

Securing the future workforce for emergency departments in England

October 2017

This report was written by Health Education England, NHS England, NHS Improvement and Royal College of Emergency Medicine.

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Foreword

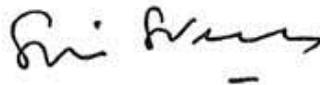
Emergency departments are at the very heart of our National Health Service, seeing 23 million patients in the last year alone. Central to this system are the doctors and nurses who, alongside other professional colleagues, work tirelessly to deliver consistently high quality care to patients and their families.

Improving A&E services and performance is a core priority in the NHS and ensuring we have properly staffed emergency departments is central to this. We know we need more clinical staff, both senior decision-makers and those making up the broader clinical workforce, to address the significant pressure on our emergency departments. For the first time, NHS England, NHS Improvement, Health Education England and Royal College of Emergency Medicine have come together to develop a plan to address the shortages we face and ensure we have sustainable staffing in our emergency departments.

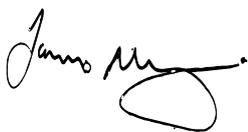
We are committed to this agenda and will work together to ensure its successful delivery. This will include additional investment in our existing and trainee workforce through the commitments set out in this document. Together these provide a clear plan to grow the workforce, reduce attrition in medical training and ensure emergency departments are attractive places to work. We believe that this plan sets out a comprehensive package of proposals, supported by the required focus and resource, to ensure a sustainable workforce to meet the growing demands of the future.



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Summary of commitments

Growing a multiprofessional workforce

- ✓ Emergency medicine is already set to be the fastest growing specialty over the next five years. Health Education England (HEE) will support this growth by continuing with **four additional years of 'expansion cohorts'**. This will result in a **minimum of 300 people** starting on Acute Care Common Stem-Emergency Medicine (ACCS-EM) programmes each year for the **next four years**.
- ✓ HEE will work with RCEM to recruit an **additional 100 doctors per year for four years** into other training programmes that develop skills in emergency medicine at a range of levels to ensure the best mix of junior and middle grade expertise for emergency departments (EDs). These will include the **defined route of entry into emergency medicine (DRE-EM) training programme**, international recruitment, particularly as part of **'work, learn and return' schemes** with countries such as India and Pakistan, and other routes.
- ✓ This will mean a total of **400 people entering emergency medicine training for a period of four years** from next year as compared to **300** this year.
- ✓ We will invest in the growth of the advanced clinical practitioner (ACP) workforce in emergency care, with **funding for 42 ACPs across 14 trusts** this year, **rising to 84 ACPs** next year.
- ✓ The physician associates (PAs) training pipeline will increase significantly over the next few years: we will have **3,200 qualified PAs in 2019** compared to around 350 now. With approximately **30% of PAs currently working in emergency medicine** this will provide **significant additional clinical resource** for EDs.
- ✓ Royal College of Emergency Medicine (RCEM) and NHS Improvement will continue to encourage and **share best practice on Certificate of Eligibility Specialist Registration (CESR) programmes**. A series of development events run by RCEM and HEE and a best practice toolkit from RCEM, supported by HEE, will support alternative routes to becoming an emergency medicine consultant.

Reducing attrition in medical training

- ✓ From **April 2018**, we will invest in a **leadership/personal development training programme for every emergency medicine trainee** in England to help reduce attrition and improve the support for trainees in this intense and pressurised specialty. The offer of training support will increase in breadth and complexity as people progress through their training to prepare them for becoming consultants.
- ✓ Starting in **April 2018**, we will provide funding to and work with **a third of the trusts (45)** highlighted in the General Medical Council (GMC) training survey as having the biggest problems with their training environment, to develop and implement **clinical educator strategies**. These support all staff working in EDs by improving the training and working environment. Learning from this approach and good practice will be rapidly shared with other trusts. All trusts will be expected to consider clinical educator strategies as part of their overall emergency care workforce planning.
- ✓ From **August 2017** HEE is piloting less than full time (LTFT) training for all ST4 and above trainees in emergency medicine.
- ✓ Following a successful pilot, the General Medical Council (GMC) has approved **permanently incorporating run-through training** into the curriculum.

Improving retention

- ✓ Next year **20 trusts** with the most challenging recruitment and retention problems will be given **dedicated HR support** to develop bespoke plans to address them.
- ✓ RCEM will develop a **range of post Certificate of Completion of Training (CCT) fellowships** in areas such as geriatric emergency medicine, ambulatory emergency care and humanitarian work. These will be supportive of and attractive to certain types of systems and also support thinking on new models of care in these areas.
- ✓ RCEM will publish a best practice **clinical development fellows toolkit** to support the creation of such roles as a way to both broaden the workforce and

improve the retention of staff in our EDs.

- ✓ RCEM and NHS Improvement will jointly publish a **best practice guide** that trusts will be expected to use to improve their recruitment and retention in EDs.
- ✓ RCEM and NHS Improvement will work together to jointly describe how we can better support emergency medicine consultants at different stages of their careers – for example, consultants in the first three to five years after appointment, those aged over 55, as well as those nearing retirement age – to improve retention in these groups and share best practice widely across trusts.

Monitoring progress and impact

- ✓ A senior steering group from NHS England, NHS Improvement, HEE and RCEM will **develop the detailed implementation plan for these commitments** and annually review progress in growing a multiprofessional emergency care workforce, reducing attrition in medical training and improving retention.

The workforce challenge in emergency medicine

1. Emergency care and the work of emergency departments (EDs) is one of the pillars on which our NHS is built. Staff working in EDs aim to deliver high quality patient care for all patients whether they present with minor or critical life-threatening and life-changing conditions.
2. The numbers of staff working in our EDs has increased. The medical consultant workforce in emergency medicine grew from 1,187 to 1,632 whole time equivalents (WTE) between 2012 and 2017, a growth of 37% at an average rate of 6.6% per year. The medical workforce other than consultants and foundation trainees grew at a slower rate – from 2,738 to 3,268 (19%, averaging 3.6% per year). The registered nursing workforce grew from 12,491 to 14,613 WTE between 2012 and 2017, a growth of 17% at an average rate of 2.7% per year. While these rates exceed growth in activity, attendances and admissions have continued to rise, as has the overall complexity of the needs of patients.
3. A number of previous initiatives have looked to address the workforce challenge and adapt the model of care to better suit the needs of the changing environment. As such, we have moved towards a service that is increasingly led by consultant emergency physicians seven days a week, supported by a broader multiprofessional workforce to manage the vast variety of patients coming through the doors.
4. However, despite the positive effect previous work has had, clinical staff remain stretched to deliver safe, effective patient care due to the historical mismatch in supply and demand. This intense working environment of the ED is well recognised to be a leading cause of medical staff dissatisfaction, attrition and premature career 'burnout',¹ increasing the burden on the staff who remain. It also compromises the attractiveness of the specialty for the next generation of doctors who will be vital over the next decade.

¹ https://www.rcem.ac.uk/docs/Policy/CEM7461-Stretched-to-the-limit-October_2013.pdf

5. In summary, we need more clinical staff – both senior decision-makers and those making up the broader clinical workforce – to meet the significant pressures on EDs. Evidence of the pressure facing EDs is clear from the high spending on locums and agency staffing in EDs (emergency medicine accounted for 20% of all medical locum spend in a sample of 52 liaison trusts), attrition rates for those in training and early retirement of experienced senior emergency physicians. In 2016, providers reported they wanted to recruit an additional 300 WTE consultants, which equates to 15% of the current number.
6. This document describes our plan to address these problems. While this plan primarily focuses on the emergency medicine workforce, we are aware of the significant challenges faced by ED nursing. These will be considered as part of further work on the broader urgent and emergency care workforce over the coming months.

Responding to these challenges

7. Responding to these challenges will require a concerted effort and investment from all national bodies, professional organisations and providers, to help recruit and retain a large enough workforce with the right skills, behaviours and values to deliver care in our EDs now and in the future.
8. A stable, well supported and resilient workforce in EDs enables improved and sustainable patient care, alleviates pressures on the existing workforce, and improves providers' finances through reducing staff turnover costs and use of locum and agency staff over the short, medium and long-term.
9. This workforce plan for emergency care should be seen in the wider context of the transformation underway in urgent and emergency care as set out in the [Next steps on the NHS Five Year Forward View](#).² Through developing better, more co-ordinated out-of-hospital care services, including by expanding mental health liaison teams; implementing measures to improve patient flow through hospitals; and improving discharge from hospital into patients' homes and communities – not only will patients receive better care but importantly the pressure on staff working in EDs will reduce.

² <https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf>

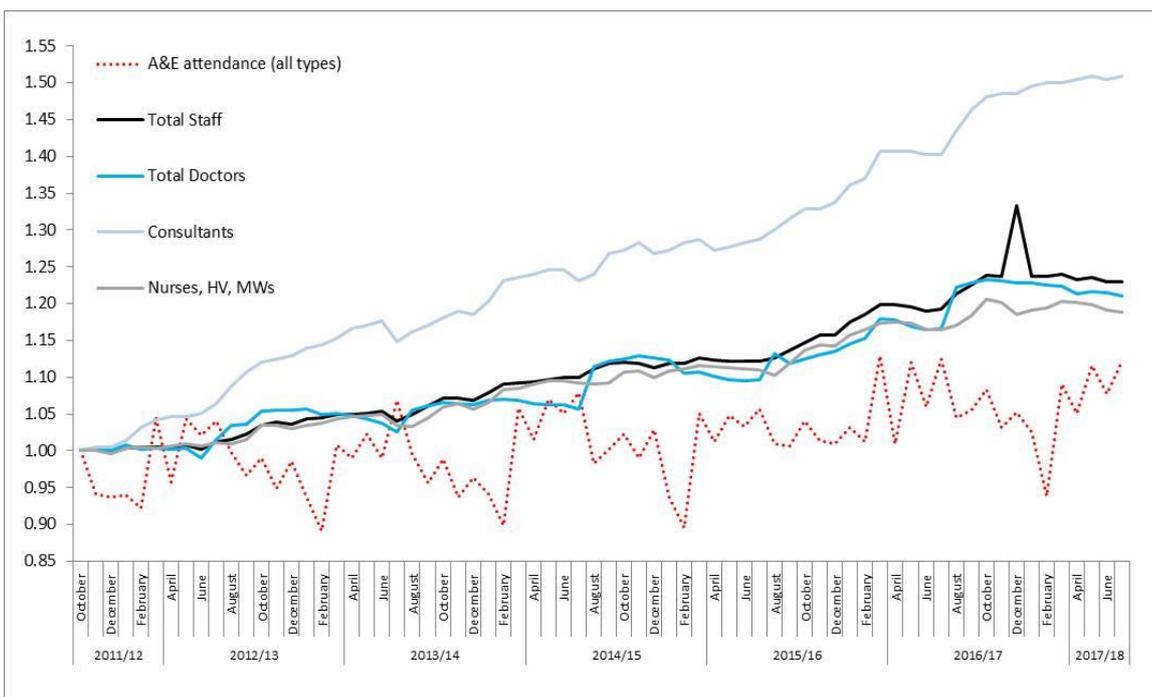
10. This plan sets out the steps that we as national leaders will take together to support providers and local systems to address the workforce challenges in EDs, focusing on three key areas:
 - growing a multiprofessional workforce, including creating a resilient senior decision-maker layer of emergency medicine staff
 - reducing attrition in emergency medicine training
 - improving retention of staff working in our EDs.

11. It covers all clinical staff working in our EDs who see patients autonomously, including doctors, advanced care practitioners and physician associates. It provides examples of where other specialities and professions are working within EDs and the benefits of these approaches in increasing the breadth and depth of cover in EDs.

Progress to date

12. The problems facing the workforce in EDs have been recognised for a number of years and progress has already been made to address them; for example, the number of consultants in emergency medicine has risen on average by 9% a year over the past 10 years (Figure 1).

Figure 1: Increase in ED workforce, October 2011/12 to June 2017/18



13. Health Education England (HEE) recognises emergency medicine as one of its four priority shortage areas. In 2013, HEE and the then College (now Royal College) of Emergency Medicine together published a plan to address the shortages in the specialty. The range of measures included:
 - three years of expansion of training posts from 225 to 300
 - piloting a run-through training option
 - creation of the innovative direct route of entry emergency medicine (DRE-EM) training pathway
 - the work, learn and return initiative whereby overseas doctors are offered training places to develop emergency medicine skills and gain valuable clinical experience.

14. Professional groups such as advanced clinical practitioners, pharmacist clinicians and physician associates are also being developed and supported to take on collaborative, frontline clinical roles in EDs under the supervision and mentorship of consultants in emergency medicine. These groups form an important part of today's emergency care workforce, giving it greater resilience and sustainability.

Advanced clinical practitioners

- Advanced clinical practitioners (ACPs) are experienced registered healthcare practitioners. Their practice is characterised by a high level of autonomy and complex decision-making, underpinned by a masters level award or equivalent that encompasses clinical practice, management and leadership, education and research, with demonstration of core and area-specific clinical competence. Advanced clinical practice embodies the ability to manage complete clinical care in partnership with patients/carers.
- Recruited from a pool of senior experienced practitioners, providing them with the opportunity for career progression in a clinical capacity rather than a traditional management role.

Physician associates

- ✓ Physician associates (PAs) are a group of collaborative healthcare professionals with a generalist medical education who can undertake tasks such as history taking, physical examination, diagnosis, and patient management and education under the supervision of a clinician.
- ✓ First introduced in 2003, currently there are 450 qualified PAs and 1,200 student PAs, and 1,000 student places are available next year; approximately 30% of the current PA workforce is working in EDs.
- ✓ Tend to come from a pool of science graduates rather than existing NHS staff and students follow an intensive two-year programme to train as a PA.

15. While progress has been made to help reduce workforce pressures now and particularly over the coming years, we know we need to do more to ensure the sustainability of the ED workforce over the next decade. The rest of this document sets out the steps we as system leaders will take to deliver this sustainability at both senior decision-maker and broader clinical workforce levels.

Growing a multiprofessional workforce

Summary of commitments

- ✓ Emergency medicine is already set to be the fastest growing specialty over the next five years. HEE will support this growth by continuing with **four additional years of 'expansion cohorts'**. This will result in **a minimum of 300 people** starting on ACCS-EM programmes each year for the **next four years**.
- ✓ HEE will work with RCEM to recruit an **additional 100 doctors per year for four years** into training programmes that develop skills in emergency medicine at a range of levels to ensure the best mix of junior and middle grade expertise for EDs. These will include the **DRE-EM training programme**, international recruitment, particularly as part of **'work, learn and return' schemes** with countries such as India and Pakistan, and other routes.
- ✓ This will mean a total of **400 people entering emergency medicine training for a period of four years** from next year as compared to **300** this year.
- ✓ We will invest in the growth of the ACP workforce in emergency care, with **funding for 42 ACPs across 14 trusts** this year, **rising to 84 ACPs** next year.
- ✓ The physician associates (PAs) training pipeline will increase significantly over the next few years: we will have **3,200 qualified PAs in 2019** compared to around 350 now. With approximately **30% of PAs currently working in emergency medicine** this will provide **significant additional clinical resource** for EDs.
- ✓ Royal College of Emergency Medicine (RCEM) and NHS Improvement will continue to encourage and **share best practice on Certificate of Eligibility Specialist Registration (CESR) programmes**. A series of development events run by RCEM and HEE and a best practice toolkit from RCEM, supported by HEE, will support alternative routes to becoming an emergency medicine consultant.

16. Sustainability and success in our EDs requires effective working across multiprofessional teams with no single group able to provide a complete service in isolation from their colleagues. Several models of multiprofessional working have been successful, but their applicability will depend on local circumstances of providers and systems, and will vary across the country.
17. With regard to the medical workforce specifically, it is well recognised that the role of today's emergency physician can be highly stressful and this has increased both the breadth and depth of cover required, with extended hours of working to cope with demand. The different functions within an ED therefore need to be delivered concurrently by a consultant and/or other senior decision-maker such as an experienced staff grade and associate specialist (SAS) doctor or ST4+ trainee. These functions include command and control, resuscitation room leader, supervision of junior staff, rapid assessment function, paediatric ED cover, ambulatory emergency care/clinical decision unit cover and de novo review of new patients.
18. While this plan focuses on the medical workforce, here we also describe a number of initiatives that are underway or in development to strengthen the workforce across the spectrum of staff working in the ED.

Growing the numbers of emergency medicine staff working in emergency departments

Emergency medicine consultants and trainees

19. There has been significant investment in growing the number of ED consultants over recent years. HEE is currently in the fourth year of its expansion of emergency medicine training places from 225 to 300. The benefits of this are already being seen. As a result of both increased recruitment and the introduction of run-through training the total number of trainees on a programme leading to specialist registration in emergency medicine has doubled from 536 in 2012 to 1,075 in 2017. Further, from 2020 we expect the numbers of new entrants to the register from the English training system to approach 200 per year, but recognise anecdotal evidence regarding relatively high attrition rates among emergency medicine trainees; plans to address this are discussed later in this document.

20. The expansion in training places was initially intended to last for three years only, but was then extended by a year and due to end in 2017. However, recognising the continued pressures on the service and increasing demand for emergency medicine consultants, **HEE will continue with an additional 75 places for the next four years.**
21. HEE will work with RCEM to recruit an **additional 100 doctors per year for four years** to other training programmes that develop skills in emergency medicine at a range of levels to ensure the best mix of junior and middle grade expertise for our EDs and to maximise the likelihood of trainees continuing onto consultant roles. These will include the DRE-EM training programme, international recruitment, particularly as part of the ‘work, learn and return’ schemes with countries such as India and Pakistan, and other routes. We will consider options about how to ensure these additional doctors can be targeted towards the systems with the greatest need in terms of workforce shortages.
22. This will mean 400 people entering emergency medicine training programmes next year, compared to 300 this year.
23. HEE will continue to work with RCEM to annually review data on training attrition, employment conversion rates and the entry routes to training to determine the composition of the additional 100 doctors a year and training number decisions beyond the next four years.
24. We will continue efforts to achieve a near 100% fill rate, with HEE working with RCEM to promote the specialty and a career within it, and NHS Improvement supporting providers to take on additional trainees.

Supporting the international workforce

25. Overseas clinicians play a significant role in the emergency care workforce, and as such many programmes have been initiated to support international healthcare professionals joining the workforce, often at individual employer level.
26. We recognise the need to take a more systematic approach to supporting international healthcare professionals to work in emergency medicine both for the benefit of the NHS and their home nations in terms of the experiences and skills they are able to take back.

27. To do this HEE and RCEM will work together to develop an overall international recruitment strategy for emergency medicine that will include:
- RCEM's work with international partners to create ethical collaborations that support training for overseas doctors who then work in UK hospitals with one to two-year fellowship and optimise MTI (medical training initiative) schemes. RCEM will provide further information on this in late 2017.
 - HEE continuing its Global Health Exchange to engage cohorts of postgraduate trainees from the Indian subcontinent in two to three-year placements in the NHS.

Ensuring staff grade and associate specialist doctors are sufficiently supported in their roles

Support for SAS doctors

28. Staff grade and associate specialist (SAS) doctors make up a small but important proportion of the medical workforce in the ED. They have fewer opportunities for career progression compared with other senior doctors, and the development of SAS doctors is not always afforded the same attention. In addition, many specialty and SAS doctors choose to continue working as locums as they are put off by the rigour of the CESR process.
29. HEE is supporting the training and development for SAS and non-training grade doctors in the ED through a number of initiatives. For example, HEE started an SAS emergency medicine 'shop floor' skills training programme in the West Midlands in December 2013. The 12-month programme was developed in collaboration with local providers in response to specific training needs of SAS doctors and as a basis for considering the skills mix that an SAS grade doctor requires to develop into a highly functioning middle grade doctor. The programme aims to support the development of more versatile and autonomous clinicians who are better able to manage the increasingly diverse range of conditions presenting in EDs, improve patient care and support a key proportion of the clinical workforce.
30. Between 2014 and 2016 the West Midlands programme trained over 140 SAS doctors in emergency medicine shop floor skills. In 2017, following successful

evaluation outcomes, the programme will be rolled out across the Midlands and London with an anticipated start date of December 2017.

31. Plans for a national rollout will be considered for 2018/19, following successful evaluation of the programme. RCEM and HEE will work together to provide a consistent delivery model for these schemes.

Certificate of Eligibility for Specialist Registration

32. A number of specialty doctors apply for specialty registration through the Certificate of Eligibility for Specialist Registration (CESR) scheme. In 2016, approximately 25 doctors completed CESR schemes successfully. CESR provides an opportunity for non-training grade doctors to advance their careers and gain access to the specialist register to be consultants in emergency medicine. Both individual EDs and RCEM have a role in supporting individuals through the process. RCEM and NHS Improvement will continue to encourage and share best practice on CESR programmes, supported by a series of development events run by RCEM and HEE and a best practice toolkit from RCEM, also supported by HEE.
33. We are aware that many specialty and SAS doctors choose to continue working as locums as they are put off by the rigour of the CESR process. Some trusts have programmes to support doctors with this process – for example, by allowing doctors to take part in the appropriate rotations to build the necessary competencies, and by providing support with the bureaucratic elements of the process. We encourage trusts to initiate these schemes and can provide implementation support through our soon to be published best practice guidance. As set out in this guidance, these schemes can lead to savings by encouraging substantive working and converting locum to substantive spend. For example, Derby Teaching Hospitals NHS Foundation Trust made savings of £900,000 by converting locum expenditure to PAYE for trust-employed doctors. In addition, HEE, RCEM and NHS Improvement will work with the GMC to consider improvements to the CESR process.

Supporting the role of wider professional groups in the emergency department

Advanced clinical practitioners

34. ACPs play a vital and increasing role in many EDs and come from a variety of backgrounds (pharmacists, paramedics, nurses, occupational therapists and physiotherapists). However, the use of ACPs varies significantly across the country. There is significant scope to grow this workforce group in a more systematic way which will bring significant benefits:
- increasing the breadth of cover and skills in EDs to deliver a more sustainable workforce
 - offering a further career development opportunity for senior nurses working in EDs and across the hospital, thus improving retention
 - reducing reliance on locums and increasing stability of rotas.
35. To further support the development and growth of this role NHS Improvement, HEE and RCEM are:
- **developing and funding an ACP fast track programme**, with funding for 42 ACPs to start working across 14 trusts this year, rising to 84 ACPs starting work next year
 - **developing a national ACP framework** to establish a clear definition, level of practice and capabilities for any practitioner working at an advanced level, thus helping to ensure a more consistent approach to the training, deployment and outcomes for these vital roles. It will be published in November 2017
 - **piloting a credentialing process** that was approved by the RCEM Council in 2015. Currently, 183 trainee ACPs are collating evidence on the RCEM ePortfolio, with approximately 135 applying for credentialing in 2018. This is an essential element of assuring the quality of the service provided by this key group of staff. ACPs are a core part of the future workforce in EDs. The national competency framework, credentialing process and central commissioning of ACP places will provide the foundation for growing this part of the workforce as part of multiprofessional teams.

Physician associates

36. The physician associate (PA) is a healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care. Currently approximately 85% of PAs and PA students are **not** from established clinical professions (the vast majority being bioscience graduates). Their broad skills mix means they can practise across a range of medical specialties – enabling senior medical grades to deal with more complex cases. As such, PAs are well placed to help mitigate workforce shortages and work collaboratively as part of the multiprofessional ED team.
37. There are over 360 qualified PAs working across the UK, approximately 30% of whom are working in emergency care, and PA training numbers are increasing. Annual graduate numbers are projected to exceed 900 by 2019, bringing the total number of qualified UK PAs to more than 3,200.
38. HEE is committed to investing in the growth of the PA workforce. As numbers of PAs increase we will monitor how many choose to work in emergency medicine and look at recruitment and retention models for PAs across the system. We will work to ensure that the proportion of newly qualified PAs currently entering emergency medicine is at least maintained and that emergency care remains an attractive option for PAs in the longer term.

Engaging other specialties in the emergency department

39. In a number of EDs, staff from elsewhere in the hospital (eg acute physicians or respiratory specialists) are successfully providing support, working side by side with emergency care staff to deliver their specialist services at the front door of the hospital. The model for doing this will vary from department to department depending on issues such as size, status of the department (eg major trauma centre) and workforce availability. These physicians do not take on emergency medicine responsibilities and roles, but rather initiate the treatment of ‘their’ patients at an earlier stage in the pathway by working alongside emergency medicine clinicians.
40. The engagement of other specialties in the ED does not, of itself, address workforce shortages in EDs but it helps to alleviate pressures and improve patient care by improving patient flow through trusts. Below are examples of

approaches that have been tested. This is not intended to be an exhaustive list but it provides examples of existing initiatives that can support the ED workforce with the challenges it faces.

Case study: Engaging other medical specialities in the ED – Ipswich Hospital NHS Trust

Doctors from other specialties see patients in the ED, assisting with surges in patient numbers by seeing selected patients directly, as well as seeing patients who have already been assessed by the ED team.

Acute medicine, the general surgery team and the paediatric team have their own assessment areas where they see GP referrals but all specialty teams see GP-referred patients in the ED.

The stroke team see potential thrombolysis stroke patients directly in ED. This is triggered by the pre-hospital team on Monday to Friday 9 am to 5 pm, and by the ED staff at other times. During times of poor flow into the hospital the medical team will see their referred patients in the ED.

Our elderly care team see patients before assessment by an emergency medicine clinician in the ED.

We operate separate rotas for each specialty. Some ED staff have allocated sessions across more than one specialty – to enhance training and improve links between specialties.

When we have incorporated acute physicians and GPs into the ED this has allowed us to improve the staffing levels within the department. It has clearly made a significant difference at times of acute high patient flow. We do also perceive an increased and valuable engagement from the whole hospital workforce in the challenges faced in the ED as we start to share ED involvement more widely.

Primary care

41. Local and national enhanced GP training programmes (often termed **fellowships**) have been piloted to support GPs gain additional skills and equip them to work in other settings such as EDs. The training provides a defined framework for up-skilling GPs to work in an enhanced manner across primary, urgent and emergency care settings; supporting admission avoidance and making greater use of community-based alternative care pathways, thus reducing the burden on EDs and supporting the recruitment to and retention in the GP workforce.

Mental health liaison teams

42. Liaison mental health services are specialist services providing mental healthcare in a physical health setting such as EDs. They enable staff to assess and manage patients with mental health conditions more effectively, support prompt and well co-ordinated discharge, and improve experience of care for those with mental health needs.
43. More staff are needed in liaison teams to fully realise these benefits. HEE recently published a [mental health workforce plan for England](#)³ which sets out plans to substantially increase the mental health workforce including in mental health liaison teams; for example, with an increase in medical posts from 400 to 700 and nursing and midwifery posts from 1,600 to 2,000.

Pharmacist clinicians

44. HEE's national Pharmacists in Emergency Departments (PIED-Eng) study considered the potential for pharmacist prescribers trained in clinical health assessment skills to be deployed in EDs and acute medical units. The study suggested that pharmacists trained in this way may support the multiprofessional ED team with clinical services including:
 - undertaking **medicines-focused** duties such as pre-discharge medicines optimisation, medicines reconciliation and prescribing
 - optimising the use of medicines on **admission** to emergency and acute care
 - supporting medicine reconciliation **pre-discharge** of acutely ill patients.

³ <https://www.hee.nhs.uk/our-work/person-centred-care/mental-health/mental-health-workforce-plan>

45. These duties are often undertaken by junior medical staff who face significant demands on their time. Clinically trained pharmacist prescribers are drawn from an existing sustainable workforce and can work alongside junior doctors to take on some of these duties to free up the doctors' time to focus on more complex clinical work. Ultimately this model helps reduce patient waiting times and delivery of safe patient care.
46. While the PIED-Eng study suggested that an advanced clinical training pathway is appropriate for pharmacists, HEE identified a need for pharmacists to undertake preparatory skills training in clinical health assessment and diagnostics to support this pathway. Consequently, HEE in the West Midlands launched a Clinically Enhanced Pharmacist Independent Prescribing (CEPIP) programme in 2014. There has been a high level of interest in the programme from employers, commissioners and the profession itself, across primary, community and secondary urgent, acute and emergency healthcare economies. To date, CEPIP has trained over 300 pharmacists in the West Midlands.
47. In summary, this section sets out what we are doing to ensure there are more doctors and other professions available to work in EDs from 2020 and what we are doing in the meantime to support a range of professionals and specialties to work together as part of a multiprofessional emergency care team. While this package of support can help to alleviate workforce pressures on EDs, it is also important to consider more broadly how EDs operate, including ways to reduce unwarranted variation in services and practice. The national Get it Right First Time programme (GIRFT) which looks at unwarranted variation has recently been expanded to consider emergency medicine. We will work alongside this programme of work to understand any implications for the emergency care workforce.

Reducing attrition in medical training

Summary of commitments

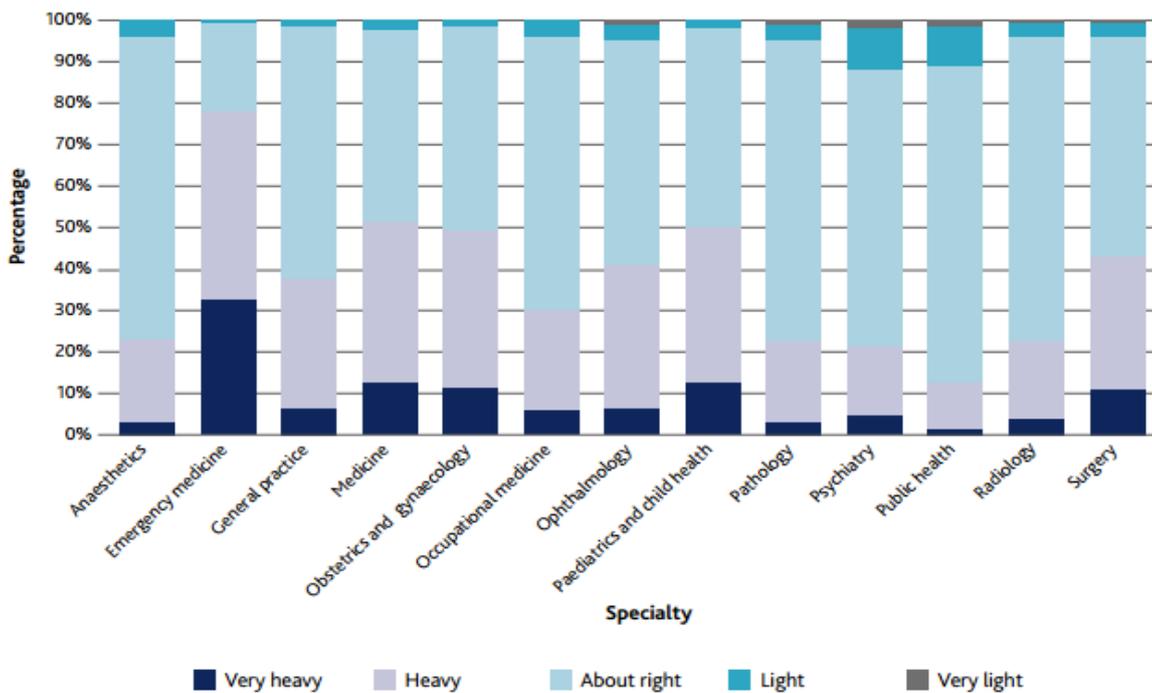
- ✓ From **April 2018**, we will invest in a **leadership/personal development training programme for every emergency medicine trainee** in England to help reduce attrition and improve the support for trainees in this intense and pressurised specialty. The offer of training support will increase in breadth and intensity as people progress through their training to become consultants.
- ✓ Starting in **April 2018**, we will provide funding to and work with **a third of the trusts (45)** highlighted in the GMC training survey as having the biggest problems with their training environment, to develop and implement **clinical educator strategies**. These support all staff working in EDs by improving the training and working environment. Learning from this approach and good practice will be rapidly shared with other trusts. All trusts will be expected to consider clinical educator strategies as part of their overall emergency care workforce planning.
- ✓ From **August 2017** HEE is piloting less than full time (LTFT) training for all ST4 and above trainees in emergency medicine.
- ✓ Following a successful pilot, the GMC has approved **permanently incorporating run-through training** into the curriculum.

Challenges around training and development

48. Overall, doctors in training highly value the quality of the teaching they receive. However, there is also anecdotal evidence of high leaver rates in emergency medicine.

49. In 2016 more emergency medicine trainees reported their workload as ‘very heavy’ or ‘heavy’ than trainees in any other specialty (Figure 2)⁴ and trainees have also expressed concerns that rota gaps jeopardise their ability to train.

Figure 2: Workload by specialty (GMC training survey)



50. There will always be a small number of trainees who choose to leave before completing their training for a variety of reasons. However, ensuring that trainees have dedicated time to build the necessary clinical and leadership skills, and creating a flexible, inclusive and supportive training environment can help reduce this number significantly.

51. This section sets out a comprehensive plan to address these issues and significantly reduce attrition in medical training. Through additional investment in personal development support for every trainee in the country and clinical educator strategies in our most challenged systems, together with existing strategies to enable more flexibility in training, we will ensure the focus and resource necessary to have a meaningful and necessary impact on attrition.

⁴ http://www.gmc-uk.org/education/national_summary_reports.asp

Ensuring a supportive and effective training environment within emergency departments

52. EDs are important for the training at all stages of many junior clinical staff, including medics, nurses, ACPs, paramedics, physiotherapists, PAs and emergency physicians. The casemix is unrivalled for variety and complexity and the unselected nature of attendances supports the development of the breadth of clinical skills from history taking and diagnosis, to complex decision-making, including when not to treat and end-of-life care.
53. A culture that supports learning and challenge enhances patient safety, leads to fewer clinical incidents, improves morale and ensures that staff feel valued. Specialties that offer significant time with senior decision-makers tend to have higher levels of retention and staff satisfaction than those that do not.
54. We know that given the pressures faced in EDs this time and focus is often squeezed out. These problems are more acute in certain providers that do not have a teaching infrastructure, have a relatively small senior clinician base and have existing workforce gaps.
55. To address this, starting in April 2018, we will provide funding to and work with a third of the trusts (45) highlighted in the GMC training survey as having the biggest problems, to develop clinical educator strategies to support staff working in EDs. We expect our funding to be matched by the trusts. This will improve both training and the working environment as a whole and therefore reduce attrition. We based this proposal on a model of improved clinical educator support that ring-fenced a third to half of a consultant's time for this. The details of the clinical educator strategy will depend on a trust's individual circumstances and will be agreed on a case-by-case basis by postgraduate deans and NHS Improvement with oversight from the steering group for the implementation of this plan.
56. The clinical educator strategies will cover doctors, PAs and ACPs to ensure that training and development is inclusive and to facilitate closer team working. This will involve funding of specific clinician time for shop floor training and assessment against RCEM and other curricula. The programmes will be implemented in conjunction with the local universities and training providers.

57. This programme will be evaluated through feedback from trainees (medical, PAs and ACPs) and identified good practice rapidly rolled out to other trusts. All trusts will be expected to consider clinical educator strategies as part of their overall emergency care workforce planning.

Supporting trainees with additional personal development

58. Working in emergency medicine brings particular challenges and pressures that require well-developed leadership and resilience skills. Trainees have routinely fed back that they would value additional support in developing these skills.
59. Providing this support will help reduce attrition in the training workforce. It will also ultimately improve the working environment for future teams as these trainees become consultants and start to lead teams in EDs with a broader set of skills.
60. Therefore, RCEM and HEE are moving towards all junior trainees spending three to four days each year in leadership and personal development training from April 2018, and this will significantly increase this as doctors move through higher training. The details of the programme will be agreed by the steering group and confirmed early next year, ready for implementation from April 2018.
61. The programme will be delivered in conjunction with HEE and RCEM and employ a 'train the emergency medicine trainers' approach to ensure sustainability of the model. We will monitor the impact of this programme on training attrition from the start and share learning across the system.
62. HEE will accelerate its work on enhancing leadership training in medical education, with the leadership academy and the Faculty of Medical Leadership and Management. As with LTFT (see below), HEE will seek to start a pilot of this in emergency medicine in 2018.

Less than full time training

63. Increasingly trainees value flexibility in their training programmes to reflect their range of ambitions for their personal and working lives and to allow for more options in their careers.
64. Less than full time (LTFT) training has been offered for a number of years to individuals who met predefined criteria (eg those with an illness or caring responsibilities). Training can be at 50%, 60% or 80% of a full-time post and gives trainees the additional flexibility necessary for a positive work–life balance.
65. However, there is significant demand for LTFT from the wider trainee population. To help address the attrition and retention issues in emergency medicine training, **HEE is now piloting an offer of LTFT training for all trainees at ST4 and above.** The pilot commenced in August 2017 and will last for one year. Once complete it will be evaluated, including through feedback from all higher emergency medicine trainees and other officials with an interest in the pilot, to consider whether the pilot should be rolled out on a permanent basis.

Run-through training

66. Since 2014 HEE has been piloting the option of trainees having uninterrupted progress from ST1 to ST6, avoiding the need to reapply for a training post at the transition between ST3 and ST4.
67. This offer has been very well received and as a consequence we have decided to **permanently incorporate run-through training into the curriculum.** Run-through training was permanently approved by the GMC in July 2017.

Improving retention

Summary of recommendations

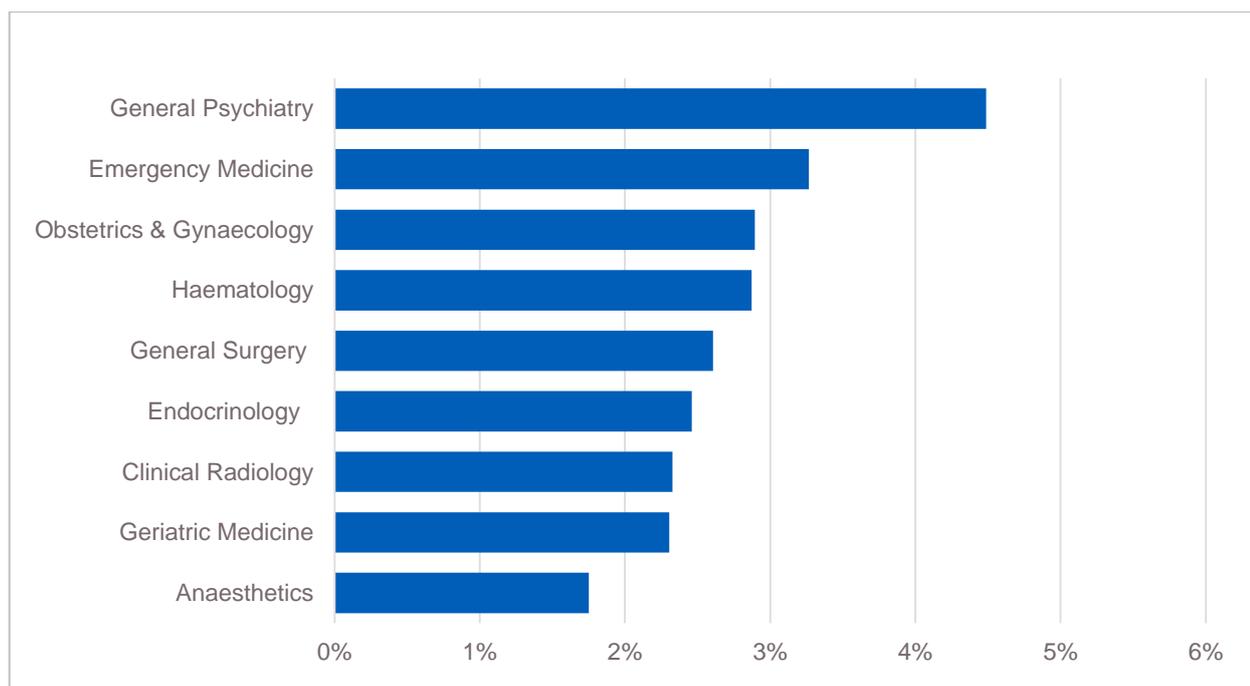
- ✓ Next year **20 trusts** with the most challenging recruitment and retention problems will be given **dedicated HR support** to develop bespoke plans to address them.
- ✓ RCEM will develop a **range of post CCT fellowships** in areas such as geriatric emergency medicine, ambulatory emergency care and humanitarian work. These will be supportive of and attractive to certain types of systems and also support thinking on new models of care in these areas.
- ✓ RCEM will publish a **clinical development fellows toolkit** to support the creation of such roles as a way to both broaden the workforce and improve the retention of staff in our EDs.
- ✓ RCEM and NHS Improvement will jointly publish a **best practice guide** that trusts will be expected to use to improve their recruitment and retention in EDs.
- ✓ RCEM and NHS Improvement will work together to jointly describe how we can better support emergency medicine consultants at different stages of their career – for example, consultants in the first three to five years after appointment, those aged over 55 as well as those nearing retirement age – to improve retention in these groups and share best practice widely across trusts.

The retention challenge

68. As important as building a sustainable workforce and reducing trainee attrition is retaining the existing dedicated and hard-working workforce. Staff who work in emergency care tell us that they are attracted to the specialty because of its fast pace, the regular and direct contact with large numbers of patients, and the variety and interesting nature of the work.

69. However, the reasons that staff are attracted to the specialty can also be the very reasons they want to leave. The fast paced nature of the work can lead to stress and burnout, and evidence suggests that we are at risk of significant numbers of staff leaving the service if we do not do more (Figure 3).

Figure 3: Consultant leavers under 55 as a % of staff in post



Source: Electronic Staff Record, 2016

70. There are some factors that it is hard for providers to control. However, focusing on those they can – such as work–life balance, career development and staff engagement – can make a real difference. By doing this one provider reduced vacancies in its ED from 65% to 14% in a year. Below we describe a number of initiatives that are underway, or in development, to support trusts to improve retention of all staff in EDs.

Dedicated support to providers with workforce problems

71. While the emergency care workforce across the country is facing problems, we know that these problems are particularly acute in certain areas; for example, those that just outside urban centres or geographically isolated. Organisations in these areas often need to take extra measures to ensure they have a sustainable workforce.

72. Over the next year **NHS Improvement will work with 20 organisations to provide dedicated HR support and additional funding to develop bespoke recruitment and retention plans for emergency care.** The proposals taken forward will be evaluated and tested and where good practice is identified, it will be rapidly shared across the system.
73. This dedicated support and funding will test initiatives including:
- enhancing CPD, training and research time for emergency care staff
 - enhancing study leave allowance for emergency care staff across different roles
 - providing dedicated support for young consultants
 - putting in place more options for staff aged over 55 and those nearing retirement, such as dedicated educator support, additional study leave, sabbaticals, less management time, pastoral or teaching role opportunities that help keep staff who otherwise may retire prematurely
 - funding for psychological support for staff working in emergency care who have experienced traumatic events, such as Schwartz rounds which provide a structured forum where all staff come together to discuss the emotional and social aspects of their work.

Improving health and wellbeing

74. Health and wellbeing of staff has been proven to have a significant impact on retention, outcomes and the cost of providing care. There is a clear link between employers who have good staff engagement strategies and plans, high levels of staff health and wellbeing and improved patient care. The NHS staff survey shows sector and provider staff engagement scores can vary significantly. Some organisations routinely examine their ED staff surveys and alongside their staff, build plans to address and improve health and wellbeing. NHS Employers has a [range of resources](http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing)⁵ to support providers to improve health and wellbeing of staff.

⁵ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing>

Post CCT fellowships

75. RCEM will work to develop a **range of post CCT fellowships** in areas such as geriatric emergency medicine, ambulatory emergency care, humanitarian work and others. These will be supportive of and attractive to certain types of systems and also support thinking on new models of care in these areas.

Clinical development fellows

76. Clinical development fellow posts have been developed in many systems in the UK as a way to retain staff who wish to gain further exposure to emergency medicine and continue working in frontline care delivery but also wish to reduce the amount of time they spend doing so. By allowing doctors to combine academic work and training with clinical care, these posts both retain this vital resource in EDs and benefit the ED through the academic and quality work they do. **RCEM will publish a toolkit of good practice for trusts in late 2017.**

Setting out expected best practice for providers to improve retention

77. Following the publication of this document, we will publish our guidance *Creating workforce stability in emergency care*. This guidance will share with the system expected good practice from providers who have managed to create workforce stability within a challenging context. It sets out what providers can do themselves and now to stabilise their workforce while we implement the plans outlined in this document. We will expect all trusts to carefully consider the measures outlined and how they can implement them including:
- **implementing annualised/self-rostered rotas** – these help to reduce burnout and create a better work–life balance by organising rotas around staff preferences as well as patient demand, and by building in leave, bank holidays and non-clinical time before allocations begin
 - **creating CESR schemes** – to support locums and other non-training grade staff in developing substantive careers in the NHS
 - **developing a broader pool of staff** – including ACPs, PAs and clinical development fellows.

Understanding consultants at different stages of their career

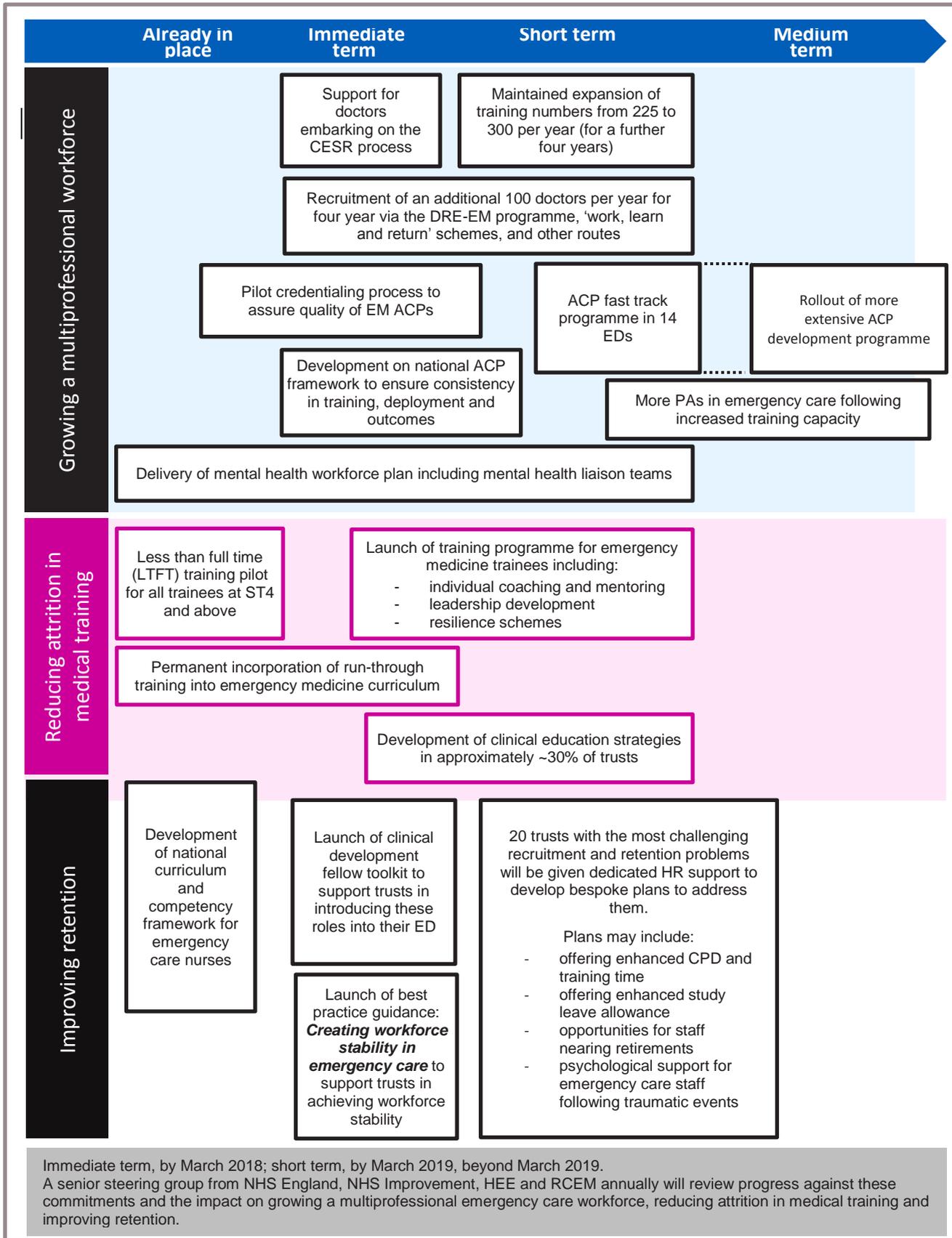
78. RCEM and NHS Improvement will work together to jointly describe how we can better support emergency medicine consultants at different stages of their career – for example, consultants in the first three to five years after appointment, new clinical directors, those aged over 55, as well as those nearing retirement age – to improve retention in these groups and share best practice widely across trusts to retain our highly skilled staff.

Next steps – making this happen and monitoring progress

79. This document sets out a significant programme of work on a vital agenda for the health and care system. We now need to develop detailed implementation plans to ensure its successful delivery, and to constantly review initiatives and the wider workforce environment to ensure that we continue to make progress towards a sustainable ED workforce.
80. To drive implementation and monitor progress we will establish a senior steering group, chaired by HEE and including representatives from NHS England, NHS Improvement, RCEM, Royal College of Nursing (RCN) and others, that will meet quarterly. This group will regularly review progress in delivery of the programme of work and monitor a series of indicators that show whether or not we are broadening the workforce, reducing attrition and increasing retention. Such indicators include:
- % fill rate of emergency medicine training places;
 - number of doctors training in emergency medicine
 - % vacancies reported by providers at consultant, middle grade and junior doctor levels
 - value of locum spend in EDs
 - number of CCT holders each year
 - number of emergency medicine consultants working in EDs
 - number of SAS doctors working in EDs
 - number of ACPs and PAs working in EDs
 - number of CCT holders emigrating abroad
 - annual satisfaction surveys of trained senior staff and those in training
 - GMC training data.

81. The steering group will seek dedicated feedback from trusts and staff, specifically on the impact of the commitments in this plan and will ensure related workforce areas, such as delivery of the mental health workforce plan, are considered when reviewing progress.
82. It will also commission and co-ordinate further supply and demand modelling when required to understand future training requirements for EDs.
83. The steering group will publish a short annual update of progress which will include changes in the above metrics.

Annex: Timeline of key initiatives



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