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Royal College of Emergency Medicine

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Revised position statement on RCEM Workforce tiers – published February 2025

RCEM's tiered workforce approach was adopted in 2015 as part of the guidance Medical and Practitioner Staffing in Emergency Departments.

The recent statement about the role of PAs in Emergency Medicine has meant that this approach needed to be revisited. As part of this we have taken the opportunity to bring the tiers up to date with developments around ACPs, new terminology around SAS doctors, and to introduce clearer guidance around supervision

This new position supersedes our previous recommendations around workforce tiers and was adopted by Council in January 2025.

Original tiers table

Tier	What it means	Example
1	Require complete supervision. All patients must be signed off before admission or discharge	F1 doctors, trainee practitioners
2	Require access to advice or direct supervision, or practice independently but with limited scope (L)	ENPs, ANPs / ACPs, PAs, ESPs, F2 doctors, CT1-2 doctors, some primary care clinicians
3	More senior / experienced clinicians, requiring less direct supervision. Generally fewer limitations in scope of practice	CT3 in EM, junior Speciality Doctors, some ANPs /ACPs and PAs, some primary care clinicians
4	Senior clinicians able to supervise a department alone with remote support, possess some extended skills. Full scope of practice	CT4 and above, senior Speciality Doctors
5	Senior clinicians with accredited advanced qualifications in EM/ full set of extended skills	Consultants in EM

New tiers table

This revised guidance refers to doctors, ACPs and PAs working in Emergency Departments. ENPs and GPs working in ED have now been excluded to reduce confusion since they may work independently but within a limited scope of practice.

Broadly speaking RCEM workforce tiers refer to the supervision required for different clinicians. **It is important to note that being in the same tier does not imply equivalent training or expertise.**

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Revised RCEM Workforce Tiers 2025				
Tiers refer to the supervision required for different clinicians. It is important to note that being in the same tier does not imply equivalent training or expertise. See notes which support this document and *existing arrangements.				
Tier	What it means	Doctors	ACPs	PAs
1	Require direct supervision At a minimum patients being admitted should be discussed with a more senior clinician, and reviewed in person by a senior clinician if being discharged	F1 doctors Some doctors in their first year of NHS practice Patients must be discussed with, or reviewed by, tier 3 clinicians or above	Year 1-2 tACP Patients must be discussed with or reviewed by tier 3 clinicians or above	PAs Patients must be discussed with or reviewed by tier 4 SAS doctors or tier 5 doctors
2	Require reduced supervision compared to tier 1 Require access to on-site supervision but able to see some patients independently within a limited and agreed scope of practice RCEM senior sign-off guidance applies Progression of increasing responsibility and experience as per RCEM curriculum	Progression of increasing responsibility from F2 through to ST1-2 Starting point for most locally employed doctors If required, patients should be discussed with tier 3 clinicians or above	Year 3 tACP and non-credentialed ACPs If required, patients should be discussed with tier 3 clinicians or above	
3	More senior / experienced clinicians, requiring access to on-site supervision but able to see some patients independently within a broader and agreed scope of practice RCEM senior sign-off guidance applies Progression of increasing responsibility and experience as per RCEM curriculum	ST3 in EM Early career specialty doctors, more experienced locally employed doctors	RCEM Credentialled ACPs	
4	Senior doctors able to lead a department with remote supervision from a tier 5 doctor. Possess some extended skills that can be practiced independently. Full scope of practice Progression of increasing responsibility and experience as per RCEM curriculum	ST4-6 in EM More experienced specialty doctors, specialist doctors and associate specialists		
5	Senior doctors with a full set of extended skills and who have demonstrated their ability to take independent clinical responsibility for an ED Reference point: RCEM curriculum	Consultants, CCT holders, or on the Specialist Register for Emergency Medicine		

Notes

Support versus supervision of others on the shop floor:

"Support" is the provision of practical and clinical advice in the workplace, and is normal and common practice within the multidisciplinary environment of an Emergency Department. "Supervision" implies a combination of providing shop-floor clinical advice and taking overall clinical responsibility / accountability for the advice offered. It does not imply providing formal educational supervision, which is a role undertaken as part of postgraduate training pathways.

There should always be a tier 4 clinician on the shop floor.

Doctors learn to supervise other clinicians as part of their training. Tier 1 and 2 doctors should not supervise other clinicians. Tier 3 doctors will be developing their supervisory skills, and will gradually take on a supervisory role, whilst under supervision themselves.

Trainee ACPs should not supervise other clinicians. Credentialled ACPs will normally be expected to supervise trainee ACPs on the shop floor as part of ACP training. Local governance will determine the extent to which tier 3 ACPs may supervise other clinicians, or run clinical areas, whilst under supervision themselves.

PAs should not supervise other clinicians.

Senior decision maker:

A clinician with sufficient training and experience to make independent decisions about patient treatment and disposition. This may be within a full or limited scope of practice within the context Emergency Medicine Service, and does not imply that clinical support / supervision is never required.

All tier 4 and 5 doctors should be regarded as senior decision makers, usually without limitations on scope of practice.

Tier 3 clinicians may work as senior decision makers within their agreed scope of practice, and guided by their competence.

Senior sign off:

A process whereby responsibility for a patient's current clinical management is formally accepted by a senior clinical decision maker, following a discussion about, or review of, the patient whilst they are still in the department. The responsibility for completing the necessary components of the assessment to make this judgment lies with the senior decision maker. RCEM sign off standards define which patients should have a senior sign off, and who is able to undertake senior sign off.

Tiers:

Tiers refer to the supervision required for different clinicians. It is important to note that being in the same tier does not imply equivalent training or expertise.

Tier 1: should not be factored into workforce planning except for consideration of the supervisory requirement. They generate additional work due to their training and supervision needs.

Tier 2-3: The distinction between tier 2 and 3 for doctors is often based on a combination of experience, skill set, and the case mix handled, and may involve a degree of judgment

Tier 3-4: the critical distinction between tiers 3 and 4 is that tier 4 clinicians are all doctors, and may be expected to manage an ED alone at night with remote support from a tier 5 doctor

Tier 4 doctors should be capable of independently managing a modern ED, leading a multiprofessional team, and handling high-acuity patients across all age groups and presentations. Ideally, they will hold postgraduate qualifications in Emergency Medicine (e.g., MRCEM) and have completed courses in adult and paediatric life support, as well as advanced trauma management. They must have immediate access to a Tier 5 doctor, either on-site or on-call.

Tier 5 doctors are the only tier able to be independently clinically responsible for the ED whether on site or on-call.

***Existing arrangements**

RCEM recognises that many departments will have existing arrangements in place whereby individuals, or professional groups, are working within tiers in a way that is inconsistent with this document. We would recommend that such arrangements and the governance surrounding them are reviewed by the Clinical Lead for the service. However, this document is not intended to affect such arrangements retrospectively, and should not be used for this purpose.

Locally Employed Doctors

Many organisations employ LEDs to support their departments. Each LED should be individually assessed and assigned an equivalent tier based on this guidance. Supervision requirements should align with the assessment and be clearly communicated to both the doctor and their supervisors.

Locums

RCEM recommends that locum doctors in senior roles undergo careful screening. The standards for locums operating at a specific grade should match those of permanent staff. This includes verifying their CV, obtaining evidence of appraisal, and ensuring ongoing

CPD. Locum doctors should also receive a departmental induction. Further guidance on best practices for employing locum doctors is available on the RCEM website.

Physicians Associates

PAs should not see undifferentiated patients.

Paediatric Emergency Departments

RCEM recognises that terminology used by RCPCH differs from that used above, although the principles remain the same.

Links

RCEM curriculum
RCEM ACP pages
RCEM EMSAS pages
RCEM PA statement
Consultant_Sign_Off_Standard_June_2016.pdf
Statement_on_the_Consultant_Sign_Off_QIP_January_2024.pdf
GPEMS staffing pages