priority to ensure the safe delivery of care, the use of locums is costly. RCEM's Scottish and Welsh Census reports both revealed that an inability to recruit was the driving theme, leaving funded posts unfilled due to a lack of candidates. Furthermore, agency staff and consultant locums covering a more junior gap are costly options for the ED, as both roles come at a higher rate. Therefore, this use of locums represents an excess cost which would be saved if there were no rota gaps.

In 2015, NHS bosses were spending almost £4 billion on agency staff. In attempt to curb that spend, the government introduced a cap which meant that agency staff could only earn a maximum of 55% more than contracted NHS workers. However, in recent times, NHS trusts have begun to frequently exceed this cap due to the pressures they are under and the lack of staff at their disposal. For many shifts, trusts have been so short-staffed they have willingly breached the government pay caps for these agency workers, most of whom are doctors and nurses. In 2021,

[12] https://www.bmj.com/company/newsroom/clinicians-suffering-burnout-are-twice-as-likely-to-be-involved-in-patient-safety-incidents/
[13] https://members.nhsbenchmarking.nhs.uk/dashboard/6

90% of agency shifts for doctors and dentists exceeded this pay cap while the figure was at 40% for nurse shifts.[14]

When the cap was initially introduced, the government set out that trusts could only exceed the pay cap if there was a significant risk to patient safety. This exemption has become largely redundant now, as system pressures and workforce shortages threaten patient safety every single day and the extent to which the cap is being ignored attests this.

Encouraging workers back into substantive and bank roles could help ease some of the financial pressure facing the NHS however this is not a short-term project. It is common for departments with a lack of staff to be the same departments that struggle to recruit – after all, joining a struggling team is not the most attractive job prospect and is a hard sell. Retention issues are compounding, as more people leave the specialty, the working lives of others gets harder, incentivising them to leave. But this phenomenon is also true regarding recruitment; the better staffed a department is, the easier it is to recruit.

Looking to the future

There are a variety of factors to consider when undertaking workforce projections; arguably the most significant consideration should be striving to achieve patient safety. In recent times there has been an increase in arguments that focus on reasons not the expand the workforce anymore. One prominent rationale is that there has been no historic correlation between A&E performance and staffing numbers. In other words, expanding the workforce seems to have little effect on improving performance against time-based metrics. While this may be true, it does not acknowledge the quality of care that patients receive while they continue to spend more time in the ED. Increasing the workforce may not speed up this process, however having enough senior decision makers allows for better decisions around hospital admission, more rational investigation use and better patient experience. Emergency medicine is a high-risk environment for litigation and patient safety and having experienced doctors reduces this litigation.

As has been outlined, the pulse of the ED is kept going by a diverse team of people that form a much more complex picture than just the trainee to consultant route. Nonetheless, this pathway is the most predictable and secure way to guarantee the future EM workforce and ensure that patients are treated by senior decision makers who are trained in Emergency Medicine. While RCEM's recommendation of one WTE consultant to every 4000 annual attendances made be a simplified method, at the heart of it is the patient. To achieve this ratio, we must establish what the workforce expansion needs of today are by estimating the demand of the future.

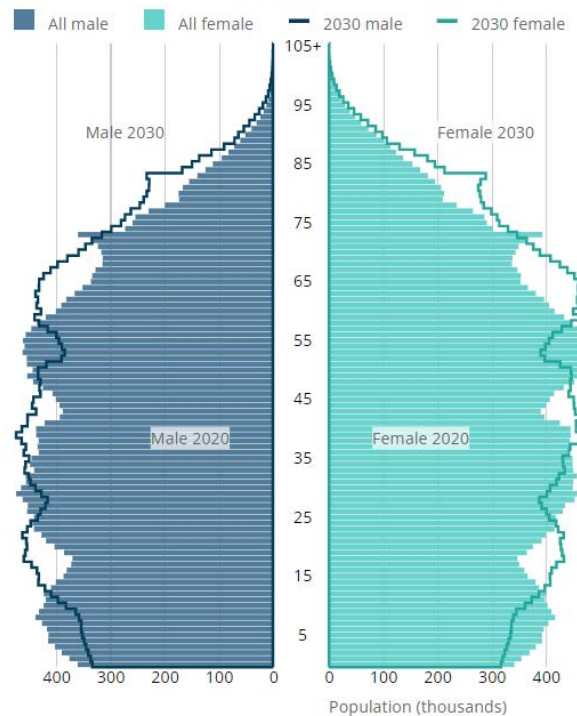
Despite the best efforts of policymakers to manage demand and divert patients away from the ED with initiatives such as NHS 111, these have not been effective. Much broader and more meaningful intervention is required if we are to see a drastic difference in the numbers attending emergency departments, the scope of which extends from, preventative interventions and improving public health to appropriately funding primary and social care. Most of what determines demands lies outside of emergency medicine yet is acutely experienced within the walls of the ED. In some ways, the emergency department can be thought of as a microcosm of not just the general state of the healthcare system, but the health of the population too. In 2018/19, there were more than twice as many attendances to EDs in England for the 10% of the population living

[14] https://www.bbc.co.uk/news/health-63588959

in the most deprived areas compared with the least deprived 10%.[15] Furthermore years spent in poorer health states decrease progressively from the most deprived areas (21.3 years) to the least deprived areas (14.2 years). With an ageing and growing population, we can anticipate more people spending a larger proportion of their lives in poorer health. England's population is set to grow faster than any other UK nation in the coming years: 3.5% between mid-2020 and mid-2030, compared with 2.6% for Wales, 2.0% for Northern Ireland and 0.3% for Scotland.

The image below is taken from the ONS Nation Population projections for mid-2020 and mid-2030. In mid-2020 there were 1.7 million people aged 85 years and over, making up 2.5% of the UK population. By mid-2045, this is projected to have nearly doubled to 3.1 million, representing 4.3% of the total UK population. There are projected to be many more people at older ages by 2045, in part because of the baby boomers from the 1960s now being aged around 80 years as well as general increases in life expectancy.[16]

Age structure of the UK population, mid-2020 and mid-2030



Source: Office for National Statistics – National population projections
Source: Office for National Statistics – National population projections

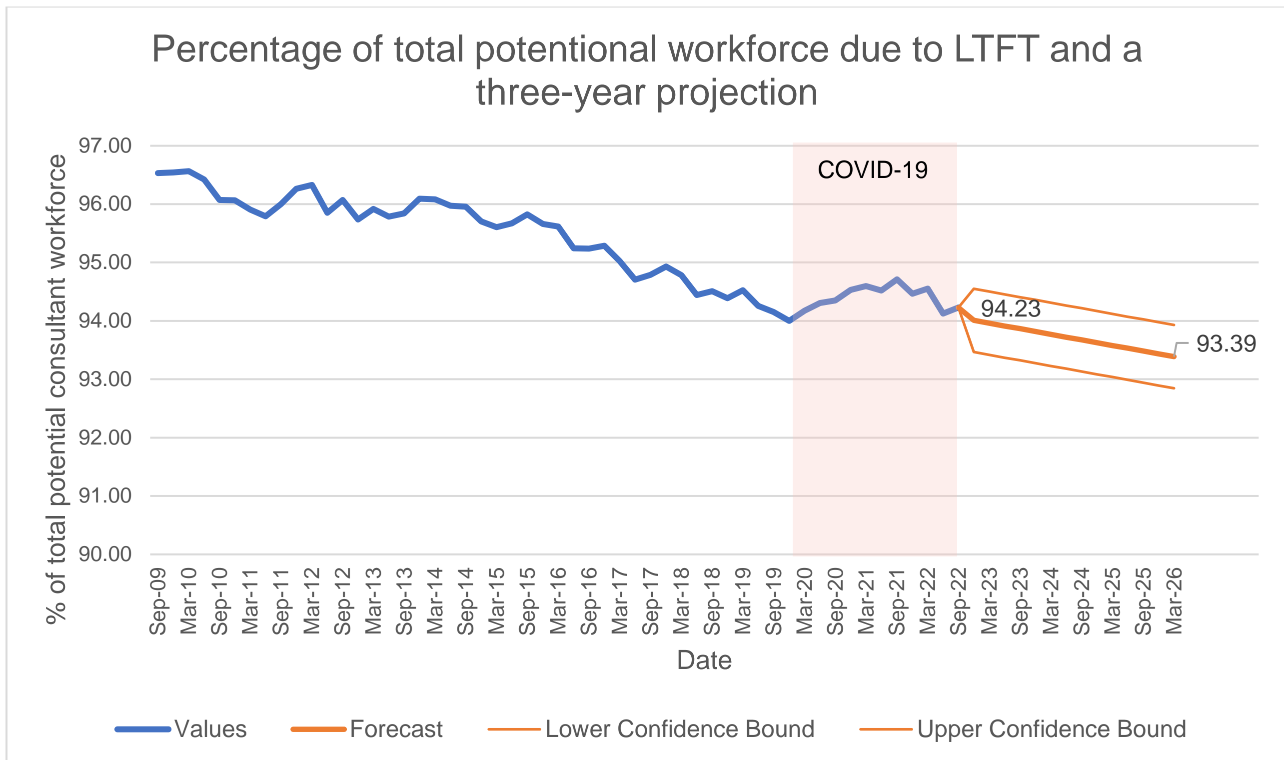
The scale of change needed to alter the trajectory of demand to ED should not be underestimated and workforce planning for the system that we desire, rather than the system we are likely to have, is incredibly risky, not least for the patient. While there has been some year-to-year variation

[15] https://digital.nhs.uk/news/2019/ae-attendances-twice-as-high-for-people-in-the-most-deprived-areas-as-in-the-least-deprived

[16] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2020basedinterim

we can assume demand will continue to grow as it has done, compounded by the demographic and population changes outlined above. With that being said, we can predict that by 2038 (roughly two whole training cycles) 4400 WTE consultants in total will be needed in England to safely staff emergency departments.

By analysing the rate at which core training and higher specialty training numbers are growing each year, and furthermore, how these numbers then translate into the consultant workforce we can anticipate a shortfall of 600 WTE consultants in 2038 if no action is taken. Given the increasing popularity of less than full time working and portfolio working, the consultant workforce will not be replenished at the pace it has been previously. By 2038, if uptake of LTFT working continues its current trajectory, the whole-time equivalent workforce will be around 91% of the headcount figure.



Emergency medicine experiences an attrition rate of about 7% and once accounting for this, as well as LTFT working, 700 additional emergency medicine training places (120 places maintained each year) are required over a six-year period in order to ensure sufficient workforce at the end of this period. This must also include an accompanying increase in Allied Health Professionals, SAS doctors, Emergency Nurses, and the faculty to train them.

The impact of doing nothing makes inaction unconscionable. What is at risk is not a slow descent into crisis but a mass exodus of staff which will cripple remaining staff further. It is essential that policy makers and workforce planners get ahead of the curb to sustain such a vital part of the healthcare system. The workforce wants nothing more than to be able to deliver the quality of care they set out to when first venturing into EM, and enough staff to do so. The front door is always open and emergency departments will continue to be there for every single one of us in our time of need – it is time that workforce provision was allocated appropriately in order to ensure that this remains a reality.

Appendix

Population projections suggest by 2038 there will be almost 60 million people in England. At present almost 28% of the population attends A&E each year, but this proportion is growing given the demographic changes discussed above. To meet the needs of these attendances and ensure there is one WTE consultant for every 4000 annual attendances, there will need to be 4480 whole time equivalent consultants to safely staff departments in 2038.

Forecasting consultant numbers is not straightforward; however, we have assumed that growth in numbers will return to the rate of growth pre-2017 as the agreed five-year expansion comes to an end this year. The 2017 expansion is set to bolster the consultant workforce by 510 WTE consultants, yet by 2038 there will still only be around 3800 WTE consultants. This leaves a shortfall for 600 WTE consultants.

Given that we know the impact LTFT working has on the whole-time equivalent figure, as well as attrition from the training programme, the output and number of whole-time equivalent consultants will be less than the input of allocated training places. This must be accounted for in the expansion to sufficiently plug the shortfall. To achieve this, 700 additional training places are required over a six-year period, assuming a 7% attrition rate, and furthermore a whole-time equivalent figure that is 91% of the headcount due to less than full time working. While one training will be filled by one trainee, we know that in reality this will not result in one WTE consultant.