Royal College of Emergency Medicine

England's Emergency Medicine Workforce Census 2024

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Acknowledgments

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Foreword

For too long, Emergency Medicine (EM) has been operating with a sizeable shortfall in workforce numbers. This, combined with increases in demand, has inevitably left clinicians under great pressure; rates of burnout in EM are one of the highest in any specialty and pose a major risk to retention.

The publication of an **NHS Long Term Workforce Plan** represented a chance to commit to addressing these issues - yet with a lack of specialty specific detail, it is unclear how policymakers intend to resource EM and protect it from ongoing and future understaffing. It is for this reason that we have undertaken a workforce census of Emergency Departments (EDs) in England. This valuable data will help provide insights into not just how many people are working in EM, but how they are choosing to work and why.

Over 60% of the 178 emergency departments answered the College's call to provide data. This is a positive response rate when considering the pressures and responsibilities that each Clinical Lead has to manage. As such, I would like to thank each and every Lead and respondent for their contribution to this work.

In spite of the unsociable working hours, high-pressured environment, and unacceptable number of long patient waits, many dedicated clinicians continue to pursue a career in EM. These staff members work incredibly hard to provide the best care they can for patients, often in a system that is not conducive to this aim. It is of vital importance that we continue to maintain the EM workforce and support those that support us in our time of need.

RCEM is keen to work closely with policymakers to ensure that these hardworking members of EM are supported, and to help build an NHS that is resilient.

We urge the Department of Health and Social Care, Members of Parliament in Westminster, and senior leaders within NHS England to acknowledge the findings of this report and to implement the recommendations made.

Future iterations of the Workforce Plan must include specialty-specific needs, based on our data and the expertise of the College.

Dr Adrian Boyle
President, Royal College of Emergency Medicine

Summary of Findings

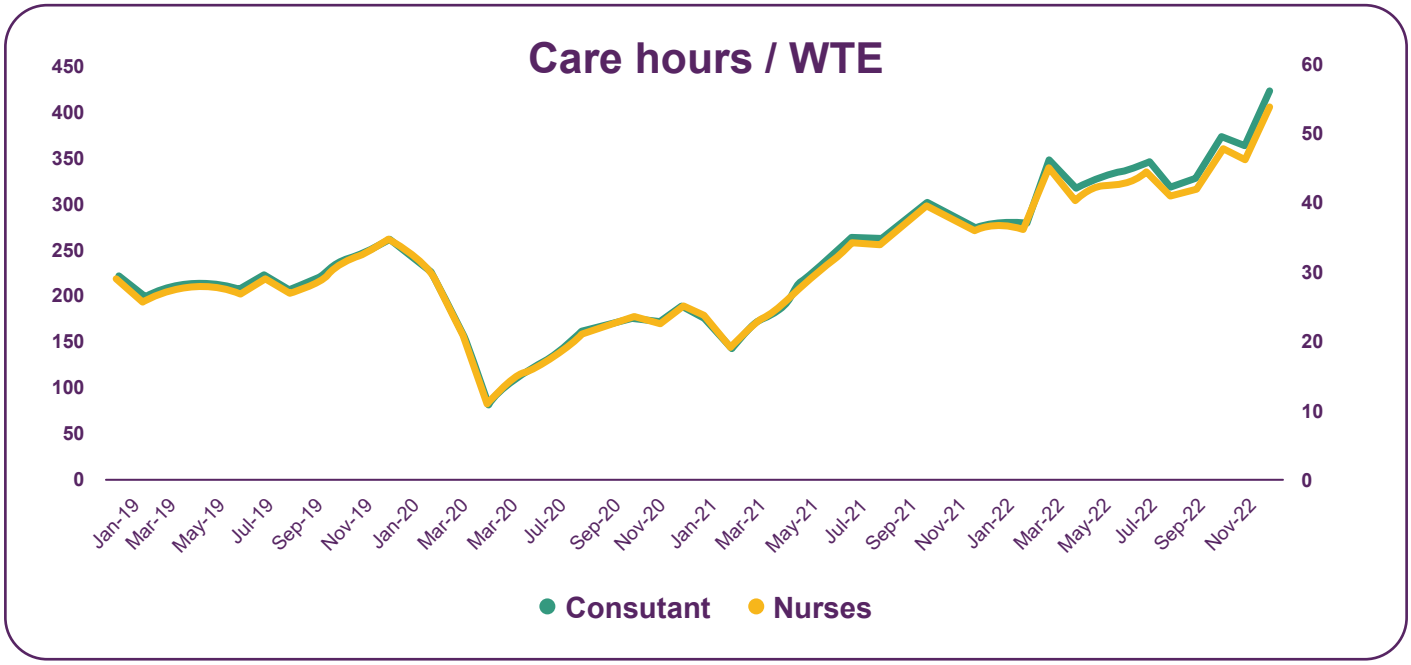
From responses received

- There are 1,500 Emergency Medicine CCT/CESR consultants working in England, 61% identify as male and 39% identify as female.
- 8,400 Direct Clinical Care shifts (DCC) are delivered per week by EM Consultants, and an additional 889 DCCs are delivered by locums. This equates to 1,057 Whole Time Equivalent (WTE) consultants, meaning that there is one WTE Consultant per 8,840 annual attendances. This is less than half of the RCEM recommended number of consultants (1:4000).
- 87% of consultants are aged between 30 and 54, with the majority being between 35 and 49 (67%). 13% of consultants are aged over 55.
- There were 1,855 emergency medicine trainees (ST1-ST6), equal to 1,678 WTE.
- There were 1,297 non-emergency medicine trainees working in emergency departments in England.
- According to Clinical Leads/Directors, there were 227 consultants planning to retire in the next six years, which equates to almost 1/6 of the current cohort.
- Emergency Medicine consultants worked an average weekend frequency of one in every 6.5 (1:6.5) weekends, while training grade Senior Decision Makers averaged one in 3.3 (1:3.3), and Post Graduate Doctors in Training (PGDiTs) averaged one in three (1:3).
- There were 614 rota gaps across all staffing groups, 125 on the consultant rota, 258 on the middle grade/SDM rota, and 231 on the PGDiT rota.
- There were 107 non-consultant locums in post.
- Departments were asked for their ideal staffing levels. To reach these, there would need to be an increase of 35% Consultants, 79% HST/Non-consultant SDM, 49% ACP, ANP and PA staff, and 27% ENP staff.

Background

Emergency Department (ED) performance has been in decline for many years in England due to increasing demand, volume, patient acuity, and length of stay. This has taken place in, and in part due to, an under resourced system. As a result, record numbers of patients are experiencing stays of 12 hours or more in Emergency Departments, often awaiting admission in clinically inappropriate areas.

In 2023, almost 10% of attendances to major EDs waited 12 hours or more from their time of arrival to the department. A decade earlier, this was the case for just 1% of patients. Overcrowding in the ED and corridor-care put an immense strain on the Emergency Medicine workforce as EDs are not resourced or designed for this situation. It also means that staff are less able to provide safe, timely and efficient care to those patients, and any subsequent patients who attend the department. While attendances remain relatively stable overtime, the aggregate length of stay for all patients has gone up considerably.



As the graph above illustrates, Attendances in 2019 (16,185,686) and 2022 (16,210,573) were comparable, yet as illustrated in the graph above, the number of care hours delivered by whole-time equivalent consultants and nurses in the ED almost doubled. The increase in care hours explains why the job is feeling increasingly more intense and unsustainable despite a marginal change in demand numerically in this time frame.

Staff may be seeing similar numbers of patients, but those patients are sicker, and are staying longer. This trend is unlikely to change as the older population in England significantly increases. In the next 40 years, the number of people aged 80 and over is set to double from three to six million; this will prove to be an additional burden on EDs, as this demographic is much more susceptible to experiencing co-morbidities.[1]

[1]https://ageing-better.org.uk/sites/default/files/2023-12/The-State-of-Ageing-interactive-summary-2023-4.pdf

Staffing numbers have certainly increased over time; Emergency Medicine has seen a steep rise in its workforce, but it is important to remember that the speciality had a sizeable shortfall to begin with. Furthermore, historic increases in emergency medicine training numbers, could not have accounted for the unprecedented change in workload that is now occurring. It is safe to say that when the expansion of EM training places was agreed in 2017, workforce planners could not have foreseen that almost 400,000 patients a year would be staying 24 hours or more just six years later.

The function of EDs has changed drastically over time, and workforce planning falls short of considering these evolutions in care. For example, only in 38% responding departments do Primary Care specialty referrals go directly to an admission area separate to the Emergency Department, meaning that EM staff play a significant role in the handling of patients that are awaiting other specialty care.

Furthermore, in 37% of those hospitals where referrals do go directly to specialty, patients get diverted to the ED when these admission units reach capacity. Finally, in 38% of responding departments, emergency department staff are required to provide a further referral to patients who have been referred directly to a specialty by the GP, rather than be seen directly by the specialty.

It is often argued that a growing EM workforce has not reduced waiting times, as the issue lies further down the patient pathway, namely in high bed occupancy and delayed discharges. While there is truth in this, patients remain under the care of EM staff for the duration of their wait, and adequate staffing is of upmost importance to ensure patient safety.

Additionally, having enough Senior Decision Makers (SDMs) allows for improved decision-making around hospital admission, more rational investigation use, and better overall patient experience. Emergency Medicine is a high-risk environment for litigation and patient safety, and having experienced doctors reduces this. This is clearly demonstrated during periods of industrial action where the increased presence of SDMs results in improved performance.

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. Staffing requirements are based on the assumption of a non-crowded ED and will need adjusting for a persistently crowded department.

The scale of change needed to alter the trajectory of demand to EDs 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 and future of the specialty.

Methodology

The census was conducted using the digital platform SurveyMonkey and consisted of 66 questions, however this varied depending on the respondents questioning route. In July 2023, a PDF version of the census was sent to ED Clinical Leads that the College had contact details for, ahead of the census going live.

This was done so that the Leads had adequate time to acquire and collate the necessary information. As such, the survey is much more likely to reflect accurate data sets rather than rough estimations. Respondents were asked to complete the survey as per their departments staffing position at the time of responding.

The live link to the census was then sent out, and great effort was made over the following weeks to contact every Type 1 Emergency Department in England. All avenues were utilised to make this survey as far-reaching as possible, such as through RCEM Regional Board meetings, RCEM member newsletters and social media posts, RCEM Council, and by phoning every department in England.

After five months, the survey was closed. Reponses were received from 111 Type 1 EDs out of 178, therefore the response rate for this survey was 62%. Of the entries, 105 were complete responses, while six were partial responses, meaning that they answered the majority of the survey questions but not all.

As this is not a complete sample size, we have taken lengths to calculate national estimates where appropriate and utilise public data provided by NHS Digital in some areas. Data acquired from RCEM's own training team has also been utilised. Not all respondents answered every question. Some datasets were easier to source than others and interpretation of results must allow for that.

Consultant Workforce

This workforce census pertains to Type 1 Emergency Departments in England.

Type 1 departments are defined as 'a consultant-led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients'.[2]

Consultants are senior doctors that have completed full medical training in a specialised area of medicine and are listed on the GMC's specialist register. They have clinical responsibilities and administrative responsibilities in managing specialty doctors, specialist grade doctors, and postgraduate doctors in training (formerly known as Junior Doctors).

Consultant-driven care is associated with a wide range of positive outcomes including rapid and appropriate decision-making, efficient use of resources such as beds, as well as fewer admissions. Furthermore, reviews have concluded that patients have increased morbidity and mortality when there is a delay in the involvement of consultants in their care across a wide range of fields, including Emergency Medicine.[3]

Headcount Consultants

In response to the census, 108 departments reported that they had a total of 1,500 consultants working in their departments. According to NHS Digital, nationally there are around 2,600 EM consultants working in England.[4] The median number of consultants across the responses was 15 per department.

Whole-Time Equivalent Consultants

The EM workforce is increasingly choosing to work Less Than Full Time (LTFT), which is largely down to the intensity of the job. Reducing hours offers staff the opportunity to remain in the job with appropriate time to rest and recuperate. For many, working LTFT is the only way for them to have a sustainable career in EM. As more consultants choose to work this way, the number of consultants versus the whole-time equivalent figure continues to diverge.

There were 1,379.5 whole-time equivalent (WTE) consultants from the 108 departments that responded to this question. NHS Digital reports there to be 2,460 WTE EM consultants working in England.

RCEM recommends that recruitment of Emergency Medicine consultants should be based on one WTE consultant for every 4,000 ED attendances to deliver safe care.[5]

[2]https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/07/AE-Attendances-Emergency-Definitions-v4.0-final-July-2019.pdf
[3]https://rcem.ac.uk/wp-content/uploads/2021/11/The_Benefits_of_Consultant_Delivered_Care.pdf
[4]https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/
[5]https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Consultant_Workforce_Document_Feb_2019.pdf

When analysing the 105 departments that gave both their WTE and annual attendances, there was one WTE consultant for every 7,457 annual attendances. There was great variation in the consultant:attendance ratio between departments. For example, the minimum ratio was 1:3,573 while the maximum ratio revealed that there was one WTE consultant for every 17,500 annual attendances.

Direct Clinical Care

In general, consultant job plans consist of 10 programmed activities per week, with each programmed activity equating to four hours of work. Typically, 7.5 of those programmed activities are dedicated to direct clinical care (DCC) which refers to “work directly relating to the prevention, diagnosis or treatment of illness”.

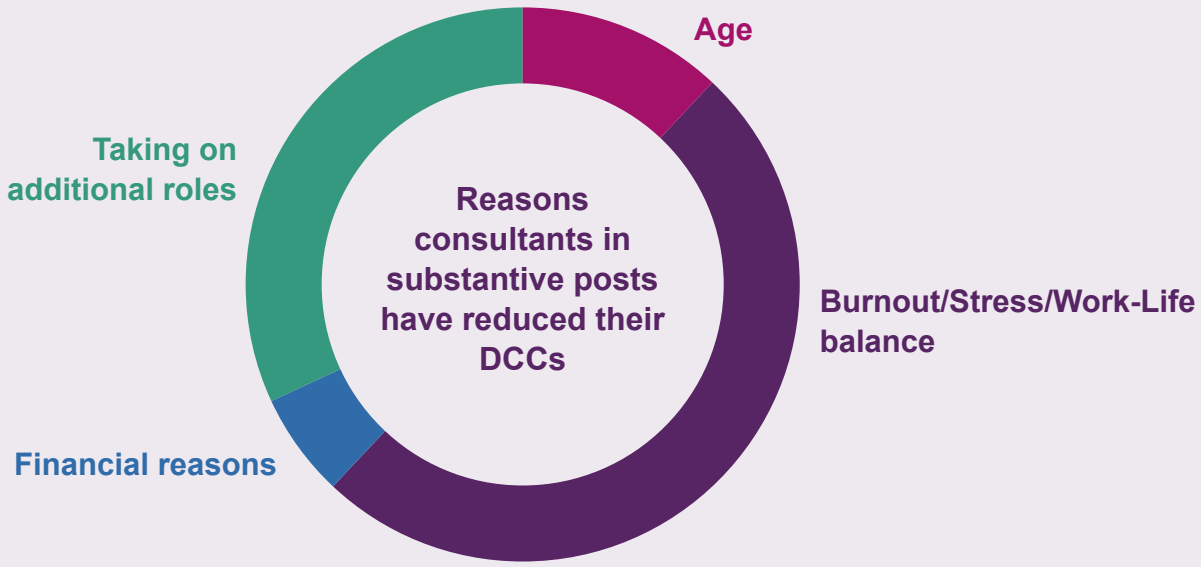
This is primarily undertaken when a consultant is physically present and working in the department (“working on the shop floor”) or on call. However, job plans vary greatly, with some consultants choosing to do less DCC in order to cover other activities that are vital to the wider NHS, such as teaching and training. As a result, it is difficult to get a clear picture of consultant presence in the department simply by looking at the whole-time equivalent figure. It may tell us how much people work, but not what work they are doing.

To obtain a more accurate depiction of whole-time equivalence, we collected the number of DCCs delivered per week by EM consultants as part of their job plan. In 105 departments, 8,400 DCCs shifts were delivered by EM consultants, with an additional 889 delivered by locums; locums delivered 9.6% of all consultant DCC shifts.

By dividing the total DCC figure by 7.5, it is possible to see how many WTE consultants are actually on the ‘shop floor’ across England. When analysing the 101 departments that gave their headcount, WTE figure, attendances, and DCCs, the discrepancy between typical whole-time equivalence and whole-time equivalence measured by patient-facing work becomes clear. This difference of about 15% represents a significant oversight when workforce planning.

	Headcount	WTE	DCCs / 7.5
Total	1,331	1,242.50	1,057.49
Consultant:attendance		1:7,524	1:8,840

In fact, 81% of respondents revealed that consultants in substantive posts have been reducing DCCs over the last year. By far, the most common reason cited was stress, burnout, and work-life balance.



74% of respondents had doctors working on the consultant rota who are not on the specialty register for Emergency Medicine, with an average of two of these doctors per responding departments.

Finally, 17% of entries said that they are holders of Emergency Medicine specialty accreditation from outside the UK working in a consultant role within their ED, without being on the GMC Specialty Register for EM. The total headcount for this staff group in these departments came to 35. When asked what EM Specialty accreditation they hold, several departments answered Fellowship of Australasian College of Emergency Medicine (FACEM). Accreditation from other countries such as South Africa, Saudi Arabia, Poland, Romania, and Egypt were also mentioned.

Regional distribution of DCCs

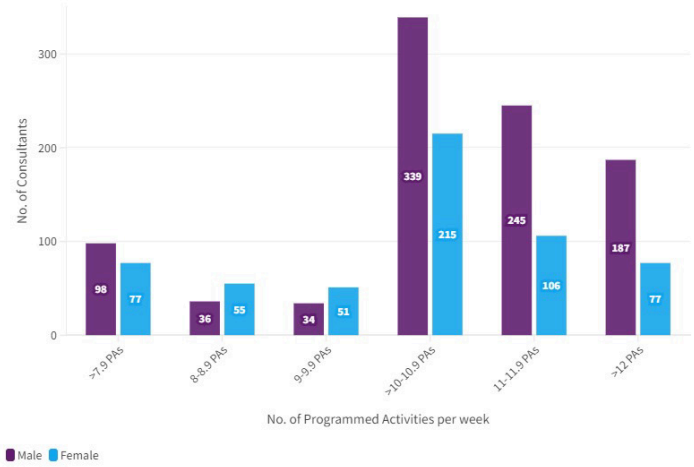
The table below shows the consultant:attendance ratio for all the responding EDs divided into NHS regions, and the WTE figures have been calculated using the above formula of dividing the total DCCs by 7.5. The survey responses show that the South West region is currently operating with the highest consultant to attendance ratio, with one WTE consultant for every 6,788 annual attendances. Although, it should be noted this is still considerably higher than the recommended ratio. On the other hand, London appears to have the lowest consultant to attendance ratio at 1:9,803.

	No. of responses	Headcount	WTE	Consultant: attendance
South West	13	177	146	1:6,788
North East and Yorkshire	18	276	229	1:7,012
East of England	11	153	135	1:7,222
North West	18	264	211	1:7,832
Midlands	16	178	182	1:8,752
South East	7	86	77	1:8,887
London	18	245	194	1:9,803

Gender

Of the 1,500 consultants in England, 61% identify as male and 39% identify as female. This is a significant disparity, representing an imbalance within Emergency Medicine's leadership roles. In the two groups which constitute 11 programmed activities or more, only 30% of consultants identify as female, whereas they make up 52% of consultants doing less than 10 programmed activities. This is perhaps due to the fact that women are often more likely to take on caring responsibilities than men, as well as career breaks.

Figure 1. Gender Distribution of Programmed Activities



Age

When it comes to age, 87% of consultants are between the ages of 30 and 54, with the majority being between 35 – 49 (67%). 13% of consultants are over the age of 55. Some consultants may choose to amend working patterns after the age of 55. For instance, to enable them to work fewer unsociable hours. As a result, in the coming years we may begin to see an increase in rota gaps as the bulk of the workforce reach this age. When asked whether departments had agreed guidance for a change in on-call working or working patterns as a consultant (e.g. based on age), 20% of entries said 'yes', 49% said 'no', and 31% skipped the question. When asked what the guidance was in place in the departments that responded 'yes', the majority stated that consultants are permitted stop undertaking on call cover from 55, however for a few respondents this was age 50. In several responses, reference was made to the RCEM Sustainable Working document as a guide for policy, which states that the option should be given to come off on-call/night shifts for 55s.[6]

Age	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Percentage	3.8%	18%	26%	23%	16%	8.5%	4%	0.7%	0.1%

Departmental Presence

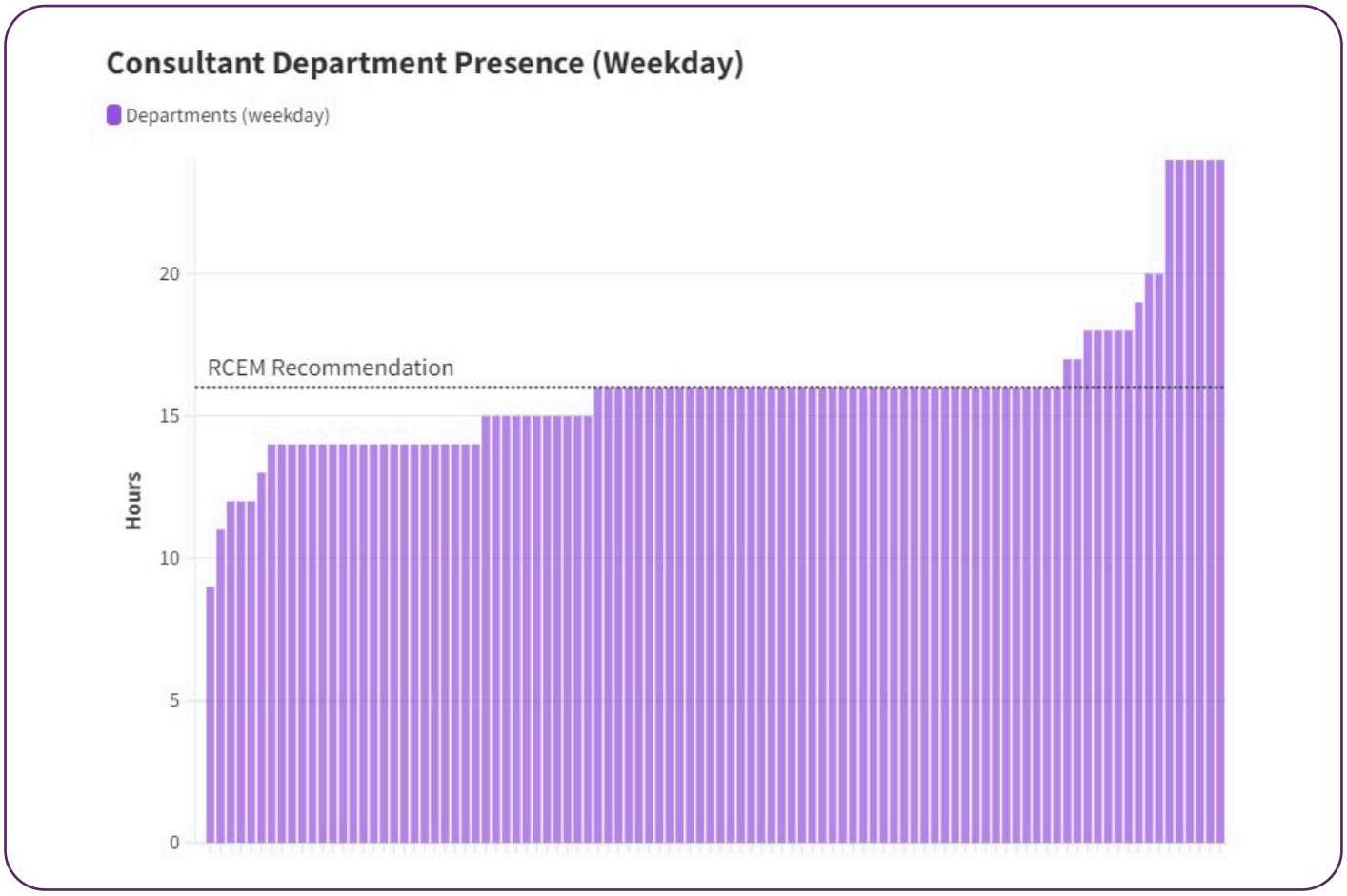
All respondents (111) provided figures for both weekday and weekend consultant presence in the ED. The lowest weekday consultant presence that an entry reported was nine hours. In contrast, the maximum presence was 24 hours. On the weekend, the minimum consultant presence reported was six hours and the maximum was 24. The average for weekday presence is 15.9 hours, while the weekend average is 15.2 hours.

Mounting pressures, constant demand, increasing complexity of case mix, and the challenges that come with overcrowding, all mandate the presence of a Senior Decision Maker.

Best practice RCEM recommends is that there should be EM consultant presence for at least 16 hours a day (0800hrs – 0000hrs) in all medium and large systems.[7] The graph below shows the majority of departments in England do have consultant presence for at least 16 hours. However, 31.5% of the 111 respondents are still not meeting this requirement.

[6]https://res.cloudinary.com/studio-republic/images/v1635703478/Creating_successful_satisfying_sustainable_careers_Emergency_Medicine/Creating_successful_satisfying_sustainable_careers_Emergency_Medicine.pdf?_i=AA, p.15

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

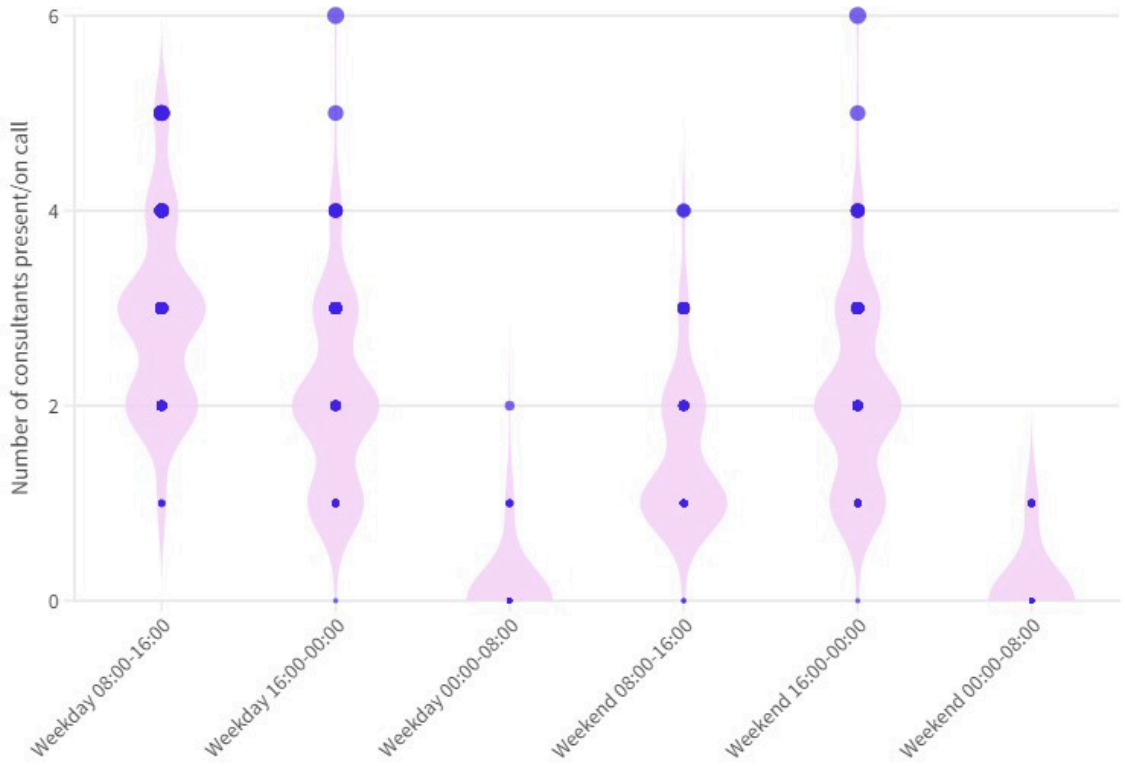


Presence on the ‘Shop Floor’

We asked departments about their consultant presence within the department, often referred to a being on the ‘shop floor’, and on call presence throughout the day on both weekdays and weekends.

The graph below demonstrates the variability and range in responses. The dots signify departments’ responses with the bulges around dots illustrating multiple departments having responded with the same answer. It was discovered that consultant presence was most concentrated between 0800hrs – 1600hrs on weekdays. In contrast, the period between 0800hrs – 1600hrs on weekends saw about half the amount of consultant presence. Between 0000hrs – 0800hrs, there are only 12 EDs that reported consultant presence on the shop floor on weekdays and only 16 EDs for weekends.

Figure 2: Number of consultants present on the shop floor/on call weekdays and weekends



Certificate of Eligibility for Specialist Registration (CESR)

The Certificate of Eligibility of Specialist Registration (CESR) is a means by which doctors who have not completed an approved deanery training programme can be entered on the Specialist Register. It is now also known as 'CCT by portfolio.' It is a competency-based process where the trainee provides a portfolio of evidence that demonstrates that their training, qualifications and experience meet the requirements of the Emergency Medicine Certificate of Completion of Training (CCT) curriculum. Successful completion of the CESR process results in entry onto the Specialist Register and the doctor will then be able to apply for Emergency Medicine Consultant posts in the traditional way.[8] In 2023, the General Medical Council revised the methods for evaluating the evidence. The new approach represents a move from demonstrating full equivalence to the CCT programme, to one based on the applicant's ability to demonstrate they have achieved the Knowledge, Skills and Experience (KSE) required for practising as a consultant in the UK. This should make it easier for CESR applicants to move through the process while not compromising standards.

[8]https://www.hee.nhs.uk/sites/default/files/documents/CESR%20portfolio%20documentation.pdf

We asked departments whether they had appointed consultants who are on the specialist register via the CESR route in the last two years – 41% of respondents said they had with a total of 71. When asked why doctors chose to follow this route, the most common answer was that they were International Medical Graduates (IMGs) with relevant experience now working in the UK. The next most common response was lifestyle reasons, with some CESR applicants choosing the route to avoid rotating between regions/hospitals. Data from the RCEM Training team show that around 70 CES applications are received each year with roughly 50% gaining approval.

Post Graduate Doctors in 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 (PGDiTs) formerly known as Junior Doctors. 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 much longer.

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. Often referred to as “trainees”, these members of the workforce have spent numerous years completing bachelor’s and master’s degrees; as such, they are highly competent members of the workforce.

For this section, the data being used has been provided by the RCEM Training team through the Annual Review of Competency Progression (ARCP) and various other training touch points. This data accounts for roughly 75% of the total trainee workforce.

The total headcount provided is 1,855, while the WTE is 1,678 – as per the table below. Using these figures, it can be estimated that the national headcount for trainees stands at 2,500 with a WTE of 2,240.

Training programme	HC	WTE
ST1/CT1	276	268.5
ST2/CT2	283	271
ST3/CT3	356	322
ST4	345	300.5
ST5	303	266
ST6	292	250
Total	1,855	1,678

The table below shows the uptake of LTFT working, revealing the percentage of PGDiT that finish their grade working full time.

Training programme	Percentage of trainees finishing their grade at Full Time
ST1	90%
ST2	85%
ST3	67%
ST4	54%
ST5	55%
ST6	50%

There is a stark contrast in the percentage of full-time trainees operating at ST1 grade compared to ST6; a difference of 40 percentage points. The increase in LTFT working can be largely attributed to reasons such as work-life balance, raising families, and the ever-growing intensity of the ED environment. It is also worth noting that the dropout rate for PGDiTs currently stands at 10%.

Distribution of EM Trainees

The table below shows the distribution of trainees in correspondence with the nation-wide NHS deaneries. East of England appears to have the highest volume of trainees in the country. Although, if the deaneries were joined together to represent their NHS regions, the North East and Yorkshire region (Yorkshire & Humber, North East) would have the highest volume at 21%. Regionally, the North West and the South West have the lowest volume of trainees, accounting for only 8% and 9% respectively.

Deanery	Regional distribution of trainees
East of England	16%
Yorkshire & Humber	15%
West Midlands	9%
London (North, Central and East)	6%
London (South)	6%
Kent, Surrey and Sussex	6%
North East	6%
East Midlands	6%
South West (Severn)	6%
Thames Valley	5%
North West (NW)	5%
Wessex	4%
London (North West)	4%
South West (Peninsula)	3%
North West (Mersey)	3%

While the North East and Yorkshire region has the highest volume of trainees, it is also the joint highest region with London for the number of unfilled consultant posts, with both regions each accounting for 24% of all unfilled posts. In contrast, the South West region accounts for only 7% of unfilled posts, and in the North West it is 12%. This may aid in explaining why trainees are distributed as such, as there will be more positions available in specific regions once their training has been completed.

Non-Emergency Medicine trainees

85% of responding departments reported that they had non-Emergency Medicine trainees (such as GP Trainees/ACCS AM), with a total of 1,297 and a WTE of 1,255.5.

While these doctors in training are not aiming to become EM consultants, at any point in time they will be working in the ED to gain competencies and experience to then take back into their own chosen specialty. Whilst these figures can change frequently, the significance of this is that these doctors need consultant supervision both from a clinical and training perspective.

	Headcount	WTE
FY1	114	112.5
FY2	664	651
CT/ST1	356	339
CT/ST2	75	73
CT/ST3	22	20
>ST3	66	60
Total	**1,297**	**1,255.5**

Non-Consultant Senior Decision Makers

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. This group generally take up substantive posts and can operate at a trainee-like level, to senior-decision maker (SDM) level.

Due to the increasingly high and complex workload that is being placed upon consultants in EDs, the presence of non-consultant senior decision makers (SDMs) has become fundamental in ensuring the management of the ED shop floor. As a multi-disciplinary body that does not require consultant supervision, the clear advantage is that they allow consultants to attend to other tasks such as training, but this is not the limit of their utility. These doctors bring a blend of experience, stability, and versatility to EDs. Their contributions, as well as a tendency to remain in one department for extended periods, help to improve patient outcomes, foster strong team relationships, and generally ensure the smooth operation of the department.

However, while consultant trainees follow a fairly linear pathway, non-consultant SDMs typically undertake local trust programmes such as "The Certificate of Eligibility for Specialist Registration" (CESR) route, which is often under the control of the local employing trust. As such, it is hard to consistently predict pathways for these staff members, and so there is no guarantee that this staff group will continue to consistently replenish itself.

70% of the 111 respondents reported having 763 non-consultant SDMs, with the WTE being 720.5. 53% of respondents said they have a total of 107 Associate Specialists working in their EDs, and 23% said they have a total of 167 Senior Locally Employed Doctors.

Advanced Clinical Practitioners

Advanced Clinical Practitioners (ACPs) come from a range of regulated clinical professions such as nursing, pharmacy, paramedicine and occupational therapy.[9] They hold a Master's level of education, while also having essential skills gained from experience in fields such as nursing, that allows them to have an expanded scope of practice and effectively care for patients in the ED. ACPs are able to offer consistency, stability, and reliability, as they often have long term careers within their areas of clinical practice, and as such they have come to be valuable members of the EM workforce.

63% of the 111 respondents provided ACP figures, amounting to 431 ACPs with a WTE of 408.5. Alongside this, 44% of respondents answered that there were 208 ACP trainees with a WTE of 194.

Physician Associates

Physician Associates (PAs) are a relatively new addition to the EM workforce. They are health professionals that require a two-year training course to become qualified. Their scope of practice ranges from taking medical histories from patients to performing diagnostic and therapeutic procedures, all while under the supervision of a senior doctor.[10]

31% of the 111 respondents reported having PA clinicians, amounting to 131 in total with a WTE of 128. Furthermore, 9% of respondents reported having PA trainees, totalling at 21 with a WTE of 18.5. This number may increase significantly, as the English government is aiming to raise the number of PA training places to 1,500 by 2031/32 and establish a workforce of 10,000 PAs by 2036/37, as part of their NHS Long Term Workforce Plan.[11]

[9]http://president.rcem.ac.uk/index.php/2022/08/30/advanced-clinical-practice-past-present-future-a-brief-overview-rcem-position/
[10]https://www.fparcp.co.uk/about-fpa/who-are-physician-associates
[11]https://www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf

Emergency Nurse Practitioner

ENPs are trained nurses providing expertise in the management of minor injuries working under the governance umbrella of the EM consultant. They provide a service in assessing, diagnosing and managing injuries such as fractures and wounds.

62% of the 111 respondents reported there being 674 ENPs, and 24% reported there being 74 ENP trainees. However, the WTE figure for ENPs comes to 588.5, almost 100 fewer than the total headcount figure shows, while the WTE for trainees is much closer at 69.

GP CCT Holders

24% of responding departments said that they had General Practitioner Certificate Completion of Training Holders working in their department with a total 68. Their presence in the department is a reflection of the broad nature of what presents to EDs, and the scope of departments. They largely function as Senior Decision Makers.

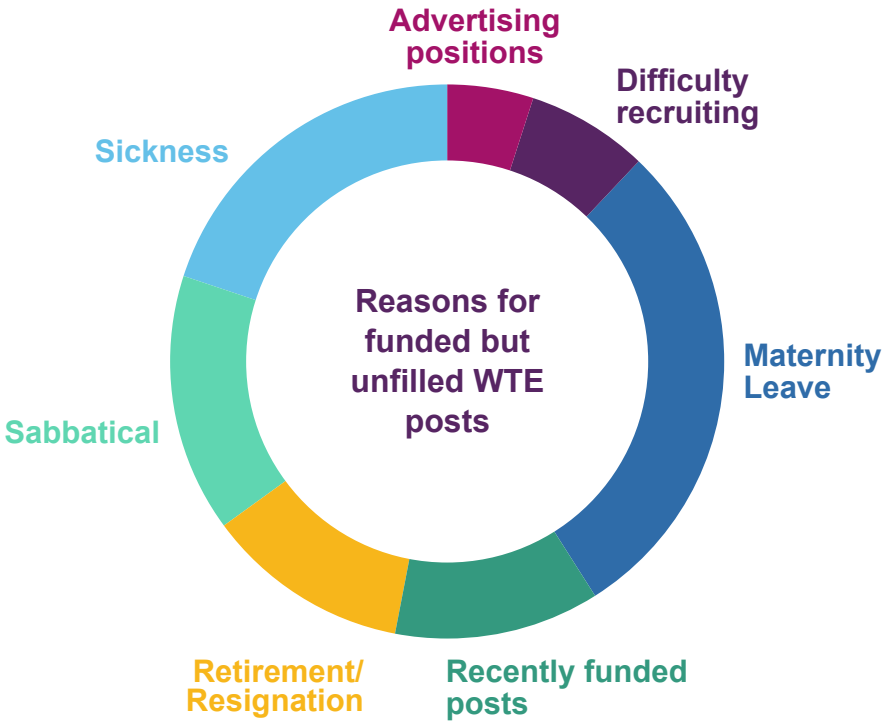
Paediatric Emergency Medicine Sub Specialty

72% of the 111 respondents said they have Paediatric Emergency Medicine Sub-Specialty CCT Holders with a total of 169. Additionally, 20% of reporting departments responded that they have PEM trained specialists not on the GMC sub-specialty, with a total of 92.

Workforce Gaps

At the time data was collected, 106 EDs reported there were 178 funded but unfilled WTE Emergency Medicine consultant posts in England. This equates to around 10% of funded posts in reporting departments.

The most common contributing factor to unfilled posts was maternity leave, although it is worth mentioning that a significant portion of these factors overlap. For instance, almost all the EDs that reported retirements or resignations stated that this was a result of long-term sickness. Furthermore, some of the EDs that have recently opened newly funded consultant posts may experience issues with finding suitable candidates as is explained further below. As such, many of the reasons are comorbid and interrelated.



Interestingly, 17% of responding departments said that they have not advertised or put together a business case for a consultant expansion due to a real or expected lack of applicants.

Planned Retirement

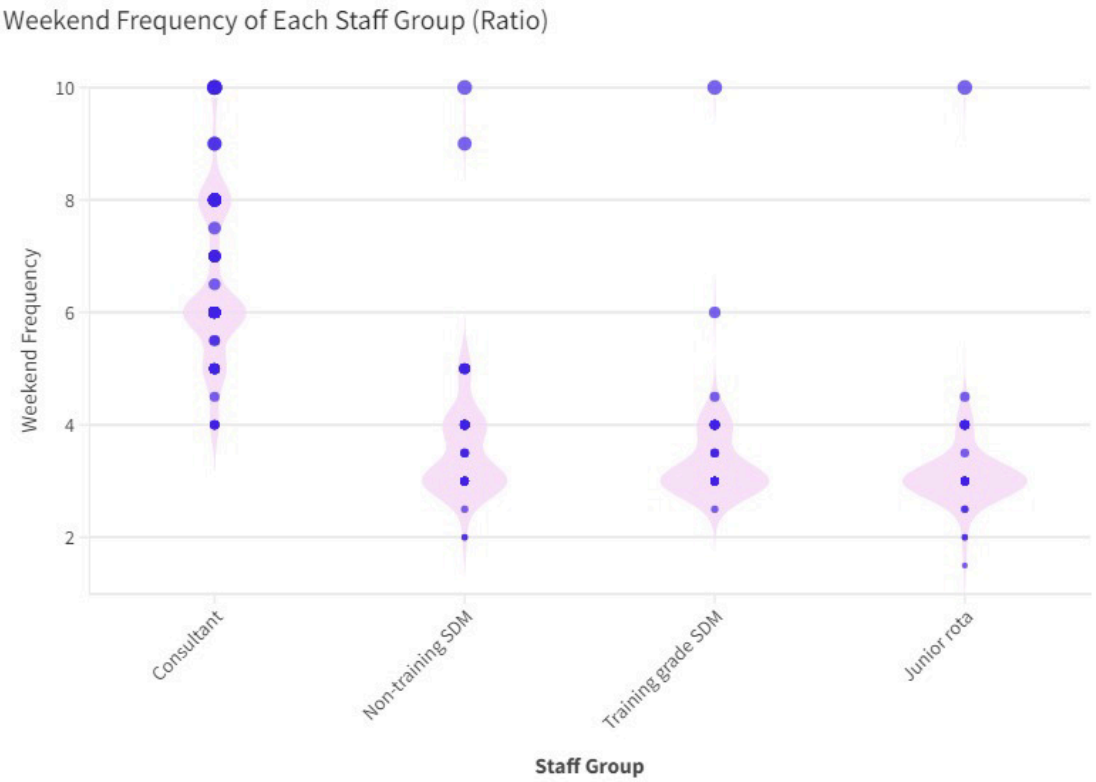
There were 96 EDs which reported at least one consultant planning to retire by 2030, culminating in a total of 227 consultants, or roughly 15% with the highest number being nine in one department. On a national level, this is estimated to be 420 consultants, notwithstanding any unfilled posts.

In addition to this, 87 non-consultant CCT holders / Associate Specialists / non-consultant Senior Decision Makers are expected retire by 2030 according to the 30 EDs that responded. When looking at current posts shown in the census, this retirement figure would account for 9% of the non-consultant SDM group.

Rotas

Weekend Frequency

Emergency Medicine consultants work an average of one in every 6.5 weekends, although this can range between 1:4 to fewer than 1:10. All other staff groups work weekends more frequently. Portfolio route SDMs average one in every 3.6 weekends; training grade SDMs average one in every 3.3, and PGDiTs average 1 in every 3. If we were to equate this to a years worth of weekends, consultants would work eight weekends a year while PGDiTs would work 17 a year.



On Call Frequency

The average on-call frequency from responses gathered was one in every 10 days, although the mode for this was actually 1:8 days. Entries for this section varied from one in every five days (1:5) to one in every 21 days (1:21).

Night Shifts

Out of the 111 responses we received, only 12% had nightshifts as part of the consultant job plan. Five departments reported having consultant presence every day of the year. After zero, the lowest answer given by one department was eight in a year.

Night shifts were mostly undertaken by PGDiTs (32% of all nightshifts delivered in EDs), followed by middle grade doctors in training (29%) and staff grade / specialty doctors (22%). The least number of night shifts were delivered by ANPs (1.3%).

Consultant Remuneration for Night Shifts

While 100 EDs responded to this question, only 29% have a form of consultant remuneration in place. 15% offer remuneration for 1.5-2 hours, 6% remunerate for three hours, and 2% remunerate for one hour. 6% say that there are alternative agreements in place for remuneration, which typically relates to on-call services or evening shifts (until 0000hrs or 0200hrs) in lieu of shop floor nightshifts (0000hrs – 0800hrs).

RCEM recommends that Consultants should be remunerated two hours per PA from 0000hrs – 0800hrs. For this working pattern to be sustainable, and not have a detrimental consequence such as burnout and decreased staffing levels, it is important that night shifts are acknowledged to be very different from evening shifts in their remuneration.

Rota Gaps

We asked departments for the number of unfilled posts on the consultant rota, middle grade / Senior Decision Maker rota, and PGDiT rota. From 79% of respondents, it was gathered that the total number of rota gaps among all staff groups was 614. Out of the three groups it was the middle grade group that made up the largest percentage of this, accounting for 42%; although PGDiTs were not far behind, and accounted for 37%. The largest consultant rota gap for a single department was 13, while for the middle grade group it was 30 and for PGDiTs it was 28.

Reasons for this range from short-term situations such as maternity leave and sickness, to long term reasons such as being unable to recruit due to an inability to find suitable candidates or a lack of funding in the budget. These reasons are aligned with those that are given for why some funded consultant posts are currently vacant, showing that recruitment issues are a consistent theme.

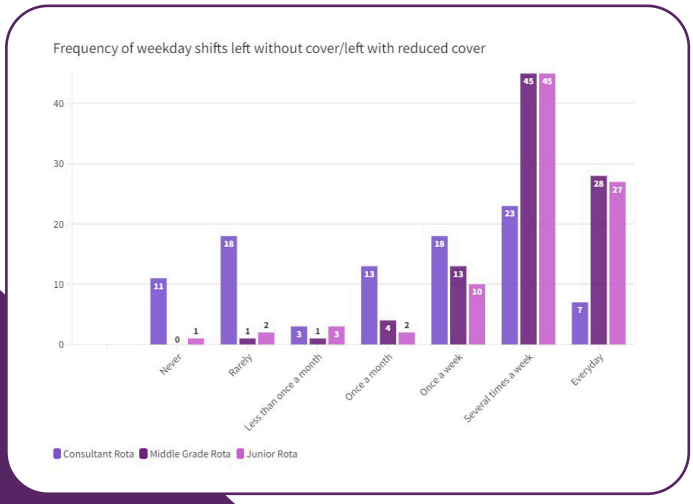
The total number of rota gaps among non-consultant career grade groups was 201. For associate specialists, the highest number of gaps was only two for a single department, although for non-consultant Senior Decision Makers this was 15 and for specialty doctors this was 18.

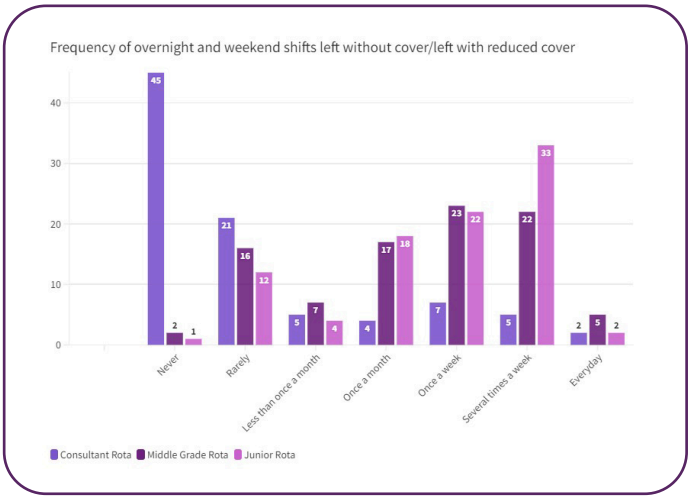
Rota gap cover

7% of EDs said they were covering consultant shifts every day. This is in significant contrast to 28% saying they need to cover middle grade shifts every day and 27% saying they need to cover PGDiT shifts every day. 45% of EDs reported needing to cover both middle grade and PGDiT shifts several times a week.

The amount of cover needed for overnight and weekend shifts is not as high, but 33% reported that PGDiT shifts needed to be covered several times a week, while for middle grade it was 22% and for consultants it was 5%.

In the final part of the rota gap section, the survey asked whether gaps have changed between April 2022 and March 2023. 20% of respondents said that gaps had decreased over the year, while 30% stated that gaps had increased. 50% of respondents said the number of gaps had stayed about the same throughout the year.





Locums

A locum doctor is one that does not work permanently at any one ED. They can either choose to cover short-term rota gaps or be contracted on a longer-term basis in cases where staff are absent due to sickness or maternity leave. Since locums work on an ad hoc basis with varying patterns of workload, it is not practical to try and calculate a fixed figure for the number of locums. Though, as stated previously, consultant locums deliver almost 10% of all consultant DCCs in England, which offers a gauge of the impact they have in EM.

The use of locums is a costly solution, and one that should only be used to manage short term staffing needs. The fact that a tenth of consultant patient-facing work is delivered by locums is indicative of insufficient workforce provision. Furthermore, almost a third of respondents stated that they had locums covering night shifts in the last year. The total number of night shifts delivered by locums in reporting departments in the last year was 981, with an average of 15.

A quarter of respondents stated that they had non-consultant career grade locums in post, with a headcount total of 107 and a WTE of 104.8. The range varies to a fair degree, with some EDs only having one non-consultant career grade locum while others have upwards of nine.

We asked departments how they cover gaps in the Middle Grade / Senior Decision Maker overnight and weekend rotas – 57% of responding departments shared that they use at least one kind of locum. Of these departments 90% stated that they used internal locums, 56% use external locums, and 30% use consultant locums covering more PGDiT rota gaps. One ED shared that:

"Regular external locums are used to fill regular vacancies on middle grade rota. We have almost daily requests from management to increase staffing above template due to operational pressures, in addition to sickness cover, therefore internal locums are also daily sought."

Regional Distribution of Locums

As stated above, locums can be beneficial in gauging what condition EM is currently in, as a high reliance on locums will mean that EDs are struggling while a low reliance on locums generally means EDs are healthier. At a regional level, the responses show that the East of England region currently has the highest reliance on locums to cover patient-facing work, standing at 12.8%. At the opposite end, the South West region currently has the lowest reliance on locums at 7.2%.

	Total DCCs	DCCs undertaken by locums	Percentage
East of England	1,014	130	12.80%
London	1,535	167	10.90%
North West	1,583	156	9.90%
Midlands	1,630	158	9.70%
South East	580	52	9%
North East & Yorkshire	1,583	156	7.90%
South West	1,094	78.5	7.20%

Workforce Planning

Planned expansion

We asked departments to provide any agreed planned expansion of consultant numbers for the next two years. Over the next two years, 63% of entries reported that there is a plan to expand consultant posts by 208 in total, an increase of 14% when compared to consultant numbers given by all entries. However, there is no certainty that these posts will be successfully filled or even retained if they are filled, as it has been reported that there are issues with finding suitable candidates as well as high staff turnover.

The Workforce of the Future

Demand

In seven years' time, we may see attendance numbers reach 17.5 – 18 million. It is hard to predict for acuity, but we do know 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%. 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 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. A general trend of the population living longer in poorer health will inevitably have an impact on the healthcare system, particularly emergency care. Furthermore, we know that likelihood of a long stay increases exponentially against age and those presenting with mental health as a primary diagnosis are also far more likely to experience long stays in EDs than other patients.

Requirements

Consultants in Emergency Medicine enhance safety, quality and efficiency of care. The value of having enough 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. Case mix 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 clinicians trained in emergency medicine.

RCEM has previously outlined guidance on safe staffing needs based on the size of a department and their systems. 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: Size of systems

Size of ED	New patient attendances
Small ED/Remote and Rural	<60,000
Medium Sized ED	60,000-100,000
Large ED	>100,000
Very Large ED	>150,000
Major Trauma Centre	Usually either a large or very large ED

Table: Number of consultants

Size of Department	New patient attendances
Small	12
Medium	18-25
Large	25-36
Very Large	34-48

By coding each department by their size, the safe consultant to attendance ratio can be calculated for every ED individually, and therefore the average national figure too. This equates to a safe staffing level of one WTE consultant per 4,000 annual attendances.

Therefore, based on the demand we might anticipate in seven years' time there must be 4,400 – 4,500 WTE consultants to safely staff departments and care for the number of patients. This would equate to 4,850 – 5,000 consultants in headcount, assuming that the trend in LTFT working continues its trajectory.

At present there are 2,600 consultants in England, or 2,460 WTE, just over half of what is required in seven years' time. By 2030, 15% of those currently working as consultants are planning to retire, which would leave 2,090 WTE consultants remaining from the current workforce. This is a generous estimate as it does not factor in those leaving the specialty before retirement.

In recent years an average of 195 PGDiT (175 WTE) gain CCT each year through the EM training programme, with 35 (30 WTE) moving into consultant posts through the CESR route, meaning that there are 230 (205 WTE) additional consultants each year. This may likely to rise to 385 (345 WTE) in the coming years as a result of the 2017 expansion of EM training places coming into fruition, with the first PGDiT from this cohort being awarded CCT soon.

Year	Projected number gaining CCT
2024	194
2025	295
2026	330
2027	350
2028	350
2029	350
2030	350
2031	350

As a result, there will be an estimated 2,465 (2210 WTE) additional eligible consultants in the next seven years through the training programme and CESR route combined. This brings the total number of WTE consultants to 4,300 WTE consultants, shy of the number required to meet safe staffing recommendations by 100 – 200 WTE consultants. Once accounting for the drop out rate and LTFT working this would amount to around 120 – 250 additional PGDiT over a seven-year period (18 – 36 per year).

Recommendations

1. The government must act now to achieve safe staffing levels in EDs and plan for the long term. To achieve this there must be an expansion of 250 consultants over the next seven years which equates to 36 per year.

2. Plan for and fund 4,500 EM consultant posts nationally so that Trusts have sufficient funding to recruit the necessary number of consultants to safely staff their emergency departments.

3. Incentivise doctors to enter substantive employment as SAS doctors rather than career locum working.

4. Implement an extensive recruitment and retention campaign to attract doctors to train, work and stay in emergency medicine.

Royal College *of* Emergency Medicine

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