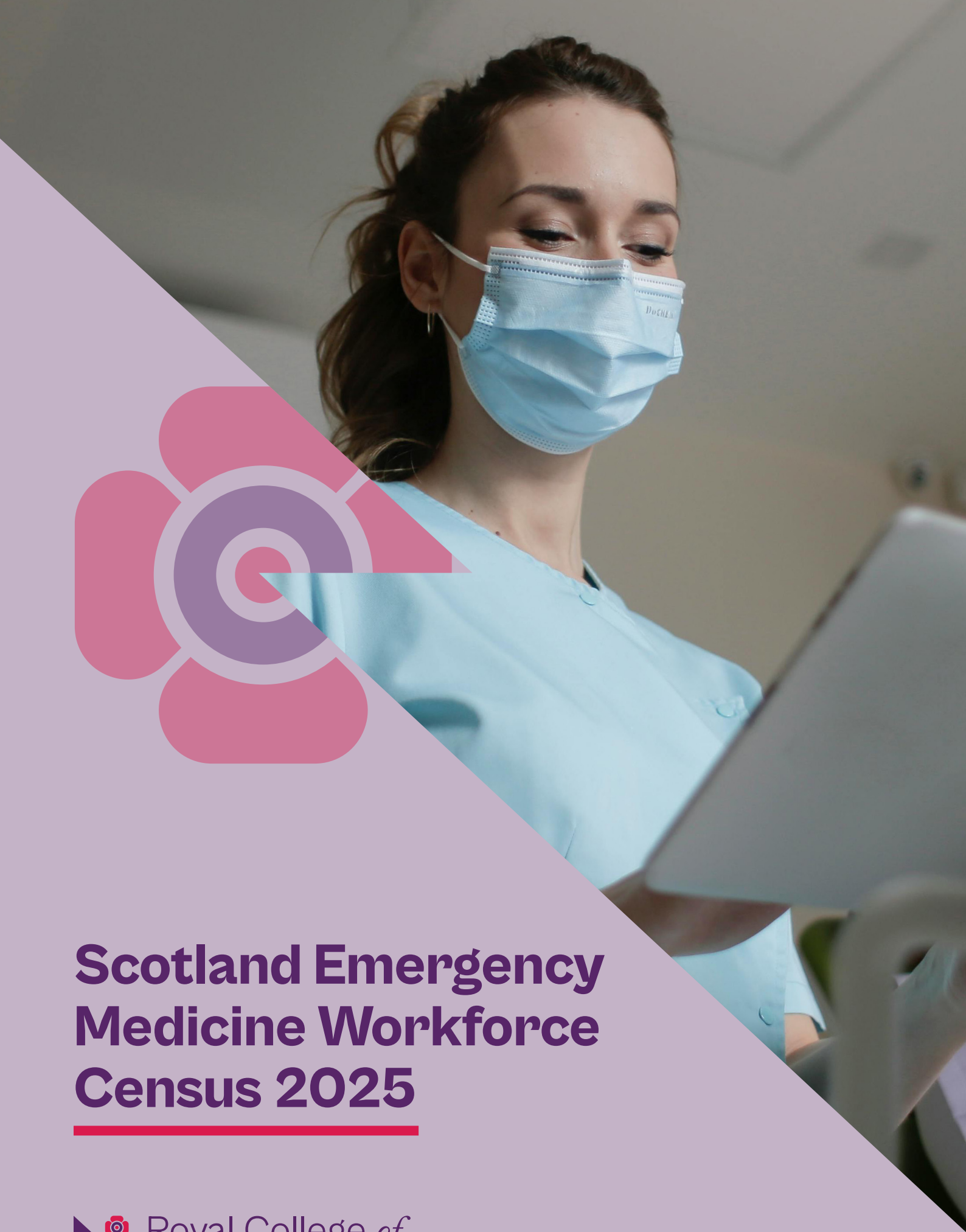

Scotland Emergency Medicine Workforce Census 2025

Royal College *of* Emergency Medicine

Contents

Acknowledgements

This report was written by Freddie Stoker, Tom Burgess, and the rest of the RCEM Policy Team with the help of Dr John-Paul Loughrey, former Vice President RCEM (Scotland), and Dr Fiona Hunter, the current Vice President for RCEM Scotland. Special thanks go to the RCEM Scotland Board for their support and the clinicians who filled out this survey and took the time to contribute during one of the busiest times for Emergency Departments.

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Foreword

Emergency Medicine in Scotland is on the brink. Departments and staff are under unprecedented pressure with dangerously long waiting times, patients being treated on trolleys in the corridors due to lack of space, and an increasing number of staff leaving the specialty or moving abroad. The workforce operates with a substantial staffing deficit. This shortfall, combined with increases in demand, has left clinicians under great pressure; burnout is higher than almost all other specialties and poses a major risk to retention.

The life of an Emergency Medicine clinician requires staff to work unsociable hours and can be immensely taxing even at the best of times. Staff members work incredibly hard to provide the best possible care for patients, often in a system that is not supportive of this aim. Currently, the demand of this work goes beyond the call of duty. As a specialty, we are not trained to treat patients for long periods, but this is becoming increasingly normalised and is demonstrably dangerous for patients. It is vital that staff are supported by the system so that they can provide the best possible standard of care for patients. Without an adequately sized workforce, patient safety is under further significant threat.

The Scotland Workforce Census is crucial for identifying any gaps in the workforce that are creating pressures on staff in Emergency Departments. Our 2021 Census was the first of its kind in the specialty and well received; due to its publication, the specialty saw a modest increase in trainee positions, and we hope for continued support on workforce issues on this occasion too.

We call on the Scottish Government, Members of the Scottish Parliament, and senior leaders in NHS Scotland to pay close attention to the findings of this report and work to implement its recommendations. We look forward to working closely with policymakers to ensure that Emergency Medicine is fit for purpose in Scotland.

Dr John-Paul Loughrey, Former Vice-President RCEM (Scotland) and Emergency Medicine Consultant

Summary of findings

There are a total of **329 CCT/CESR consultants** working in EDs across Scotland. An increase from the 2021 census.

The **329 headcount equates to 286.5 WTE consultants**. The average number of WTE consultants in Scotland is one consultant for every 5,874 attendances.

Of the 329 consultants in Scotland, **53%** identify as male and **47%** are female.

38% of people who take up 10 PAs or more are female.

In the previous census, 34.1% were aged between 30 and 39 whereas EDs reported only **27%** this time.

The average weekday consultant presence was **14 hours a day**. The RCEM recommendation is 16 hours a day.

Departments reported **77 Emergency Medicine Specialist, Associate Specialist, and Specialty (SAS) doctors in Scotland**. There are **63 WTE SAS Doctors**.

There are **169 Emergency Medicine resident doctors** from ST1-ST7 across Scotland.

There are **38 EM consultants planning to retire by 2030**. 10 SAS doctors are expecting to retire by 2030.

There were **16 consultant rota gaps**, **32 SAS rota gaps**, **26 resident doctor rota gaps**.

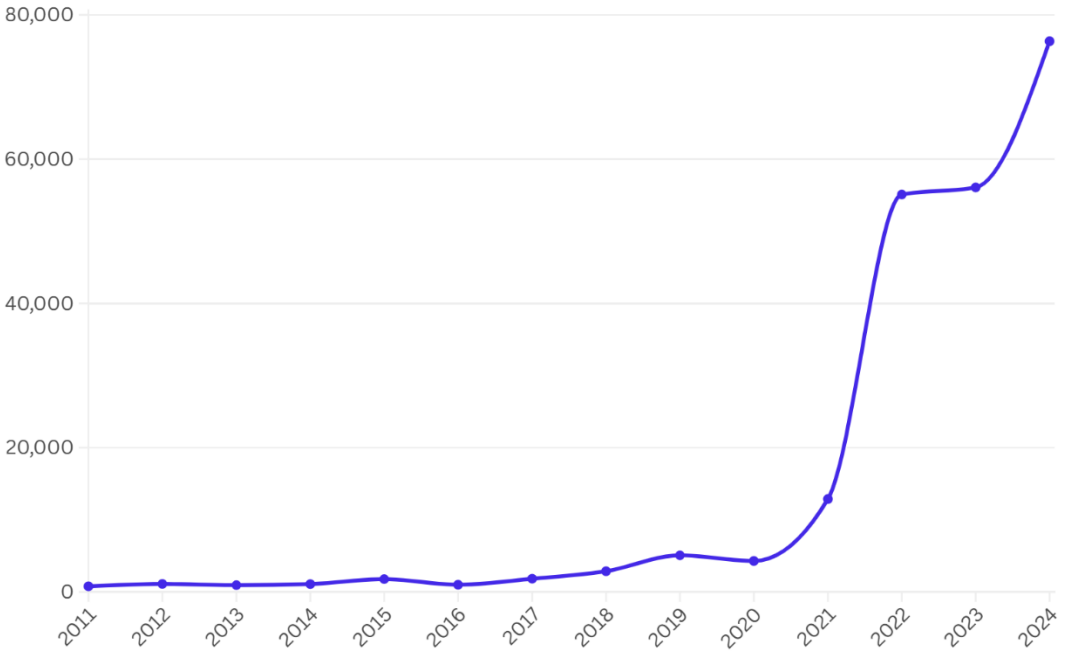
Background

A strong and healthy workforce is vital to Emergency Department (ED) performance. Across Scotland and the rest of the UK, ED performance is measured using patient waiting time metrics. Whilst EDs in Scotland generally perform better than those in the rest of the UK, performance across the country has been falling dramatically since the mid-2010s.

Performance against the four-hour access standard[1] has fallen sharply. For every month since July 2017 (with the exception of May and June during the 2020 COVID-19 pandemic), Scottish EDs have failed to meet the 95% four-hour target.

Whilst the four-hour metric is important, long wait times beyond eight and 12 hours are extremely dangerous to patients and can be indicative of wider systemic issues. As can be seen in the below graphs, the amount of annual 12- and 24-hour waits have increased significantly in recent years. Compared to January 2017, 12-hour waits in 2024 were 33 times higher. In 2024, 12,990 patients waited over 24 hours to be seen in an ED – an increase of 76% compared to 2023. In January 2017, this number was 0.

Scotland 12-hour waits since 2011

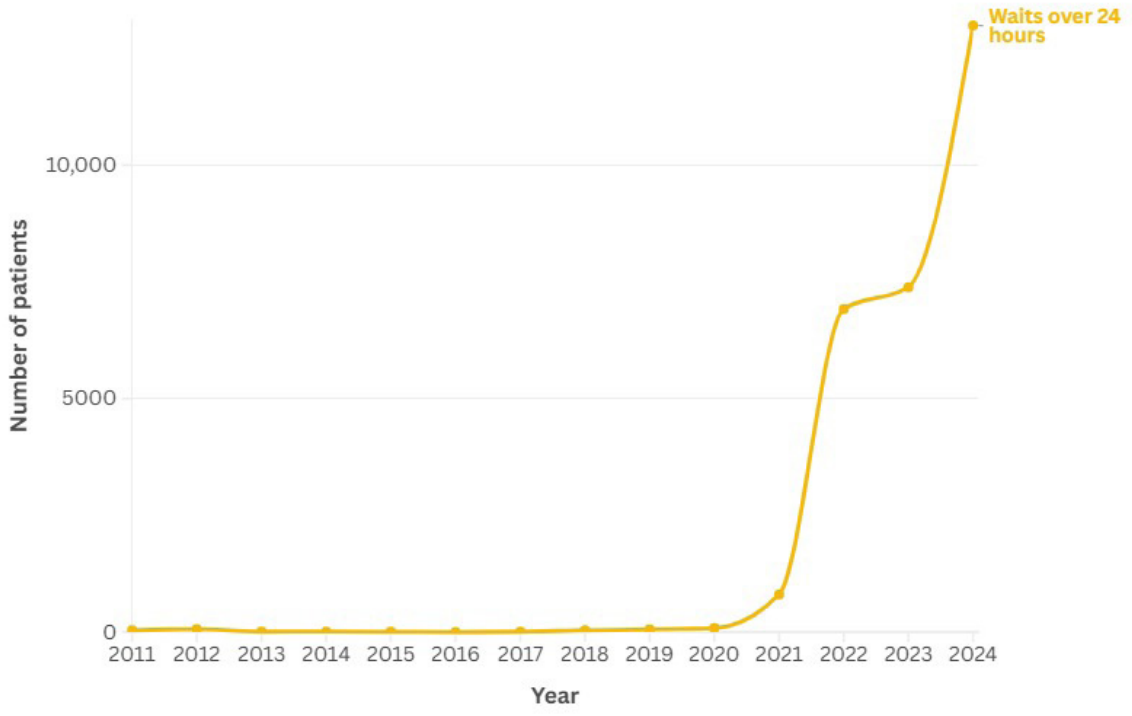


Source: Public Health Scotland

RCEM

[1] https://www.gov.scot/publications/four-hour-emergency-access-standard-expert-working-group-recommendations-report/pages/2/.

Scotland 24-hour waits since 2011



Source: Public Health Soctland

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It is important to note that whilst these annualised graphs show a stark rise, they somewhat hide the fact that waits were already starting to increase before the pandemic. The 12-hour graph does highlight a spike pre-2020. Covid-19 cannot be solely blamed for increases.

Long waits like these are not only unpleasant, but they are also associated with worse outcomes for patients, and an increased risk of patient mortality[2]. Using the Jones et al. mortality calculation we can see that in 2024 as a whole, 818 deaths can be linked to ED waits of 12 hours or longer – compared to a total of 612 in 2023.

Performance in the summer months has seen a particularly sharp decline, with the same pressures now affecting EDs all year round. The Quarter 2 (July to September) statistics in 2024 were significantly worse than all Quarter 3's (October to December) and even Quarter 4's (January to March) statistics between 2011 and 2021. In July 2024, 12-hour waits were double what they were just a year before, and 279 times higher than in July of 2017.

Understaffing in these conditions is not only unmanageable for existing staff, but it is less favourable for patients. The 2021 Scotland Census highlighted the significant impact that workforce shortages and burnout were having on ED efficiency. In response, the Scottish Government increased the number of Emergency Medicine trainees by 10 in 2023.

While the number of patients being seen has remained relatively stable, the patient population is aging and presenting with more complex health conditions, and thus, staying in the ED longer. This trend places a greater strain on EDs and makes timely patient discharge more challenging. As Scotland's population continues to age, the demand for emergency care will only intensify. It is therefore essential to build a resilient workforce capable of meeting these growing challenges.

[2] https://emj.bmj.com/content/39/3/168

Methodology

The census was made using SurveyMonkey and consisted of 79 questions. In summer 2024, a PDF version of the census was sent out to ED clinical leads ahead of the survey going live to give them enough time to submit an accurate representation of the staffing levels on the ground.

Two weeks after this, they were sent a follow up email with the hyperlink to the live census. Survey respondents were asked to complete the survey as per their departments' staffing in late 2024. We received responses from 28 type-1 EDs. Five responses combined two EDs. Three remote and rural EDs responded and two did not respond. We have included the three R&R EDs when appropriate – for example, excluding them from the consultant analysis as they are not as reliant on them as the larger EDs.

Where possible, we have drawn comparisons throughout with the **2021 Scotland EM Workforce Census**.

EM Workforce

Consultants

This workforce census pertains to Type 1 Emergency Departments in Scotland. Type 1 departments are defined as 'a consultant-led 24-hour ED service'.[3]

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 (resident doctors - formerly known as Junior Doctors).

The benefits of consultant-driven care are clear and include rapid and appropriate decision-making, efficient use of resources such as beds, as well as fewer admissions. 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.[4]

We have removed three remote and rural EDs from our consultant analysis, as they do not require consultants in the same way as medium and large EDs.

Consultant Headcount

There are a total of 329 CCT/CESR consultants working in EDs across Scotland. 54 are Paediatric Subspecialty CCT holders. Entries ranged from having one consultant to 39 consultants, with the average across Scotland being 14.

In the previous census, the total consultant headcount was 252, meaning there has been around a 30% increase in the number of EM consultants working in the specialty.

Whole-Time Equivalent

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. There were 286.5 whole-time equivalent (WTE) consultants. In the previous census, this number was 217. This translates to an increase of 32% WTE consultants working in the specialty.

Direct Clinical Care

The WTE number is useful. However, using the amount of Direct Clinical Care (DCC) activities across Scotland gives a better indication of presence in the department. DCC's refer to "work directly relating to the prevention, diagnosis or treatment of illness".

Consultant job plans often consist of 10 programmed activities (PAs) each week and, typically, 8.2 of these correspond to Direct Clinical Care (DCC). In other UK nations, this number is 7.5, meaning that in Scotland, consultants get less time for non-care work related activity.

[3] https://publichealthscotland.scot/healthcare-system/urgent-and-unscheduled-care/accident-and-emergency/glossary
[4] https://rcem.ac.uk/wp-content/uploads/2021/11/The_Benefits_of_Consultant_Delivered_Care.pdf.

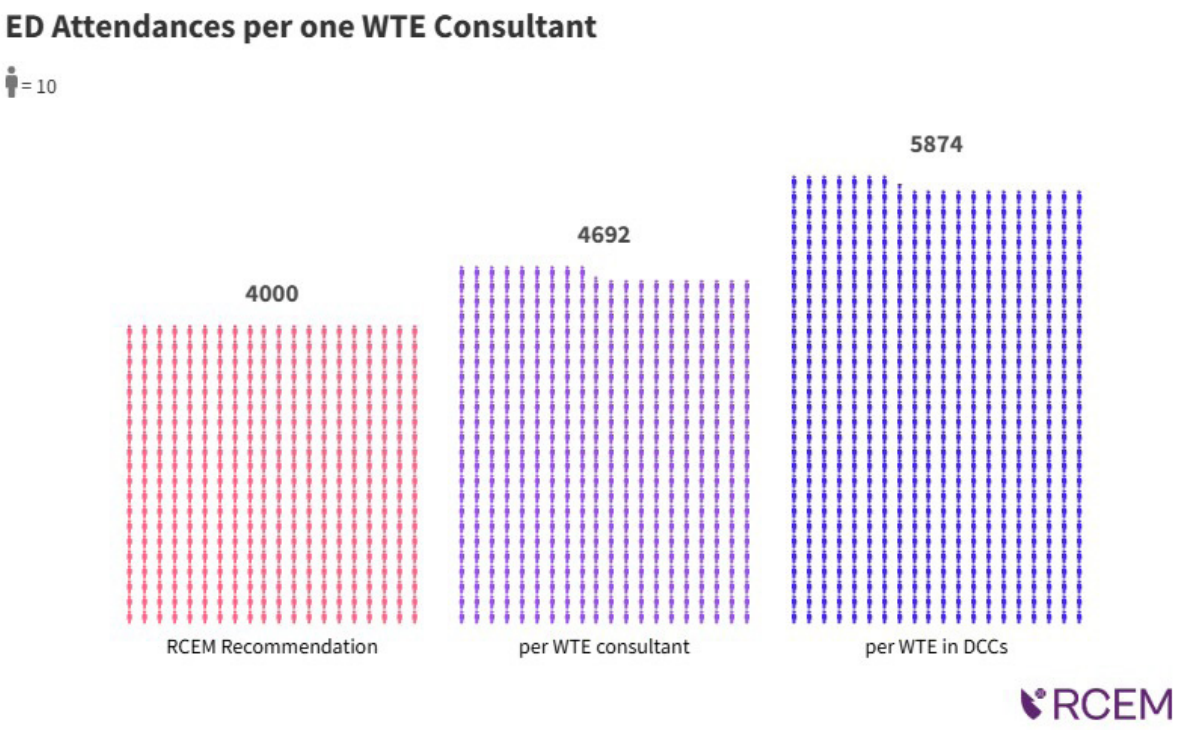
To obtain a more accurate depiction of whole-time equivalence, we collected the number of DCCs delivered per week by EM consultants as part of their job plan. By dividing the total DCC figure by 8.2 it is possible to see how many WTE consultants are actually on the 'shop floor' across Scotland.

When analysing the 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 25% represents a significant oversight when workforce planning.

	Headcount	WTE	DCCs / 8.2
Total	329	286.5	229

Consultant to Attendance Ratio

RCEM recommends that EDs should have one WTE consultant for every 4000 attendances. The average number of consultants for Scotland is one WTE consultant for every 4692 attendances, this increases to one for every 5,874 when looking at whole-time equivalence through the lens of DCCs.[5]



[5] This does not include attendances from three remote and rural EDs who do not require consultant presence.

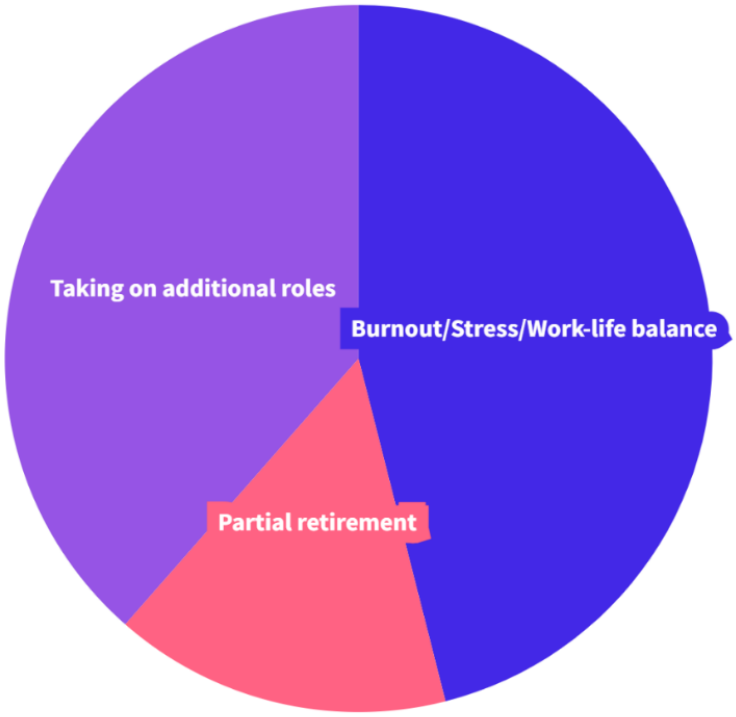
This is an improvement on the previous census, when there was one for every 6444 attendances.

However, this is still not enough WTE consultants. To reach the one in 4000 recommendations, Scotland requires an additional 49.6 WTE consultants, or 107 if direct clinical care time was used as an indicator of whole-time consultant equivalence.

The results varied significantly across Scotland. The maximum number of WTE consultants was one for every 3,866 attendances. The minimum was one for every 13,930.

13 departments reported consultants reducing DCCs in the last year. The main reasons were: burnout, work-life balance, taking on additional roles, partial retirement.

Reasons consultants in substantive posts have reduced their DCCs



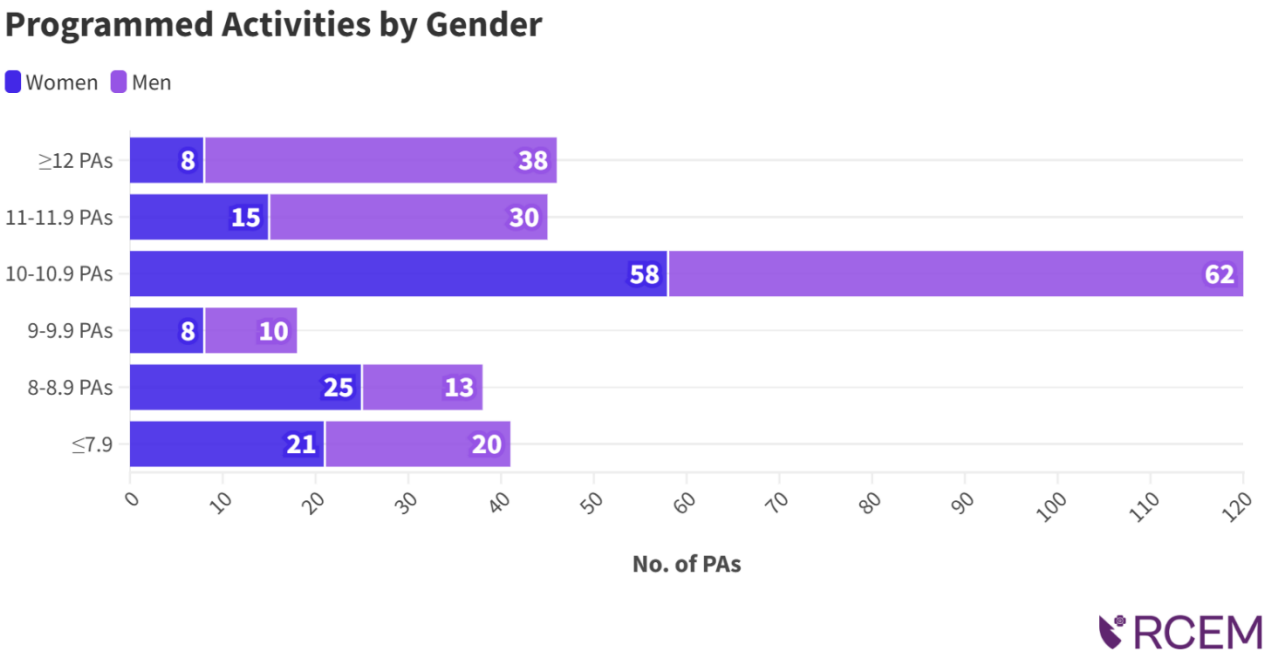
RCEM

Gender

Of the 329 consultants in Scotland, 53% identify as male and 47% identify as female. This represents a smaller difference between the number of male and female consultants compared to the previous census which saw 57% of the 252 consultants identify as male, and 43% identify as female.

In the two groups which carry out 10 programmed activities or more, only 38% of consultants identify as female, whereas they make up 56% of consultants doing less than 10 programmed activities.

Women are, however, taking on more PAs than when the previous census was taken, where of the group carrying out more than 10 programmed activities, 28% were female and 62% were male. Of those carrying out less than 10 programmed activities, 60% identified as female.



Age

90% of consultants are between the age of 30 and 54. 10% of consultants are over 55 and none are over 65. It is common for consultants to reduce hours and working pattern after age 55. The vast majority (70%) were between 35 and 49.

Age	Percentage
30-34	6.4%
35-39	20.6%
40-44	29.3%
45-49	20.3%
50-54	12.2%
55-59	7.4%
60-64	2.9%
65-69	0.0%
70+	0.0%

In the first census, 92% of consultants were aged between 30 and 54, and only 8% were aged 55 or over. 72% were aged between 35 and 49.

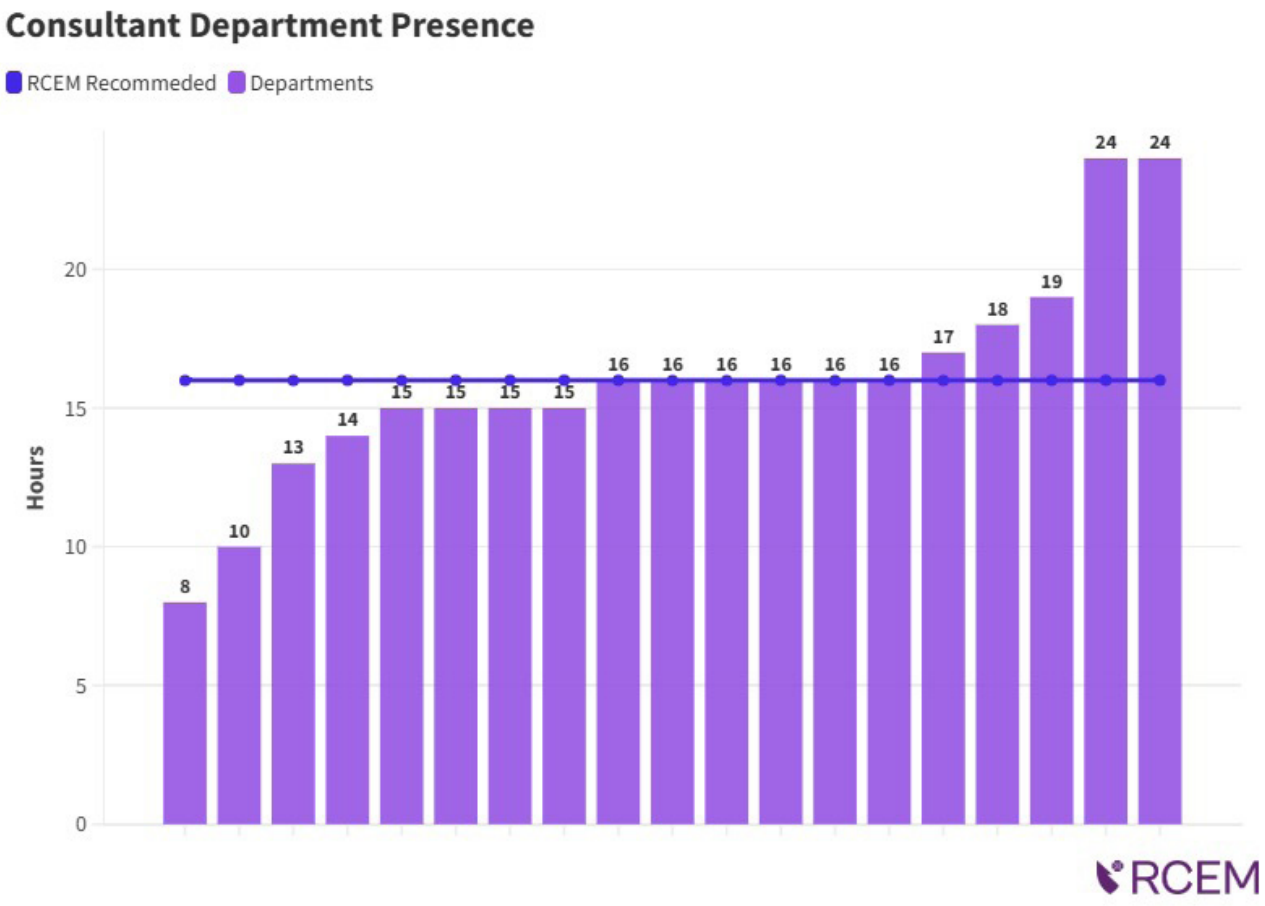
Whilst older groups have increased, there has been a notable decrease in younger consultants. In the previous census, 34.1% were aged between 30 and 39 whereas EDs reported only 27% this time. This is a worrying trend and likely due to lack of consultant jobs available, doctors leaving the specialty, or moving abroad.

Departmental presence

We asked departments to provide the average hours per day that a consultant is present in the department on a weekday and weekend. The average weekday consultant presence was 14. The average weekend presence was 12.

The minimum weekday consultant presence that an entry reported was 8 hours. In contrast, the maximum presence was in two departments at 24 hours a day. On the weekend, the minimum consultant presence reported was 0 hours and the maximum was 24.

As pressures mount, the demand placed on the EDs, the complexity of case mix, and the challenges that accompany crowding all mandate the presence of a senior decision maker (SDM). Best practice recommended by RCEM suggests that there should be Emergency Medicine consultant presence for at least 16 hours a day (08:00–00:00) in all medium and large systems.



The graph above highlights that 11 EDs meet the RCEM recommendation and eight EDs do not.

In the previous census, the minimum weekday consultant presence reported was 10 hours, and the maximum was 19 hours. For the weekend, the minimum weekday consultant presence was 0, and the maximum was also 19. There has, therefore, been an improvement in ED consultant presence.

Presence on the 'shop floor'

We asked departments about their consultant shop floor presence throughout the day on both weekdays and weekends. Consultant presence was most concentrated between 08:00 – 16:00 on weekdays. Between 16:00-midnight on weekends, there were 16 departments with consultant presence. Three departments reported consultant presence on the shop floor between 00:00-08:00 on weekends and four reported presence at this time on weekdays.

	Mon-Fri			Sat/Sun		
	08:00 - 16:00	16:00 - 00:00	00:00 – 08:00	08:00 - 16:00	16:00 - 00:00	00:00 – 08:00
Total	53	37	5	28	24	3
Average	2.3	1.6	0.2	1.2	1.0	0.1

SAS Doctors

Specialist, Associate Specialist, and Specialty (SAS) doctors are permanent trust appointed employees to individual departments. SAS doctors are not part of the EM training programme. However, they may progress to consultant if wishing to undertake CESR. A SAS grade doctor is frequently an experienced clinician in EM, with many holding the role of an SDM in their department. The specialist role was created to reflect and recognise SAS doctors who have extensive experience and high-level competencies in their specialty.

Departments reported having 77 Emergency Medicine SAS doctors in Scotland. There are 63 WTE SAS Doctors. The lowest SAS doctor weekday presence was 0 hours in two departments and 24 was the most in one department.

The average weekday presence across Scotland was 11 hours a day. The average weekend presence was 10 hours a day.

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 resident doctors, formerly known as Junior Doctors. The Emergency Medicine training programme (ST1-ST6) takes six years, although due to increasing LTFT working and out of programme training, it is a much more common occurrence for this to take longer.

There is a total of 221 trainees working in EDs across Scotland, compared to 185 in the previous census.

There are 169 Emergency Medicine resident doctors in ST1-ST7 across Scotland, or 159.4 WTE. This is an increase of nine compared to the first census.

Non-Emergency Medicine Trainees

While non-EM 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.

There were 196 non-EM trainees in Scotland. Compared to 206 in the previous census.

Advanced Clinical Practitioners

Advanced Clinical Practitioners (ACPs) come from a range of regulated clinical professions such as nursing, pharmacy, paramedicine and occupational therapy.[6] 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,

[6] http://president.rcem.ac.uk/index.php/2022/08/30/advanced-clinical-practice-past-present-future-a-brief-overview-rcem-position

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.

There are 16 ACPs. Compared to 5 in the previous census. Five departments reported having ACPs.

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.

There are 19 PAs across Scotland. Compared to 20 in the previous census. Four departments reported having PAs.

Emergency Nurse Practitioners

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.

There are 154 ENPs across Scotland compared to 170 in the previous census. 17 departments reported having ENPs.

GP CCT Holders

Some qualified GPs elect to extend their role into other areas of interest within the healthcare system. There are GPs with Extended Roles (GPwER) who work sessions in EDs.

There were 59 GP CCT Holders across Scotland and 15 departments shared these.

Paediatric Emergency Medicine Subspecialty

There were 54 PEM Subspecialty doctors in Scotland.

Workforce Gaps

At the time of recording, there were 8 funded but unfilled WTE EM Consultant posts in Scotland compared to 18 in the previous census.
There are 16 funded but unfilled WTE SAS posts across the EDs compared to 5 in the previous census. Not all these posts represent rota gaps across the departments.

Planned retirement

At the time of undertaking the census, there were 38 EM consultants planning to retire by 2030 amongst the EM consultant workforce, compared to 33 by 2027 in the previous census. This equates to 26 WTE.

Additionally, 10 SAS doctors are expecting to retire by 2030, compared to 7 in the previous census.

As this number is an impression from those Clinical Leads/Directors who completed the Census for each department, the number by 2030 could change and could be higher than estimated.

Rotas

Weekend Frequency

The frequency that staff work on weekends varies greatly between staff groups. Emergency Medicine consultants work an average weekend frequency of 1:5.5 weekends, ranging from the least frequent, one in every >10 weekends in one department, to the most frequent, 1:3.5 in three departments.

In the previous census, there was also an average weekend frequency of one in every 5 and a half weeks.

All other staff groups work weekends more frequently: Non-Consultant or SAS senior decision makers work an average of 1:3.8 weekends. Training Grade Senior Decision Makers work 1:2.9 weekends. And finally, resident doctors work 1:2.3 weekends.

In the previous Census, non-Training Senior Decision Makers and Training Grade Senior Decision Makers work an average weekend frequency of 1:3.8 and 1:3.6 weekends respectively, and resident doctor an average of one in every two weekends (1:2).

On Call Frequency

The average on-call frequency from all respondents from Emergency Medicine consultants in Scotland was one in every 14 days. There is a significant variation in this with frequencies ranging from just over once every 0.5 days to once every 24 days.

In the previous census, the on-call frequency was one in nine (1:9) for just major departments.

Night Shifts

Only one department had night shifts as part of their job plan. Despite this, three departments had consultants delivering night shifts.

Excluding locum delivered night shifts, they were mostly undertaken by middle grade doctors in training (34%), followed by resident doctors (31%) and staff grade/specialty doctors (21%).

Rota Gaps

We asked departments for the number of unfilled posts on the consultant rota, middle grade/senior decision maker rota, and resident doctor rota.

The total number of rota gaps among these groups was 74 across Scotland (67 in the last census). 16 of these were consultants (16 in the last census). 32 were SAS (23 in the last census).

26 were Resident doctors (28 in the last census). Top reasons included: poor recruitment, unable to recruit, no applicants, and recruitment is not financially viable.

Rota gap cover

We asked departments how frequently rota gaps were covered in the last year for Consultants, SAS doctors and Doctors in Training. 23% of entries said they cover unfilled resident doctor shifts every day. 46% said they had to cover SAS shifts several times per week. And 13% said the same about consultant shifts.

We also asked for frequency of weekend and overnight rota gaps. These were less prolific, with 9% every day for resident doctors. And 0% every day for Consultants and SAS doctors.

Departments were also asked whether there has been variation of rota gaps in the last year. 28% said there were more gaps. 50% said about the same. And 22% said fewer gaps.

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. The use of locums is a costly solution, and one that should only be used to manage short term staffing needs. However, it is important to note that some departments rely heavily on locums in various forms.

Locums deliver 68 DCCs across eight departments that have consultants.

The total number of night shifts delivered by locums in the last year was 321, with an average of 23.

Seven departments stated that they had non-consultant career grade locums in post, with a headcount total of 14 and a WTE of 14.8.

In the previous census, it was found that there were 739 instances of locum staff being used to cover nightshifts in Scotland. The decrease in locums and increase in consultants is encouraging, and we hope to see this trend continue.

Workforce Planning

Consultant numbers required

There will need to be around an additional 50 WTE consultant posts to safely staff EDs in Scotland at a rate of one consultant per 4000 attendances to meet future demand. It's important to remember that there will also be 26 WTE retirals taking place, and there are currently eight funded but unfilled posts – in total this equates to 84 WTE posts. However, this is a conservative estimate and if portfolio working continues to gain popularity, with staff reducing the number of DCCs they deliver, then this number could increase to 141 WTE consultant posts.

With the current number of resident doctors, and an average attrition rate of 7%, we can expect to see around 140 -150 WTE consultants emerge from the training programme. This would suggest that there are enough resident doctors due to move through the programme to meet the future demand, replace those who retire, and fill any funded but unfilled posts.

Consultant expansion

We asked departments to provide any agreed planned expansion of consultant numbers for the next two years.

Over the next two years, 72% of entries reported that there is a plan to expand consultant posts by 13 in total.

If this expansion does materialise, it accounts for just over a quarter of the increase in consultants required to meet future demand, and to ensure that resident doctors completing training have a consultant post to move into. Without these available posts, there is a risk that following completion of training, skilled individuals will look for better opportunities elsewhere, leading to a 'brain drain' in Scotland.

Whilst we have kept the census anonymous, we can work with Government and PHS to identify which hospitals and boards require more uplift than others.

Recommendations

1. Plan for an increase 50 – 107 WTE consultant posts over the next training cycle. This is equal to an increase in 2-4 WTE consultant posts in each major department over the next training cycle – a reasonable and achievable figure.
2. When appropriate, incentivise doctors to enter substantive employment as SAS doctors rather than career locum working.
3. Implement an extensive recruitment and retention campaign to attract doctors to train, work and stay in emergency medicine.
4. Increase capacity across the NHS in Scotland to ensure that EM works well and that doctors do not leave the specialty or the country.

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