The Emergency Medicine Workforce

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Introduction

The Emergency Medicine workforce consists of highly skilled doctors, nurses, other health professionals, porters, administrative and hotel staff who work together in a pressured, team-based environment. This workforce forms the basis for high quality emergency care. The nature of the workforce is changing, with a drive towards the increased availability of senior decision makers, evolution of training pathways for all staff, sub-specialised practice, enhanced practice in nursing and other health care professionals, and with the changing nature of the speciality itself.

Standards

1. Nurse staffing levels must be in line with Royal College of Emergency Medicine (RCEM) / Royal College of Nursing (RCN) guidance.
2. Doctor and practitioner staffing levels must be matched to demand, casemix, and be designed in line with sustainable working patterns and practice as set out in RCEM guidance.
3. There must be at least one whole time equivalent (WTE) consultant for every 4000 annual attendances.
    a. The minimum number of WTE consultants for a small department is 12, rising to 18-25 in medium department, up to 48 in the largest EDs.
4. There must be a consultant in Emergency Medicine available on call at all times for every Emergency Department.
5. There must be a senior decision maker (tier 4) on the shop floor 24/7/365.

Recommendations

1. RCEM supports the development of a balanced multiprofessional workforce to provide emergency care
    a. RCEM supports the development of the ACP workforce within EM along the lines of the RCEM curriculum and the ACP credentialling framework
    b. RCEM does not currently support the development of the Physician Associate workforce within Emergency Medicine
2. RCEM guidance for overall staffing, and regarding individual professional groups, should be used as the basis for workforce planning at departmental, system, and national level (across 4 nations). Staffing levels should aim to provide
    a. The right capacity
    b. The right capability
    c. Working patterns that are realistic and sustainable
3. Retention, along with recruitment of staff, will be improved through the adoption of sustainable working practices. Working practices for all staff, and job planning for senior medical staff, should be
    a. Legal
    b. Sustainable
    c. Designed to enhance recruitment and retention
4. The terms and conditions, including for senior doctors' job plans, play an important part in recruitment and retention. Employment practice should follow RCEM guidance.
5. Investing in the basic working environment of Emergency Medicine teams is an investment in both patients and staff
6. Staffing levels based on permanent staff are safer and more cost effective than those relying on temporary or locum staff
7. Emergency Department crowding should be regarded as a critical issue in terms of recruitment and retention to EM, along with its negative impact on patient experience and safety

Background

The Emergency Medicine workforce consists of highly skilled professionals from a variety of backgrounds, working within a complex system. Along with ED crowding, our ability to recruit enough staff with the right skills, and then keep them in EM, is the single biggest threat to the effective provision of emergency care in the UK.

Working out the national picture with respect to medical staff and ACPs in emergency medicine services for each of the 4 nations is complex. At the time of writing RCEM has undertaken census' for England, Scotland and Wales, and is using that to inform policy discussions.

RCEM has produced professional guidance with respect to the numbers of medical and nursing staff, and at what level, that are required to provide effective emergency care within individual services. However, numbers provide only one piece of the jigsaw. Attention to sustainable working and careers, and to wellbeing of staff, is critical.

Capacity

As far as local demand-capacity planning is concerned matching the workforce to expected demand is a basic operational requirement. The fundamentals are

1. Understanding demand. Demand for emergency care is relatively predictable within certain limits. It is important to map casemix and acuity, expected variation, how demand is segmented into streams, how this relates to the physical layout of the department, and what work is expected to be undertaken.
2. Deciding upon a capacity strategy to meet the demand. This will usually be a mixture of "level" strategies aiming to provide a baseline minimum level of cover based on physical layout / demand / resilience / personal safety etc, and then a "chase" strategy based on predicted variation in demand.
3. Understanding the capacity of different groups within the workforce, of the workforce as a whole unit, and of the processes that they undertake and interface with.
4. Working out how to ensure that demand and capacity are matched, and that the workforce has the right skill mix available, within sustainable and legal working patterns, 24/7/365
    a. Appropriate adjustments should be made for training, expected levels of sickness and maternity, and to allow for flexible working patterns and LTFT working.

Workforce productivity is complex. Simply demanding that ED staff work harder or faster will not achieve optimal productivity. Productivity is a combination of individual factors, and of workplace factors. The latter includes crowding and having enough of the right staff available. Effective informatics systems, simplified processes, and access to clinical spaces and equipment are all important. The need to dedicate senior staff to actively managing a department, and the different areas of a department, is another key factor, along with the capability, supervision and training needs of clinicians working in different areas, and the casemix they are dealing with. There is also an increasing tendency for downstream services to front-load work into the Emergency Department. Whilst this may carry benefits for both patients and for downstream efficiency, it further reduces productivity at the front door. Organisations must decide where they want work to happen, and then ensure that the resources match the requirements. RCEM workforce guidance explicitly addresses productivity, and how to account for it when undertaking workforce planning.

Capability

RCEM describes the EM medical and practitioner workforce according to the following tiers

Tier	What it means
1	Require complete supervision, with all patients being reviewed by a more senior clinician
2	Require direct supervision, and will usually have a reduced, but developing, scope of practice Progression of increasing responsibility and experience as per RCEM curriculum
3	More senior / experienced clinicians, requiring access to on-site supervision but able to see some patients independently within an agreed scope of practice Progression of increasing responsibility and experience as per RCEM curriculum
4	Senior doctors able to lead a department with remote support. Possess some extended skills that can be practiced independently. Full scope of practice Progression of increasing responsibility and experience as per RCEM curriculum
5	Senior doctors with a full set of extended skills and who have demonstrated their ability to take independent clinical responsibility for an ED. Most doctors in this tier will have an advanced postgraduate qualification in EM

Training and professional development for EM staff is challenging and requires particular attention. This applies to all professional groups working in the ED. It should be recognised that the nature of EM requires a high level of preparedness to deal with rare but critical conditions, the ability to respond effectively to common emergencies but within teams that are constantly changing, and the need to be able to know what to do across a huge range of clinical conditions in all ages. Mandatory training requirements, along with regulatory demands, mean that the burden of compulsory courses and updates is high. Staff turnover is expected to be higher than in many other services. All this needs to be factored into workforce thinking.

Sustainable working and careers

The need to consider sustainable working for staff working in Emergency Departments cannot be overstated. Effective leadership is critical here.

It has become increasingly apparent that sustainable working, and sustainable careers, are a key concern for emergency department staff. Rates of exhaustion, moral distress, moral injury, burnout, and exhaustion are unacceptably high. Crowding and understaffing are key drivers for this, as are poor attention to the basics of looking after staff, and unsustainable working patterns in high intensity environments.

For clinical staff RCEM has produced extensive guidance key relating to sustainable working and wellbeing through progressive employment practices and attention to working conditions. See the sections on job planning and wellbeing. Meeting the professional and career development needs of all staff groups is another key building block.

Organisational culture should explicitly address civility and respect, since they contribute to a positive working environment, as well as to patient outcomes. In addition, a workplace culture that empowers staff to engage with and enact change, and to speak freely where they have concerns about patient safety or about behaviours they witness or experience, is essential.

Violence and aggression towards ED staff from patients or accompanying persons is a significant concern. Where they are within the control of the organisation, root causes should be tackled (the most common issue is long waits). Conflict Resolution Training can only achieve so much, and security arrangements need to be responsive and robust, around the clock.

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