Developing people for health and healthcare

Emergency Medicine

Background to HEE proposals to address workforce shortages

December 2013

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Section One

Introduction

We recognise the difficulties of workforce development in emergency medicine, particularly the shortage of consultants resulting from poor recruitment into middle grade training posts, which we have inherited.

Much has already been done and we have made considerable progress but we know more hard work will be required to develop and implement sustainable solutions.

Health Education England (HEE) and the College of Emergency Medicine (CEM) jointly chair the Emergency Medicine Workforce Implementation Group, which comprises experts in emergency care and medical education and training.

We have inherited and continued to build upon the work of predecessors in Medical Education England (MEE) and HEE has identified the emergency care workforce as one of its strategic priorities.

There has already been agreement on the establishment of a new run through training programme and development work with Physician Associates, a professional group ideally trained to support emergency medicine.

It is crucial that we raise the profile and popularity of the emergency medicine specialty and ensure availability of more doctors to the service from 2014.

We jointly set out here proposals and recommendations to improve the future workforce of emergency departments and ensure that patients receive consistent, high quality, safe and effective care.

Professor Ian Cumming, Chief Executive, Health Education England

Dr Clifford Mann, President, College of Emergency Medicine

1.0 Background

1.1 Department of Health (DH) officials and members of the College of Emergency Medicine (CEM) established the Emergency Medicine Taskforce in September 2011 to address workforce issues in Emergency Medicine (EM). An interim report was produced outlining emergency medicine issues and making a number of recommendations on the future workforce of Emergency Departments (ED) with the aim of ensuring patients within EDs receive high quality care that is consistent, responsive, safe and effective as well as being value for money.

1.2 At the final meeting of the Medical Education England (MEE) Board in September 2012, the Emergency Medicine Taskforce Report was presented. MEE strongly supported the recommendations in the report and advised that it would pass them to Health Education England (HEE) for action.

1.3 HEE responded by establishing the Emergency Medicine Workforce Implementation Group, which is jointly chaired by HEE and the CEM. The group comprises experts in emergency care and medical education and training. The group has met on three occasions since April 2013 and the national recruitment and selection team have led work with key stakeholders between meetings.

1.4 HEE has identified the emergency care workforce as a strategic priority through the Education Outcomes Framework's 'ensuring a workforce with the right numbers, skills and behaviours' domain. This was documented in the HEE Strategic Intent document.

1.5 Emergency Medicine is also identified as part of the HEE's Mandate with the Department of Health.

1.6 The Emergency Medicine Workforce Implementation Group is working in partnership with NHS England and the group will act as the workforce advisory element of the review process on behalf of the Urgent and Emergency Care review which is being led by Keith Willets on behalf of Sir Bruce Keogh. Linking into the Urgent and Emergency Care review will ensure that the work for the group has a long term vision for the emergency care workforce.

2.0 Emergency Medicine Workforce Implementation Group (EMWIG)

2.1 The group was established in April 2013 to take forward the recommendations made by the former Emergency Medicine Taskforce.

2.2 The group was jointly chaired by one of HEE's Clinical Advisors Dr Chris Munsch and the President of the College of Emergency Medicine Professor Mike Clancy until Professor Clancy stepped down from the College in June. Following discussions with CEM the new joint chair is Dr Ruth Brown, Vice-President CEM.

2.3 The group has also recently welcomed membership from NHS England and plans to work on behalf of the Urgent and Emergency Care Review in the long term to develop a training pipeline for the emerging emergency and urgent care service as it develops.

2.4 A workshop for the Directors of Education and Quality was held by HEE on the 10th May. All LETBs were represented. The work of the Emergency Medicine Workforce Implementation Group was presented and DEQs discussed how they could get involved in many of recommendations being taken forward by the group. The workshop also discussed innovation in the LETBs and areas of practice that could be shared across the country.

2.5 LETBs have been asked to share their plans in relation to emergency medicine as many have established EM LETB Taskforces and four have appointed dedicated project managers.

2.6 The directorate has engaged a Project Support Manager for EM to manage the various working groups and bring together the emergency medicine work in a structured and timely way.

2.7 There has already been considerable progress since the group was established in April with agreement on establishment of the new run through training programme, transferable competences, and Physician Associates.

2.8 Work due for completion soon includes agreement on the role of the Advanced Clinical Practitioner and development of agreed national standards.

3.0 HEE Response to the mandate

3.1 The Taskforce report provides the basis for the proposals from HEE in response to its mandate. While the report focus was on medical staffing and, in particular, developments within training that would enhance recruitment and throughput, more recent discussions with stakeholders have identified other changes that will either reinforce the delivery of the recommendations or improve staffing levels in other ways.

4.0 The Recommendations

4.1 The HEE working group (EMWIG) supports the recommendations from the EM Taskforce. These include:

- increasing emergency medicine consultant numbers to ensure a consultant presence seven days a week in all emergency departments and 24 hours a day, seven days a week, in larger departments or major trauma centres;
- allowing earlier exposure to emergency medicine within core training where appropriate which may improve retention;
- piloting new routes into emergency medicine for trainees currently in other specialty programmes;
- the development of transferable competences from one specialty to another to shorten emergency medicine training;
- supporting Associate Specialist and Staff Grade doctors to help improve retention. This can be achieved by enabling doctors in these grades to do secondments which will increase their chances of sitting and passing the College examinations and then enter training at ST4. HEE will encourage trusts to develop this group of professionals;
- General Practice support; and
- expanding the use of supporting staff including Advanced Clinical Practitioners, Physician Associates, paramedics and pharmacists.

4.2 The recommendations around the shape of the EM workforce need to reflect NHS England's review of Urgent and Emergency Care services and HEE is working with the College of Emergency Medicine to identify the best way of undertaking a stocktake and modelling staffing within the ED

Section Two

HEE proposals to facilitate meeting the recommendations and responding to the workforce challenges in EM

1.0 Recruitment and retention of present senior medical workforce and improving the appeal of the specialty – Terms and conditions, the effect on the consultant workforce

1.1 Recruitment into vacant consultant posts is difficult both in terms of numbers of doctors available for this work from the UK training programme but also because different international systems mean many countries do not have the equivalent. Even where standards are similar recruitment programmes sourcing overseas doctors have been relatively unsuccessful.

1.2 One reason consistently reported for doctors not choosing to pursue a career in Emergency Medicine is the poor quality of life for consultants. This relates to the high proportion of unsocial hours worked and to the effect that role models have when they report high stress and high dissatisfaction levels.

1.3 There are examples within the terms and conditions for example for consultant psychiatrists where retirement early has helped to attract doctors into the specialty. Given the potential for burn-out in a front line specialty such as EM consideration should be given to constructing a consultant contract that recognises the significant proportion of unsocial hours.

1.4 Alternative professional opportunities within the consultant career would encourage this speciality. Enabling flexibility within the specialty to allow doctors to gain other skills will require a different approach to CPD allowing credentialing of acquired competencies which would potentially mean that more senior doctors could move into less acute specialties, or provide support to EM in different, less acute settings. The proposals in The Shape of Training review by Professor Greenaway encourage credentialing and may afford an opportunity to develop new ways of training throughout the medical career not only within the present postgraduate programmes.

HEE would support work with stakeholders to explore alternative consultant contractual arrangements to enhance recruitment and retention in the specialty

HEE looks forward to playing a leading role in the implementation of the Greenaway recommendations

2.0 Training – raising the popularity of the specialty

2.1 Emergency Medicine is a six year training programme, comprising three years of Acute Core Common Stem (ACCS) training and a further three years of higher specialty training. Recruitment into the specialty occurs at ACCS CT1 (year one of core training) and again at ST4 (year four of specialty training). Since 2012, EM has recruited separately as a theme within ACCS and the fill rate has improved each year. In 2013, 100 per cent of these posts were filled for the first time. The concern is about attrition during the programme, with trainees often leaving after one or two years for another specialty or ACCS theme. The low output from the ACCS EM theme has led to a resultant poor fill rate in recent years at ST4, the fill rate has been around 40 per cent for the last three years. For 2014, HEE has given guidance to its LETBs (Local Education and Training Boards) to increase their ACCS numbers to mitigate attrition. The table below indicates the future impact on EM training vacancies if these further posts are established and filled. These HEE proposals for an additional 75 ACCS posts every year for the next three years represent a major workforce investment.

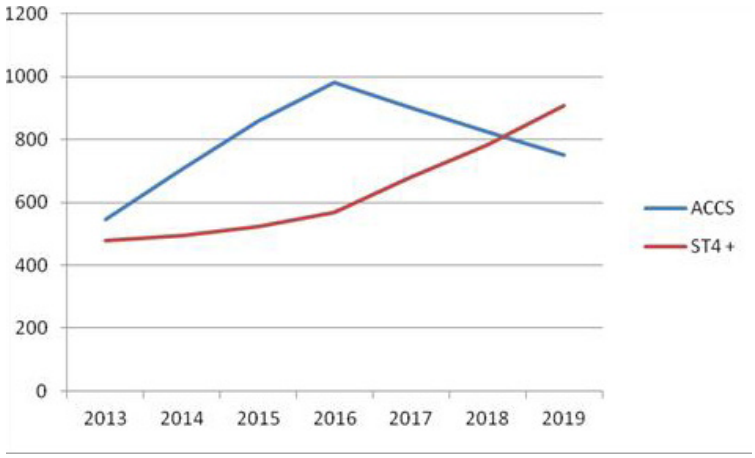
	2013	2014	2015	2016	2017	2018	2019
CT1	203	332	325	325	250	250	250
CT2	172	203	332	325	325	250	250
CT3	170	172	203	332	325	325	250
ST4	130	195	197	175	307	300	300
ST5	170	130	195	197	175	307	300
ST6	179	170	130	195	197	175	307
VACANT	151	135	108	63	-49	-152	-277

2.2 The following assumptions have been made

- Fill rate to be 100% at CT1 from 2014 and beyond;
- Attrition between CT3 and ST4 will 25%;
- Baseline ST4-6 training posts taken from October 2013 stock take (630 posts in England);
- Current trainees based on October 2013 stock take (circa 520 in England);
- 50 Trainees on OOP per year and 20 trainees on maternity leave;
- 15% of trainees working LTFT;
- Three years of 75 extra ACCS trainees appointed from 2014; and
- Two years of 50 extra trainees appointed at ST4 from 2014.

2.3 Improving recruitment into the specialty is vital if the workforce needs at consultant level are to be realised. The data for recruitment into the ACCS Emergency medicine training show a ratio of 3 applicants for every available post with at least twice as many applicants being deemed appointable as can actually enter the specialty. Increasing the numbers of training opportunities at this level will improve the fill-rate for middle grade training while ensuring more availability of doctors to the service from 2014.

2.4 The table below shows the effect of the increased number of ACCS posts over the next three years and the growth at ST4 as these move into higher specialty training.



HEE proposes to increase ACCS posts by 75 for entry in 2014. This will lead to a fill-rate for middle grade training that will produce the required number of consultants in the workforce

2.5 We are working with the Department of Health to ensure we can offer four-year programmes to middle grade doctors from India who can benefit from UK training and support the EM service at this level as the larger numbers are coming through core training and entering the middle grade as a result of the increased number of ACCS posts. The College of Emergency Medicine will be a co-sponsor of this initiative, as with the existing Medical Training Initiative (MTI). Doctors entering this programme in 2014 will have full induction and professional support from the CEM throughout their UK training programme. We are also exploring Tier 2 visa recruitment to bring in additional overseas doctors with relevant EM qualifications.

We anticipate that we will have 50 doctors entering this programme in 2014

2.6 The hierarchical model of progress through the curriculum may actually be counter-productive for the specialty.

2.7 Since the introduction of EM as a requirement in the Foundation Programme many young doctors who in the past would have done a 6 month training post in EM now do only 4 months at a very much more junior level.

2.8 Undergraduate exposure to a specialty is recognised as an important recruitment tool. Medical Schools need to prepare undergraduates for acute, front-line work and offer adequate exposure to the specialty to maximise and inform undergraduates' choice.

HEE will work with MSC and the GMC to ensure that students have sufficient exposure to EM as undergraduates. The College of Emergency Medicine will chair a group to raise awareness of the specialty within medical schools

.9 At present doctors enter a 2 year programme, ACCS, doing 6 months of EM, and 6 months each of Anaesthetics, Acute medicine and ICM. They then can choose

which of the specialties they wish to enter (by competition). Anaesthetics and medical specialties are the most popular. If they enter EM they do a 3rd 'core' year of 6 months EM and 6 months Paediatric EM. The introduction of 'run-through' training will reduce attrition and, as with other run-through specialties, may make the specialty more attractive.

HEE has developed the 'run-through' programme and this has been advertised for the 2014 cohort

2.10 Changing the structure of ACCS to 'grab' trainees into EM earlier – i.e. doing a one year programme in EM then 1 year of other specialties then competing for CT3 (as now). The content remains the same but the delivery allows more exposure to EM, and therefore should increase the pass rate of the examination required for Core 3 entry which is one of the rate limiting steps.

HEE is working with all the ACCS specialties to re-organise a proportion of the training programmes

2.11 The Shape of Training report proposed a different structure for postgraduate medical education. It is clear that, for example, a significant number of doctors fail to progress beyond core surgical training and if there are more flexible programmes within the first 5 years of post-foundation training. The opportunity to have curricula that are delivered through credentialling rather than rigid programmes will enable more doctors to spend some time in EM and some to dually accredit themselves in linked specialties. HEE should consider what areas of clinical practice should be mandatory for all doctors in basic training.

- Greenaway report may help link training opportunities more effectively at core level – changing the curriculum to a 5 year programme (including anaesthetics, ICM and Acute Medicine) with 2 year sub-specialty for some to develop specific skills to support Trauma teams, Primary/Community care etc
- Greenaway will give doctors the opportunity to develop transferrable competences and move into EM.

HEE looks forward to playing a leading role in the implementation of the Greenaway recommendations

2.12 Incentivising training financially in EM is not felt to be appropriate but the negotiation of the junior doctors' contract needs to recognise different working patterns such as shifts appropriately. There would be merit in increasing the number of dual CCTs between EM and Acute Medicine. Exploiting the overlap between the knowledge base and training for EM and Acute medicine will allow trainees to move between the two and after 'front line' service in EM some may then move into Acute Medical roles for life-style reasons.

2.13 Improving the existing system: by increasing the number of recruitment opportunities at ST3 (middle-grade) the risk of losing trainees from the specialty because they do not pass the CEM examination within the time required is reduced.

HEE has run a second round of recruitment this year for the first time. 44 posts were advertised and 34 have been offered and accepted

2.14 As part of delivering a new, innovative workforce, we have been looking at use of the paramedic profession in emergency care. The ambulance service can play an important role in reducing the number of patients that are taken to A&E in the first place, as well as in the wider emergency department alongside roles such as Advanced Clinical Practitioner and Physician Associates.

HEE intends to establish a paramedic working group.

3.0 Support Services

3.1 The EM Taskforce recognised the importance of 24/7 availability of radiology and pathology services but there are other staff groups that could significantly improve efficiency within EM departments.

3.2 Pharmacy services – the complexity of many older patients in terms of multiple medications, the delays in discharging patient awaiting prescriptions and the risk of prescribing errors mean there is merit in having trained pharmacists in the ED 24/7.

3.3 HEE is undertaking work with Physician Associate organisations. This professional group are ideally training to support EM. However it is recognised that until there is mandatory regulation, it is unlikely that there will be sufficient academic institutions establishing a programme.

3.4 General Practitioners – there are good examples of co-located GP services improving the flow of patients with emergency conditions. However the workforce issues in General Practice mean there is no 'spare resource'. The proposals in the Greenaway report will increase the number of doctors with direct training and experience of managing emergency medical conditions, many of whom will eventually work delivering community based care either as GPs or Generalists.

3.5 Mental Health Services: the impact of deteriorating mental health in terms of the numbers of patients presenting in Emergency Departments is significant. The need for more input from psychiatric specialists needs to be recognised by employers. HEE is working with the Royal College of Psychiatrists to ensure that the sub-specialty of liaison psychiatry is maintained within the output of the training programmes.

3.6 Advanced clinical practitioner (ACP) roles – the EM Taskforce supports more Advanced Clinical Practitioners, drawing from nursing and other AHP backgrounds. HEE is working on establishing national standards and nationally agreed scope and competences for ACPs.

3.7 Transport – although not directly the responsibility of HEE the need for integrated transport services to enable discharged patients to be safely transferred back into the community has been flagged as a constant issue in terms of improving the efficiency of the service.

Appendix A - Recommendations from EM Taskforce Sep 2013

Recommendation 1 – An increase in Emergency Medicine Consultant numbers to ensure a consultant presence 7 seven days a week in all Emergency Departments and 24hours a day, seven days a week in larger departments or Major Trauma Centres

3.1 It is proposed that HEE continues to train the current number of ST4 NTNs in the England while increasing the number of Acute Core Common Stem (ACCS) EM posts to account for the high attrition rates that it is currently being experienced. Based on current consultant and middle grade vacancies it is unlikely too many EM doctors will be trained whilst waiting for the NHS England policy statement.

Recommendation 2 – Work with the CfWI to explore workforce modelling in EM

3.2 This piece of work was put on hold earlier in the year due to the NHS England Urgent and Emergency Care Review. This is because it was felt the work would duplicate activities and there would be no benefit to model the current EM system if future plans were to be redesigned.

3.3 Following discussions at the last EMWIG and with CEM it has been decided by the group that it would be useful to undertake a small stocktake of staff working in the ED to identify current staff levels by profession in order to identify current gaps and models being used. This piece of work would also help determine and assess the future training pipeline required once the Urgent and Emergency Care Review is complete.

3.4 The Planning team in the Strategy and Planning Directorate are currently scoping how to take this piece of work forward as a matter of urgency. This work will be needed to support 2014 recruitment plans.

Recommendation 3 – EM trainee numbers should be carefully calibrated to support continued Consultant expansion

3.5 This recommendation was put on hold for the same reasons as above. The policy statement is required from NHS England to gain a clearer understanding of the numbers needed in future training programmes it support and develop a loner term workforce in emergency care.

Recommendation 4 – Early exposure to the EM component within ACCS core training to improve early experience and improve MCEM pass rates

3.6 The Emergency Medicine Workforce Implementation Group discussed and agreed to pilot the rearrangement of the training components of the ACCS programme. This would put the current EM third year into year 1 followed by the 4 components of ACCS.

There are a number of potential benefits:

- Doctors attempting the Membership of the College of Emergency Medicine in year 3 will have done 18 months EM potentially improving their likelihood of passing
- It is assumed that longer exposure to EM earlier in the programme will lead to retention being more likely

3.7 Expression have been received from the London LETBs to run the rearranged pilot to determine if this reduces the attrition out of EM from the ACCS programme.

Following careful consideration of the evidence it has been jointly decided that this recommendation will no longer be taken forward. CEM has requested changes to the EM curriculum which will allow local flexibility if Trusts still want to take this recommendation forward.

Recommendation 5 – Develop alternative routes into EM training for trainees currently in other specialty programmes

3.8 A proposal to develop a parallel run-through training programme was fully supported by EMWIG. Health Education Yorkshire and the Humber is the lead LETB for ST4 EM recruitment and have been asked to develop a pilot programme on behalf of the group.

3.9 HE Yorkshire and the Humber have subsequently written out to all LETBs for expressions of interest with plans to commence the pilot in November of 2013. All LETBs have indicated an intention to join the pilot with responses still to be received from Severn and Scotland. A similar pilot in cardiothoracic surgery whereby half the trainees are in a run through programme and half from core programmes has been considered successful and works well for the trainees and the profession.

3.10 The EM run through proposal was presented to the MDRS Recruitment Subgroup on 4 September where it was fully supported. The pilot is now subject to GMC approval and legal advice in preparation for 2014 recruitment.

Recommendation 6 – Explore the recognition of transferable competences of trainees currently in other specialties to increase the pool of trainee's eligible to apply for EM training at a level higher than CT1

3.11 A process is being determined via the Academy of Medical Royal Colleges and the GMC of recognising transferable competences from one specialty to another to shorten EM training. A process will be established whereby a Postgraduate Dean can sign off the agreed competencies a trainee has met in a given programme in order for the transfer to take place. The GMC will need to assure the profession that they have a mechanism that is sufficiently robust to protect trainees, training programmes and patient safety. The team will work with the GMC to ensure this assurance is provided.

3.12 A separate agreement concerning transferable competencies between the CEM and the Royal College of Surgeons is being work through. Discussions are on-going

as to the entry level for surgeons who wish to transfer into the EM given their previous experience and competences gained. Deans will look to assess trainees on a case by case basis. A process for this will be established through the English Deans.

3.13 The Shape of Training review is expected to open up further opportunities for wider acknowledgment and transfer of doctor competencies to provide easier movement between the national specialties.

Recommendation 7 – Support Associate Specialist and Staff Grade Doctors (Specialty Doctors) in their roles to ensure retention and increase work satisfaction

3.14 The Emergency Medicine Workforce Implementation Group agreed that work should take place with SAS and Staff Grade Doctors. This is one of the least explored areas and it has been agreed that stakeholder opinion should sought in order to develop an action plan.

3.15 Wessex LETB have successfully run "night safe" courses for SAS EM doctors whereby individuals are provided additional support and training in key areas of medicine in order that they can be signed of as competent to work unsupervised out of hours. This has provided more flexibility for managing middle and senior rotas. Other LETBs are now exploring establishing similar programmes.

Recommendation 8 – GPs could be invited to consider the following options

3.16 This piece of work is being led by Simon Plint, Clinical Advisor HEE and the GP Taskforce. The work will assess how General Practice may support the EM workload within ED. This includes services such as:

- Co-location of GPs in the ED, including working alongside consultant colleagues
- GPs with additional EM training to work within ED
- Acknowledging GPs and GP trainees have transferable competences which they may wish to use to transfer into EM training
- Developing methods for GPs to obtain additional EM skills, either through MCEM or a proposed diploma in EM, or a credentialing mechanism

3.17 This work is at an early stage and further examples of innovation and good practice need to be explored within LETBs. The wider role of primary care managing the EM workload is not part of the remit of the Emergency Medicine Workforce Implementation Group and is being explored by the Urgent and Emergency Care Review led by NHS England.

Recommendation 9 – Expand training of advanced clinical specialists and PAs and define their roles

Advanced Clinical Practitioners

3.18 EMWIG agreed to develop the Advanced Clinical Practitioners role with a view to the profession sustaining middle grade work in the ED. The first meeting was held

on 30th August 2013. The group is made up of experts from around England who are currently working in these roles and includes educational specialists developing university curricula.

3.19 The group has agreed a Terms of Reference and frequency of meetings to ensure that any work is completed in a timely manner given the urgency to stabilise the middle grade workforce in the EDs. The group has been asked to deliver their recommendation including a programme for moving forward by Spring 2014.

Physician Associates

3.20 The use of Physician Associates in the ED is being developed by EMWIG and subsequently a Physician Associate Working Group was held in October 2013. This group will investigate the current use of the PA role in EDs across the country and will learn lessons from their use in other countries such as America. The group with be chaired by Liz Hughes, HE West Midlands DEQ and will be made up of experts from this field. The group will look to develop national standards for the PA role and introduce a training pipeline for subsequent introduction of the role in to the emergency care workforce.

3.21 Physician Associates are usually recruited from biological science graduates and take two years to train to basic standard. There are only two active courses currently in the UK, Aberdeen and St Georges. However it is known that at least three inactive courses are opening up in 2014 and a further two universities are establishing new programmes.

Paramedics

3.22 The original work of the Emergency Medicine Taskforce led by DH did not consider the use of the Paramedic profession in emergency care and ED settings. However, recent work in this area and reports such as the Paramedic Evidence Based Evidence Project (PEEP) August 2013 has resulted in conversations between HEE and the College of Paramedics.

3.23 HEE is intending to establish a Paramedic Working Group to consider and take forward recommendations form the report. The group will be tasked to explore and review the opportunities that exist for paramedics to work in a clinical environment in the ED alongside developing roles such as ACP, PAs and ENP in order to deliver a new innovative workforce.

Appendix B - Emergency Medicine Workforce Implementation Group Membership List

Member		Title, Organisation
Alladi	Sveta	Clinical Fellow, HEE
Archer	Katie	College of Emergency Medicine Trainees' Association
Brown	Ruth	Director of Examinations, College of Emergency Medicine
Carr	Alison	Senior Clinical Advisor, HEE
Crouch	Robert	Consultant Nurse, University Hospital Southampton NHS Foundation Trust
Cugnoni	Helen	Accident and Emergency Consultant, Homerton University Hospital
Curran	Ian	HEE Clinical Adviser
Currie	Mary	NHS Employers
Hall	Lynn	HEE Clinical Advisor
Honsberger	Julie	Business Manager Lead, Yorkshire and the Humber LETB
Malin	Sally	Patient representative
Marvell	Joanne	Specialty Training Manager and EMWIG Project Manager, HEE
McDermott	Niall	Domain Team Lead, NHS England
Mitchell	Patrick	Director of National Programmes, HEE
Munsch	Chris	Senior Clinical Advisor, HEE
Parle	Jim	Professor of Primary Care, Physician Assistant course Director, University of Birmingham
Pendsé	Doug	BMA JDC Representative, BMA
Plint	Simon	DEQ, HE Wessex
Reynard	Kevin	Dean, College of Emergency Medicine
Stock	John	Workforce Planning/Information Analyst Lead, HEE
Trivedy	Chet	President, College of Emergency Medicine Trainees' Association
Wilkinson	David	Director of Education and Quality, Yorkshire and the Humber LETB