The Royal College of Emergency Medicine

Scotland's Emergency Medicine
WORKFORCE CENSUS 2021

Acknowledgements

July 2021

This report was written on behalf of the National Board of Scotland by Tamara Pinedo, Senior Policy Officer and Kelly Sarsfield, Policy Administrator.

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List of Abbreviations

ACCS	Acute Care Common Stem
ACP	Advanced Clinical Practitioner
ANP	Advanced Nurse Practitioner
CCT	Certificate of Completion of Training
CESR	Certificate of Eligibility for Specialist Registration
CT1-3	Core Training
DDC	Direct Clinical Care
ED	Emergency Department
EPA	Extra Programmed Activities
EM	Emergency Medicine
ENP	Emergency Nurse Practitioner
FY1-2	Foundation year
GP	General Practitioner
ICM	Intensive Care Medicine
LTFT	Less than full time
MIU	Minor Injury Units
PA	Programmed Activities
ST1-7	Specialty Training
UEC	Urgent and Emergency Care

Foreword

There is no National Health Service without doctors, clinicians, and nurses available to deliver care to patients. The Scottish Workforce Census, the first of its kind for the Royal College of Emergency Medicine, provides an in-depth examination of the state of our Emergency Medicine workforce.

Scotland's NHS has always been the envy of the United Kingdom. Our Emergency Departments have long outperformed the rest of the UK. However, we have – for some time now – warned that due to increasing demand and reducing capacity, this position is under threat. Before the pandemic, the last time Scottish Emergency Departments met the four-hour target was July 2017.

As Emergency Department Clinicians, we are proud to work in the only part of the health service that is open to all 24 hours a day, seven days a week. However, due to the nature of this work and increasing demand from our growing and ageing population, our specialty suffers from burnout more than any other speciality and we face significant challenges in recruiting and retaining Emergency Medicine clinicians.

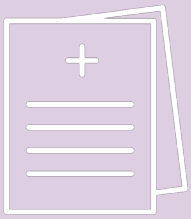
We entered the coronavirus pandemic without enough staff, and we must never allow this to happen ever again. To better understand some of the problems facing the Emergency Medicine workforce, we surveyed every major Emergency Department across the nation. This has given us an insight into much more than just the size of the workforce, but also how they operate and what the future holds. Any plans to transform the Urgent and Emergency Care system must take our findings into account.

I urge everyone – whether you are a member of the Scottish Government, civil servant, politician, or a senior leader in NHS Scotland, to read this important report and to act on the findings. Our data must be used to build a resilient Emergency Medicine workforce so we can ensure our Emergency Departments can provide safe and effective care for everyone in need.

Dr John Thomson

Vice President of the Royal College of Emergency Medicine (Scotland)
Emergency Medicine Consultant and Divisional Clinical Director at Aberdeen Royal Infirmary, NHS Grampian.

Summary of Findings



There are **252** EM CCT/CESR consultants working in Scotland, **43% of which are female and 57% are male.**

In total, they deliver 1737.25 DCC's per week which equates to **one WTE Consultant per 6444 attendances**, considerably less than the RCEM recommended figure of 1:4000.

The majority of consultants are aged between **35 and 44**.

The census revealed that there are currently **227 SAS doctors and 219 allied health professionals** working in Scotland.

There are **160 trainees** in the ST1-6 programme in Scotland, with **133 currently** working in the ED in October 2020.

As of October 2020, there were **18 unfilled funded consultant posts** and **16 unfilled career grade posts.**

Respondents reported that there are **33 planned consultants retirals** in the next 6 years as well as **12 career grade retirals.**

Consultants work on average one weekend every 5.5 weekends, while **junior doctors work weekends much more frequently**, with a ratio of one weekend worked every two weekends.

There are **five departments** where consultants do night shifts as part of their job plan.

Doctors in training do the most night shifts with an average of **48 per year.**

Most departments had to cover gaps in their rota at least or **more frequently than once a week**. Most departments answered that there have not been any changes in the amount of rota gaps in the last year.

The total number of night shifts covered by consultants as locums in the past year was **739**.

As of October 2020, there were **24 career grade locums** in post.

In Scotland there is a planned **expansion of 38 consultants** in the next two years.

When asked for immediate staffing needs to support the scheduling of unscheduled care, departments across Scotland reported needing an increase of **25% consultants**, **45%** increase in the **ACP/ ANP/PA workforce, 16%** increase in the **ENP workforce**, **22%** increase in the **Higher Specialist Trainees/Non -consultant Senior Decision Maker** and a **21%** increase in **Junior Doctors** in the next two years.

The ideal staffing numbers **by 2026** are as follows: **365 consultants** (an increase of 113); **120 ACP/ANP/PAs** (increase of 38); **172 ENPs** (a decrease of 10); **227 Higher Specialist Trainees/Non-consultant Senior Decision Makers** (74 increase); **340 Junior doctors** (an increase of 180).

Background

Although Scotland's Emergency Departments have historically outperformed the rest of the UK, due to high levels of demand and decreasing capacity and resources in Emergency Departments, performance has steadily declined over the past few years. The increasing numbers of presentations to Emergency Departments was recently acknowledged by the Scottish Government in 2020 in the Redesign of Urgent Care. The then Scottish Government committed to the long-term transformation of the Urgent and Emergency Care (UEC) system to ensure that patients receive the right care, at the right place, by the right healthcare professional. Our Scottish Workforce Census aims to inform this transformation by highlighting and evidencing the shortages in the Emergency Medicine workforce.

Since 2007, the national standard for EDs is that 95% of patients should wait no longer than four hours from arrival to admission, discharge, or transfer. The table below reveals the increasing levels of demand placed on Scottish EDs in recent years, which has been followed by deteriorating ED performance and a concerning number of patients experiencing the longest waits. The number of patients waiting 12 hours or more in an ED spiked in the winter before the pandemic.

Table 1: Performance Figures for Scotland's EDs

	Attendances to EDs	Percentage of patients admitted, transferred, or discharged within four hours	Number of patients waiting eight hours or more in ED	Number of patients waiting 12 hours or more in ED
2015/16	1,314,128	93.38%	7,152	973
2016/17	1,329,488	93.26%	6,885	1,029
2017/18	1,352,331	90.96%	13,361	2,841
2018/19	1,393,238	89.85%	13,192	2,366
2019/20	1,398,441	86.71%	24,974	6,853

Source: ISD Scotland (2021) A&E Activity and Waiting Times

ED crowding and corridor-care places a huge amount of pressure on staff, as EDs are not resourced or designed for this type of care. It also means that staff are less able to provide safe, timely and efficient care to those patients, and any subsequent patients who attend the department.

To better understand the nature of these challenges on our staff, the Royal College of Emergency Medicine carried out the Scottish Workforce Census on behalf of the National Board for Scotland. This census is the first of its kind for the College and it seeks to understand staffing numbers and the true extent of the workforce pressures present in emergency departments across the country. In doing so, the College can influence effectively with the knowledge of exactly which provisions must be made to secure a robust and sufficient workforce for the future.

Anecdotally, we have known for some time that the experience of staff on the ground is one of strain. Even though staffing numbers have increased over the years, they have still not kept up with the pace of the consistent rise in demand on EDs which can largely be explained by a growing and ageing population.

Scotland has a lot of remote and rural areas, posing a number of geographical challenges to the UEC system that are not typically experienced by the rest of the UK. Most of the population live in the 'central belt' of Scotland and while population growth has remained relatively stable over time, Scotland's population is ageing.

The National Records of Scotland projects that by 2043, 23% of the population will be of pensionable age, compared to 19% in 2018. In the last few years, life expectancy remained unchanged and healthy life expectancy has actually decreased in Scotland.[1] The Scottish Health Survey in 2019 revealed that 35% of adults reported having a long-term health condition.[2]

These demographic and population health pressures result in patients presenting to our Emergency Departments with multiple and complex needs. These challenges must be taken into consideration in any plans to transform the UEC system, especially with regard to planning for the future Emergency Medicine workforce.

1 https://www.nrscotland.gov.uk/files//statistics/healthy-life-expectancy/17-19/healthy-life-expectancy-17-19-info.pdf

2 https://scotland.shinyapps.io/sg-scottish-health-survey/

Methodology

The census was created using SurveyMonkey and consisted of 64 questions. However, this varied depending on each participant's personal questioning route. In November 2020, a PDF version of the census was then sent out to all ED Clinical Leads ahead of the census going live. This was to ensure that respondents had acquired and collated the necessary information and data to complete the census and to encourage accurate answers rather than estimations. Respondents were asked to complete the survey as per their departments staffing position on 1st October 2020.

Clinical leads were sent an initial email, attached with the PDF, explaining the purpose of the census and what the information would be used for. After two weeks another email was sent out to the leads with a hyperlink to the live census. Over the following two months, reminder emails were sent on a regular basis to encourage participation.

We received responses from 24 EDs in total, including all 20 of consultant-led EDs, one MIU, and three Remote and Rural Hospitals. 20 of these received attendances from all types of patients, two were adult only, and two were children only.

Consultant Workforce

Headcount

Our census revealed that there are 252 EM CCT/CESR consultants working in Scotland, including 48 Paediatric Subspecialty CCT holders. This equates to an average of one consultant for every 5549 ED attendances, based on the ISD Scotland 2019/20 attendance figures. RCEM recommends that recruitment of Emergency Medicine consultants should be based on one consultant for every 4000 ED attendances. When analysing the responses to the census, it was clear that there was substantial variation in the consultant:attendance ratio between departments. For example, the minimum ratio was one to 3000 while the maximum ratio revealed that there was one for every 13,685 attendances.

However, this may not be an accurate depiction of consultant workforce as consultant job plans vary greatly. In general, these job plans consist of 10 programmed activities (PAs) per week, with each PA equating to four hours of work. A proportion of PAs are dedicated to direct clinical care (DCC) which refers to "work directly relating to the prevention, diagnosis or treatment of illness".[3] This is primarily undertaken when a consultant is working on the shop floor or on call. Following guidelines set out by the Academy of Medical Royal Colleges and Faculties in Scotland, a whole-time equivalent (WTE) consultant delivers around eight DCCs per week which is equal to 32 hours of work.

Therefore, in order to obtain a more accurate depiction of the whole-time equivalent EM consultant headcount in Scotland, we collected the number of Direct Clinical Care programmed activities (DCCs) delivered per week by consultants, which came to a total of 1737.25 DCCs. To calculate the number of whole-time equivalent consultants we then divided this number by eight, which came to 217. Using this figure, a more precise consultant to attendance ratio would be 1:6444. Thus, our initial ratio perhaps does not represent the true reality of our workforce numbers and the current strain on staff.

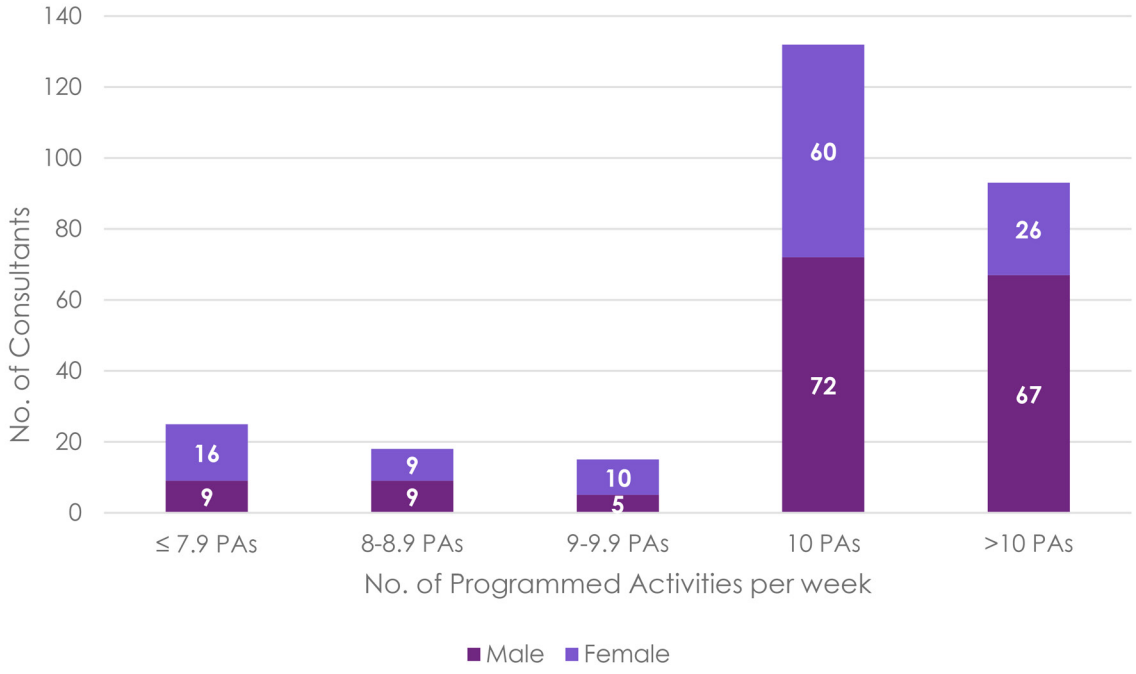
3 The Consultant Contract and Job Planning for Emergency Medicine Consultants, BMA

Gender

The 253 consultants in Scotland are composed of 144 males and 109 females. While this does not appear to be a significant gap, it nonetheless represents that there is a gender disparity in leadership roles within EM, as males make up 57% of the EM consultant workforce compared to 43% of females.

Further gender disparities can be found when examining the gender distribution of Programmed Activities. For the whole-time Equivalent of 10 PAs, which is the most common type of working pattern, we see that the distribution of males and females is in line with the difference in the total figures. In contrast, the distribution of those working more than 10 PAs and less than 10 PAs is skewed. As the graph below shows, 72% of those delivering more than 10 PAs are men. Furthermore, there is a disproportionate number of female consultants working fewer than 7.9 PAs per week compared to their male counterparts. The disparity in participation rate when analysed through the lens of gender can most likely be explained by caring responsibilities that are generally undertaken by women. Given the changing landscape of EM and the increase of women in the workforce, this trend is likely to continue to grow. More widely, there is a growing desire for flexible working to maintain a sustainable work-life balance.

Figure 1. Gender Distribution of Programmed Activities



Age

The majority of consultants (54%) in Scotland fall between the age range of 35-44, with very few (1.6%) still working past the age of 60. The concentration of consultants within the age ranges of 35-50 reflect the increase in training places and workforce expansion in recent years. While this does not pose an issue now, it is common practice for staff to change their shift patterns from the age of 55. This involves working fewer unsociable hours and therefore, in the coming years, we may begin to see an increase in rota gaps as the bulk of the workforce reach this age.

Another implication of this is that a workforce divide could develop wherein those under 55 bear the brunt of working unsociable hours. It is integral that whole-time equivalent training places account for this to ensure that all shifts are sufficiently covered. Therefore, the training programme will need to evolve to align with the changing demographics of the workforce, all of which must be considered a minimum of six years ahead in line with the training cycle.

Table 2. Age Distribution of EM CCT-Holding Consultants

Age	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Number	21	65	71	45	30	16	4	0	0
Percentage	8.3%	25.8%	28.2%	17.9%	11.9%	6.3%	1.6%	0%	0%

Daily Departmental Presence of EM CCT holding Consultants

On weekdays, the minimum hours of consultant presence that a department reported was 10 hours. In contrast, the maximum number was 19 which came from a large major department; this department also had the largest number of consultants in Scotland.

For weekends, the minimum consultant presence was 0 hours. This was the same department that had the minimum weekday consultant presence and was also the only CCT-holding department that reported having no consultant presence on weekends.

Similarly, the maximum weekend consultant presence was 19 and came from the department with the largest weekday consultant presence.

Pressures on EDs and emergency care systems in terms of demand, complexity of casemix and the challenges that exist in terms of crowding, exit block and patient flow mandate the presence of a Senior Decision Maker. Best practice recommended by RCEM suggests that there should be EM consultant presence for at least 16 hours a day (08:00–00:00) in all medium and large systems.[4]

Table.3 Average Consultant Presence in Major Departments

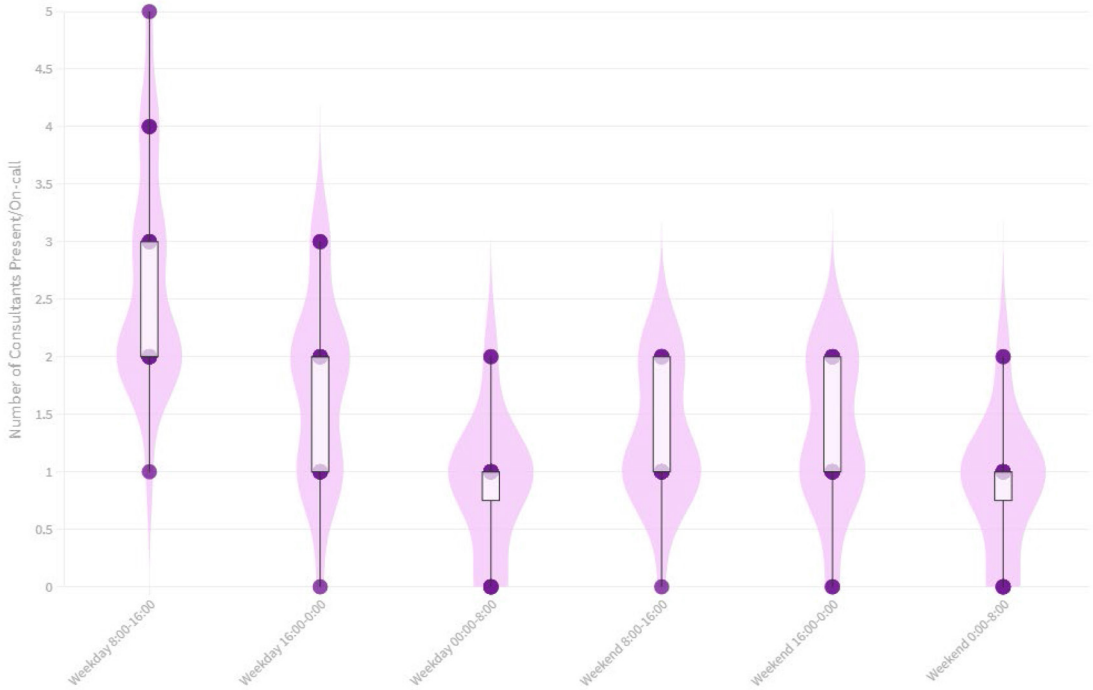
	Average	Standard Deviation
Weekday (hours)	15.2	2.8
Weekend (hours	12.4	4.8

4 https://www.rcem.ac.uk/docs/Workforce/RCEM_Consultant_Workforce_Document_(revised_Feb_2019).pdf

Presence on the Shop Floor and On Call

We asked departments about their consultant shop floor and on call presence throughout the day on both weekdays and weekends. The graph below demonstrates the variability and range in responses. The dots signify departments' responses with the bulges around dots illustrating multiple departments having responded with the same answer. We found that consultant presence was most concentrated between 08:00 – 16:00 on weekdays. The least amount of consultant presence falls between 00:00 to 08:00 on both weekdays and weekends. There are a few small departments that have no EM CCT-holding consultant availability overnight, although this is mitigated by other models of care.

Figure 2. Number of Consultants Present on the Shop Floor/On Call on Weekdays and Weekends



Non-EM CCT-holding Consultant Workforce

There are 21 non-EM CCT-holding consultants working in Scotland in some of the non-major Emergency Departments. All 12 paediatric consultants work in paediatric emergency departments, while the eight consultants that work across general medicine and general surgery are from a remote and rural hospital. Although classified as an Emergency Department, remote and rural hospitals do not employ EM consultants full-time and are therefore more likely to be staffed by consultants from other specialties.

Table 4. Non-Emergency Medicine Consultant Specialties Working in Scotland's EDs

Paediatrics	12
Orthopaedics	0
General Medicine	4
General Surgery	4
Anaesthetics/ICM	0
Other	1

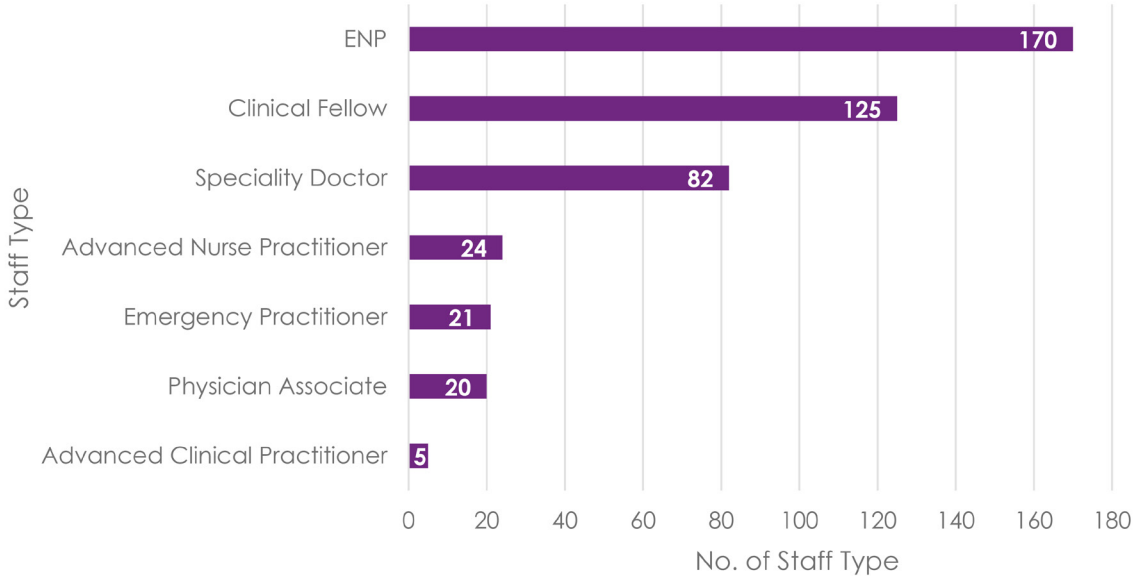
Table 5. Non-EM Consultant Workforce in Scotland's EDs

Male	14
Female	7
Total	21

Specialty and Associate Specialist (SAS) Doctors and Allied Health Professionals

There are 227 Specialty and Associate Specialist doctors and 219 Allied Health Professionals. The Emergency Nurse Practitioner (ENP) workforce is the most significant out of the Allied Health Professional staff groups, as this is a role that has been well-established in EM in Scotland. Although the current Advanced Clinical Practitioner and Advanced Nurse Practitioner (ACP) workforces are currently quite small, these roles are expanding. As delineated in the Trainee section below, both of these workforces will be doubled in the coming years. In addition to these figures, there are two EM CCT holders not working as consultants, instead working in non-consultant roles as Rural Emergency Physicians at a remote and rural hospital.

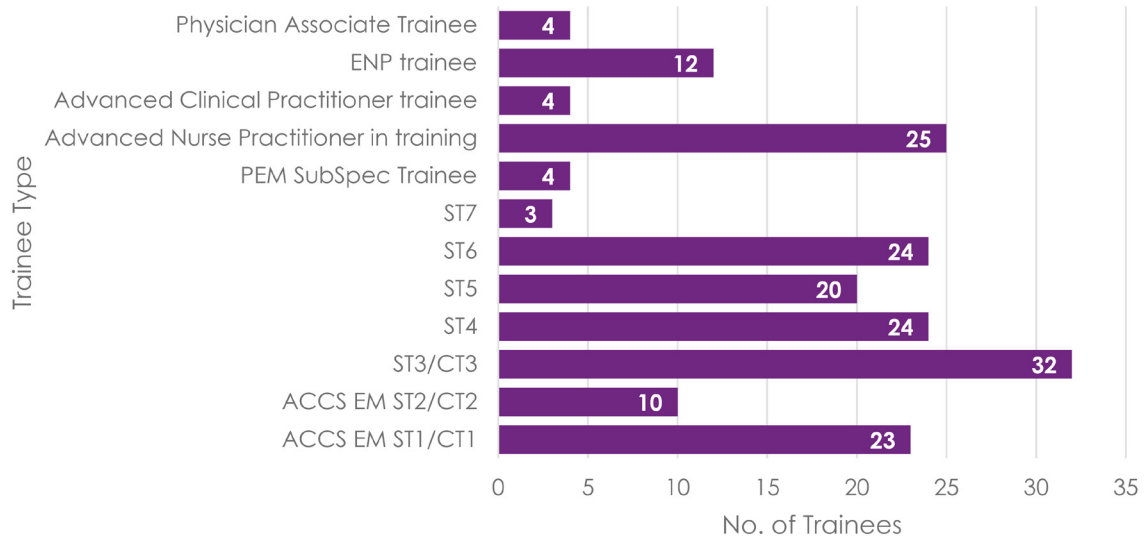
Figure 3. Total Number of Each Career Grade Type across Scotland



Trainees in Scotland

Overall, there were 185 trainees working in Emergency Departments in Scotland as of October 2020. These are divided into the various trainee sub-categories, including EM specialty trainee grades, Advanced Nurse and Clinical Practitioners trainees, and ENP trainees. According to our census, there were 133 trainees working in the ED on the ST1-ST6 trainee programme, which is the most common route taken to become an EM consultant. The figures below show that the intake of trainees each year is fairly consistent, with the anomaly of 10 ST2 trainees. This is due to the majority of trainees in this year working outside of the ED, gaining allied specialty competencies.

Figure 4. Number of EM Trainees Working in EDs in Scotland



We conducted an additional survey regarding EM ST1-6 trainees which revealed that there are currently 160 trainees in total in the training programme, both working in and out of the ED. Amongst these, 28 trainees are working less than full time (LTFT), highlighting that while flexible working is becoming more common, it is still within the minority (around 17.5%). When taking this into consideration, there are 150.5 WTE trainees. Moreover, there are currently nine trainees temporarily out of the programme due to training, research, or other experiences.

It is important to note that not all trainees will complete the programme; there is a drop-out rate of around 25%, meaning that out of the current ST1-ST6 trainee cohort of 160, we estimate that only a headcount of 120 trainees will complete the programme and become qualified as an EM consultant, or 113 whole-time equivalent consultants.

Non-EM trainees in Scotland

At the time of responding, there were 206 non-EM trainees working in EDs across Scotland. At any one point in time, there are doctors in training from other specialties working in the ED gaining competencies and experience, and these contribute to the workforce as detailed below. Whilst these figures can change frequently, the significance of this number is that these doctors need consultant supervision, both from a clinical and training standpoint.

Table 6. Number of Non-EM Trainees Working in EDs in Scotland

FY1	3
FY2	92
CT/ST1	66
CT/ST2	42
CT/ST3	1
>ST3	2

Workforce Gaps

Unfilled Posts

There are 18 unfilled funded EM consultant posts in Scotland with a mix of both short and long-term reasons, maternity leave being the most common. The pandemic has certainly affected the number of unfilled posts, with responders reporting that consultants have been unable to move and therefore work due to Covid restrictions. There are also a number of long-term sickness leaves which can result in gaps in the workforce for an undetermined length of time. While several of the reasons given below are temporary, long-term consequences may still arise. For example, those returning from maternity leave are likely to drop down to working less than full time. Therefore, gaps in rotas will still remain an issue. Furthermore, reasons such as unsuccessful recruitment, retirals and those leaving the specialty have resulted in more permanent gaps in the EM consultant workforce.

Table 7. Reasons for Unfilled Posts

Reasons for unfilled post	Number of responses
Maternity Leave	5
Long Term Sickness	4
Pandemic	1
Recruitment Issues	3
Retirals	3
Left the specialty	1
Other	1
Total	18

There are 16 unfilled Career Grade posts, comprising of mostly gaps in the Emergency Practitioner workforce. Career Grade doctors typically fill a senior decision maker role, so gaps in this workforce show that departments are facing a lack of senior decision makers.

Table 8. Number of Unfilled Career Grade Posts

Associate Specialist	1
Staff Grade	4
Emergency Practitioner	11
Total	16

Retirals

There are 33 planned retirals expected in the next six years amongst the EM consultant workforce. Expected growth in demand over the next six years needs to be considered when calculating the workforce needed to replace this group.

Additionally, there are 12 planned retirals in career grade staff. In total this means 45 planned retirals among senior decision makers in the EM workforce in the next six years. There is no predictable succession pathway for career grade staff, and so no guarantee that this staff group will continue to consistently replenish itself. Therefore, in the instance that career grade numbers decrease, there must be a sufficient number of CCT holders to ensure that there is adequate seniority and experience within the department.

Table 9. Expected Retirals amongst Career Grade Staff

CCT/CESR Holder Non-Consultant	2
Associate Specialist	5
Staff Grade	2
Emergency Practitioner	3
Total	12

We collated whether departments had agreed guidance for a change in on call or working pattern as a consultant approaches retirement. Out of the departments with EM CCT holders, only three said yes, while 18 said no. Those that did have agreed guidance all stated a policy whereby those aged 55 and over have the option to stop working night shifts and on call. One department commented further and said that there was an option for consultants approaching retirement to change the distribution of weekends that they worked, for example working more early shifts than late shifts, however, all of these policies were reached by local informal agreement.

There should be agreed guidance in every department to ensure the sustainability of consultant careers in EM. RCEM recommends a discontinuation of late shifts, night shifts and on-calls from age 55.

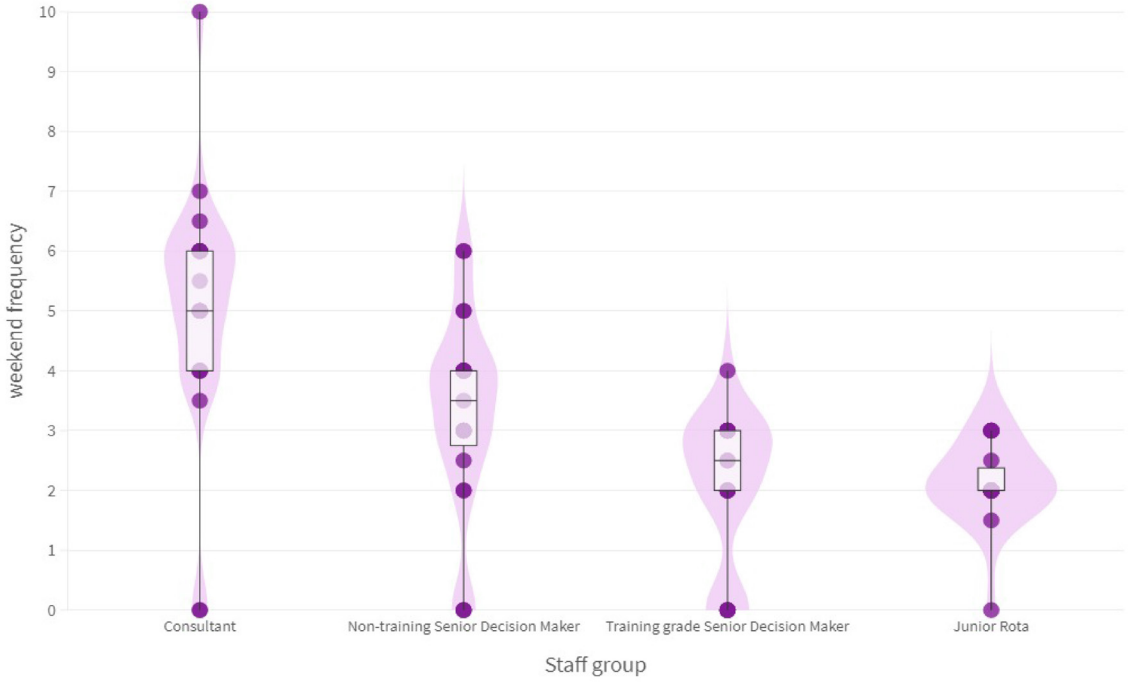
Rotas

Weekend Frequency

The frequency that staff work on weekends varies greatly between staff groups. EM consultants work an average weekend frequency of one in every five and a half weekends (1:5.5), ranging from the least frequent, less than one in every 10 weekends (<1:10), to the most frequent, one in every three and a half (1:3.5). However, as the graph shows <1:10 is an outlier and there are a small number of departments which have no consultants working on weekends.

All other staff groups work weekends more frequently: Non-Training Senior Decision Makers and Training Grade Senior Decision Makers work an average weekend frequency of one in every 3.8 (1:3.8) and 3.6 (1:3.6) weekends respectively, and Junior Rotas an average of one in every two weekends (1:2). This shows that Junior Rotas work more than double the weekend frequency compared to the Consultant workforce. There is also considerably less variation in the frequency of weekends worked by less senior staff groups.

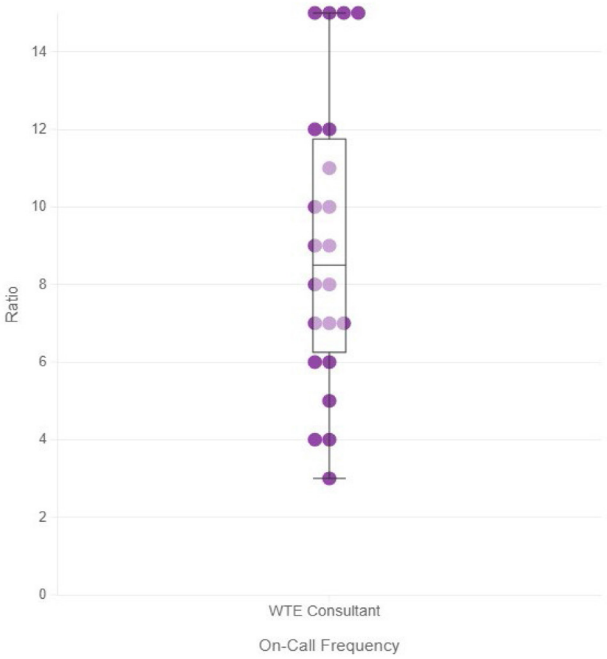
Figure 5. Weekend Frequency of Each Staff Group



On Call Frequency

The average on-call frequency from all respondents for EM consultants in Scotland is one in every eight and half days (1:8.5). This average changes slightly to one in every nine days (1:9) when analysing just the major departments. However, there is significant variation in this as frequencies ranged from a minimum of less than one in every 12 days (<1:12) to a maximum of one in every three days (1:3). As the box plot graph below shows, the most common response was less frequent than one in every 12 days (<1:12), with four departments reporting this. Yet, as the distribution of the dots in the graph highlight, there is no agreed upon on-call frequency for EM consultants.

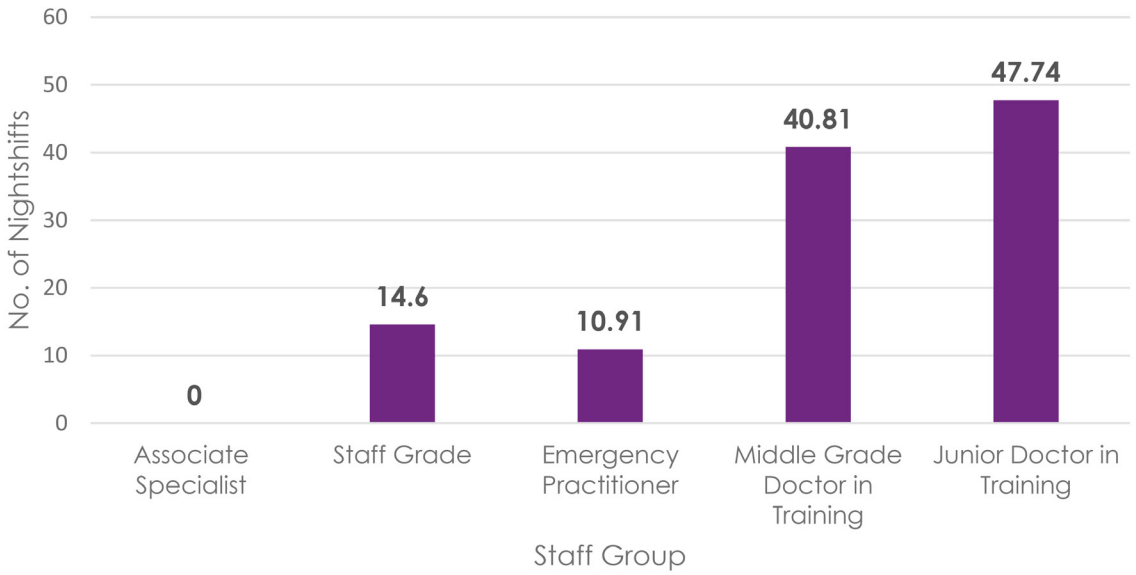
Figure 6. On Call Frequency of Whole Time Equivalent Consultants



Night Shift

The total number of night shifts delivered by consultants per year across Scotland as per their job plan was 1305. Yet this was only distributed across five departments and ranged from 27 to 418 night shifts delivered in any one department per year. Of these five departments, the number of night shifts expected to be carried out by a consultant per year ranged from 12 to 25. The graph below delineates the average number of night shifts expected to be carried out by the other various staff groups in the ED per year, with Junior Doctors in training working night shifts the most frequently, on average.

Figure 7. Average Number of Night Shifts Expected to be Carried Out by Staff Groups in a Year



Consultant Remuneration for Night Shifts

For the departments where consultants deliver night shifts, there was no agreed, consistent consultant remuneration for working these shifts in Scotland. Three departments responded that consultants are remunerated such that one PA is the equivalent of two hours of work while another three departments responded that their remuneration was three hours of work. Normally outside of the hours of 8am to 8pm the consultant contract will pay sessions as premium time such that each session equates to three hours of work. Additionally, one person said an alternative agreement has been made. Finally, one department reported that they currently give two hours remuneration for night shifts, but this is currently being disputed by the Board. As a result, consultants will likely stop providing shop floor cover beyond midnight. As that respondent demonstrates, by not having an agreed collective policy on this matter, challenges can arise which can have detrimental consequences for the night shift rota.

RCEM recommends that consultants should be remunerated two hours per PA from 00:00-08:00. This is currently the norm in England and while it is not yet common for consultants to deliver night shifts in Scotland, it is becoming increasingly more so. In order for this working pattern to be sustainable and not have a detrimental consequence such as burnout and decreased staffing levels it is important that night shifts are acknowledged to be very different from evening shifts in their remuneration.

Rota Gaps

The total number of rota gaps among all staff groups was 67 across Scotland. The largest consultant rota gap in a single department was four. For the Middle Grade group this was 6 and more significantly for the Junior group, a single department reported having 15 gaps which accounts for more than half of all Junior gaps in Scotland.

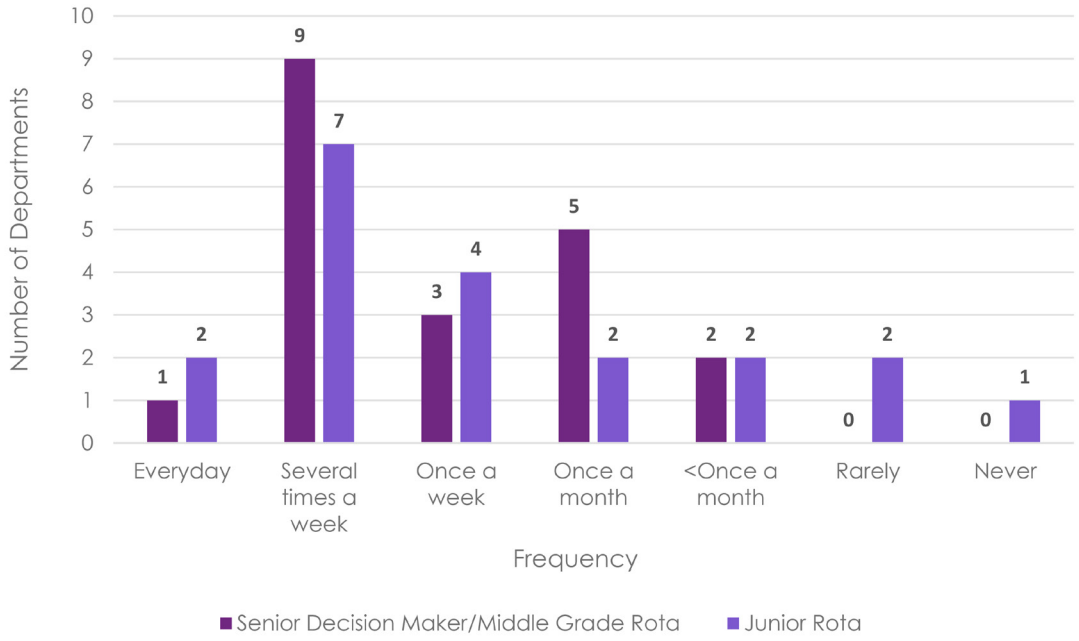
Among the Middle Grade and junior staff groups, rota gaps often occur due to sick leave and the unpredictable numbers of doctors rotating in and out of the specialty. This is dependent on other specialties' recruitment and how this then impacts their training rotations. Underfill of these rotations is usually outside of the ED's control, frequently becomes apparent at the last minute and there is often a shortage of similar grade doctors to backfill those gaps.

Table 10. Number of Rota Gaps

Consultants	16
Middle Grade	23
Junior	28

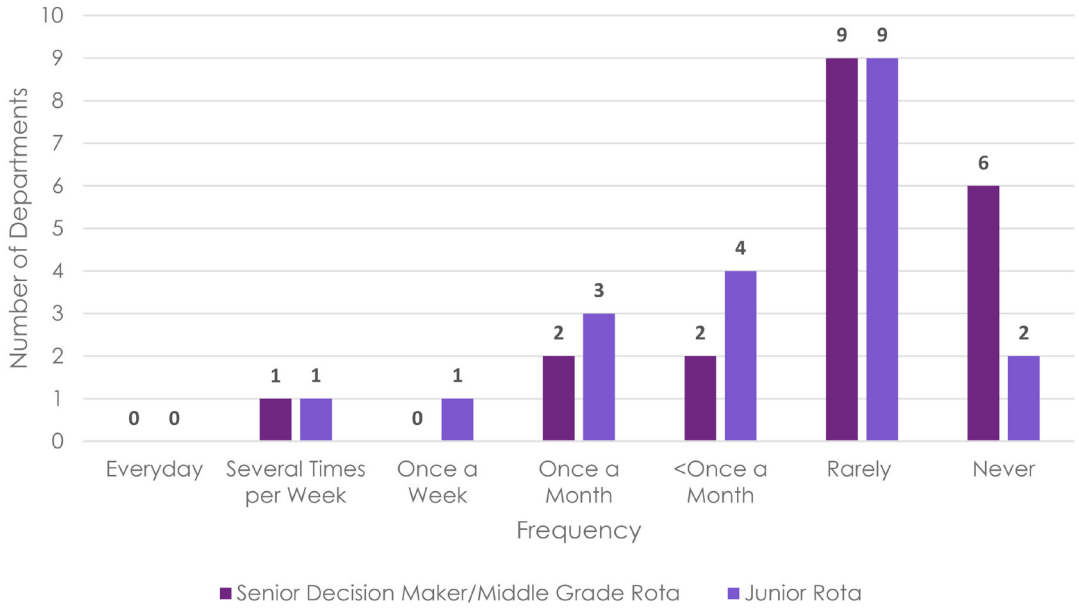
We asked departments how frequently rota gaps were covered in the last year. The most common answer for both Senior Decision Maker/Middle Grade and Junior Rotas was 'several times a week.' A total of 13 departments reported covering gaps in either Senior Decision Maker/Middle Grade or Junior Rotas at least once a week. This frequency represents the extent of staff shortages. Amongst the Senior Decision Maker/Middle Grade rotas, these figures also highlight the effect of the considerable Career Grade unfilled posts, delineated previously.

Figure 8. Frequency of Rota Gaps Covered in the Last Year.



In contrast, the graph below demonstrates how often overnight or weekend gaps are left without cover. While the census revealed that there are frequently rota gaps, these gaps are predominantly 'rarely' or 'never' left uncovered. Moreover, almost double the number of departments responded facing gaps between 'less than once a month' to 'several times per week' in Junior Rotas compared to Senior Decision Maker/Middle Grade Rotas.

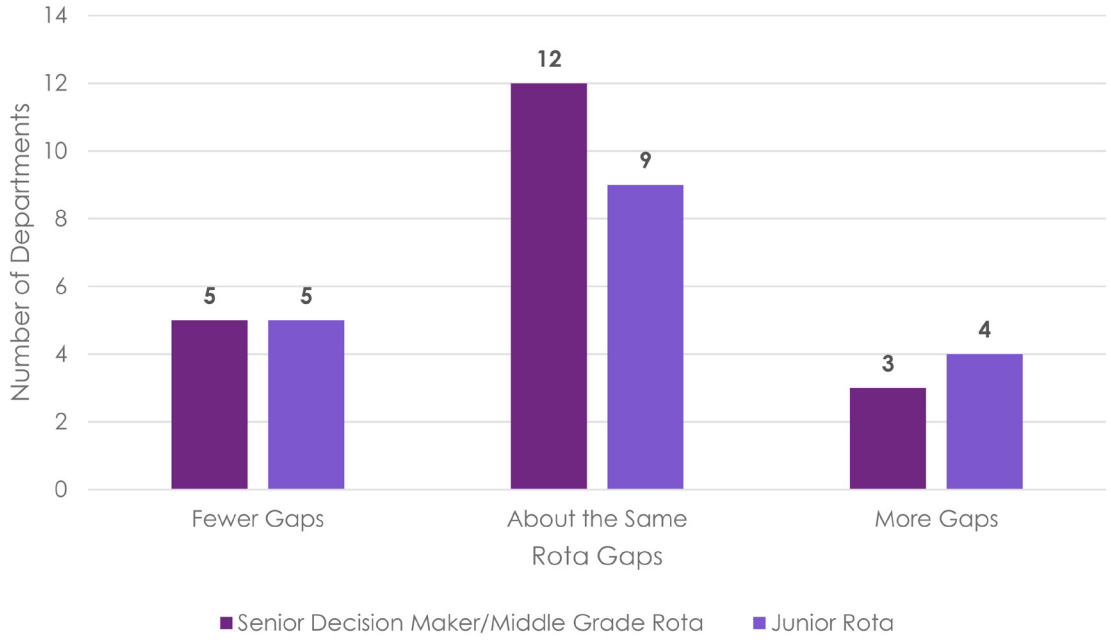
Figure 9. Frequency of Overnight or Weekend Gaps Left Uncovered



The graph below shows whether there has been any change in rota gaps in the last 12 months. The majority of departments answered that their rota gaps were 'about the same'.

Although, this could be interpreted as a positive that most departments did not report having more rota gaps, it is important to note that workforce gaps have been a consistent issue in Emergency Medicine and the use of locums has become commonplace. Therefore, the prevailing response showing there has been little change in rota gaps illustrates the continued strain the workforce has been under.

Figure 10. Change in Rota Gaps over the Past Year



Pensions

We asked departments whether consultants in their ED had reduced their Programmed Activities due to pension consideration/penalties. Nine departments answered yes, 11 responded that this was not the case, while one department said, 'I don't know'. Explanations given were that colleagues had dropped an EPA (Extra Programmed Activities) and some staff were "unwilling to take on extra [shifts] to cover rota gaps".

Following this we collated the number of major departments across Scotland where consultants had declined locum work due to pension considerations/penalties. 13 or 65% of EDs confirmed that consultants had declined locum work for this reason. Additionally, three said no, and four responded 'I don't know'.

Locums

The total number of night shifts covered by consultants as locums in Scotland in the last year was 739; however, two departments accounted for a considerable proportion of this number, with 300 and 340 night shifts respectively. Half of all major departments (10) reported that no night shifts were covered by consultants as locums while the remaining departments ranged from seven to 20 night shifts covered by consultant locums. These figures demonstrate the vast disparities across departments and, in some cases, a lack of Middle Grade/Senior Decision Maker workforce. Additionally, locums are employed across parts of the EM workforce as of October 2020 there were 24 Career Grade locums in post.

When asked why locums were being used to fill permanent posts, inability to recruit was a key theme. Reasons given for this ranged from budgetary issues to a lack of effort from management teams and having no applicants with appropriate experience or no applicants at all. A result of this was that funding from unfilled consultant posts was being used to employ locums. Career breaks and time given to allow for the completion of CESR were additional reasons given. Moreover, one department noted that a current locum is expected to be eligible to appointment in a full-time post in due course.

We then asked departments which type of locums were being used to cover gaps in Senior Decision Maker and Middle Grade overnight and weekend rotas. All major departments stated that they utilise at least one type of locum. Furthermore, nine departments had used all three. Both external locums and consultant locums covering a more junior gap are costly options for the ED, as both of these roles come at a higher rate. Therefore, this use of locums represents an excess cost which would be saved if there were no rota gaps.

Table 11. Type of Locum Covering Gaps in Senior Decision Maker and Middle Grade Overnight and Weekend Rotas.

Type of Locum	Number of departments
Internal Locum	18
External Locum	14
Consultant Locum (covering more junior rota gap)	10

Looking to the Future

Throughout the report we have touched upon the workforce shortages across Emergency Departments in Scotland. We must forecast now for future needs to ensure that workforce provisions are in place to meet growing demand. We enquired about short and long-term plans and needs to expand staffing numbers in the ED.

Short Term: Planned

Over the next two years, there is a planned expansion of 38 additional EM consultants, however, 10 departments did not report plans to expand. Of those that did plan to expand their EM consultant workforce, the maximum expansion in a single department was six. Two of the planned EM consultant posts are for a remote and rural hospital, demonstrating that there is a potential growing need for EM consultant staff in non-major Emergency Departments.

Two departments - a remote and rural and a children's hospital - outlined plans to increase their non-EM consultant presence by 14 PAs each over the next two years. No departments without any CCT/CESR EM consultants planned to employ any in the next two years.

Short Term: Aspirational

The Redesign of Urgent Care is underway in Scotland and will inevitably need to be factored in when mapping future staffing needs. We collated what that would look like for departments and asked whether they perceived any immediate need (within the next two years) for an increase in ED medical staffing to support this development. The table below delineates the total increase of staff groups across all EDs in Scotland. Departments estimated that they would need 64 additional consultants to successfully support the current developments in scheduling unscheduled care in Scotland. This represents a 25% increase on the current consultant workforce. Unfortunately, when analysing the trainees currently expected to gain their CCT and be eligible to take up a consultant role in the next two years, this number significantly falls short of 64.

Notably, the figures below demonstrate the considerable increase (45%) in the ACP/ANP/PA workforce, that respondents felt was required to successfully support the development of scheduling unscheduled care. In contrast, the responses from EDs show that a 16% increase in the ENP workforce would be necessary. This smaller growth reflects a trend wherein, when planning for future workforce needs, the ENP workforce is increasingly playing a less significant role.

Table 12. Increase Needed in each Staff Group over the Next Two Years to Support Scheduling Unscheduled Care

Staff Group	Current	Increase
Consultant	252	64
Higher Specialist Trainee/Non-Consultant Senior Decision Maker	153	34
Junior Doctor (Non-senior decision maker grade)	160	34
ACP/ANP/PA	82	37
ENP	182	29

Long Term

Looking further to the future, we asked departments to share their ideal staffing numbers for each staff group by the year 2026. Across all departments, the total number of ACP, ANP, and PA staff needed to achieve ideal staffing levels by 2026 was 120. This is a stark contrast to current numbers for this staff group which stand at 49. As mentioned previously, these are growing staff groups in the EM workforce, and this is reflected in the aspirational projections. In contrast, as the EM workforce landscape changes, we expect the ENP workforce to slightly decrease, as highlighted by the reduction in ideal staffing by 2026.

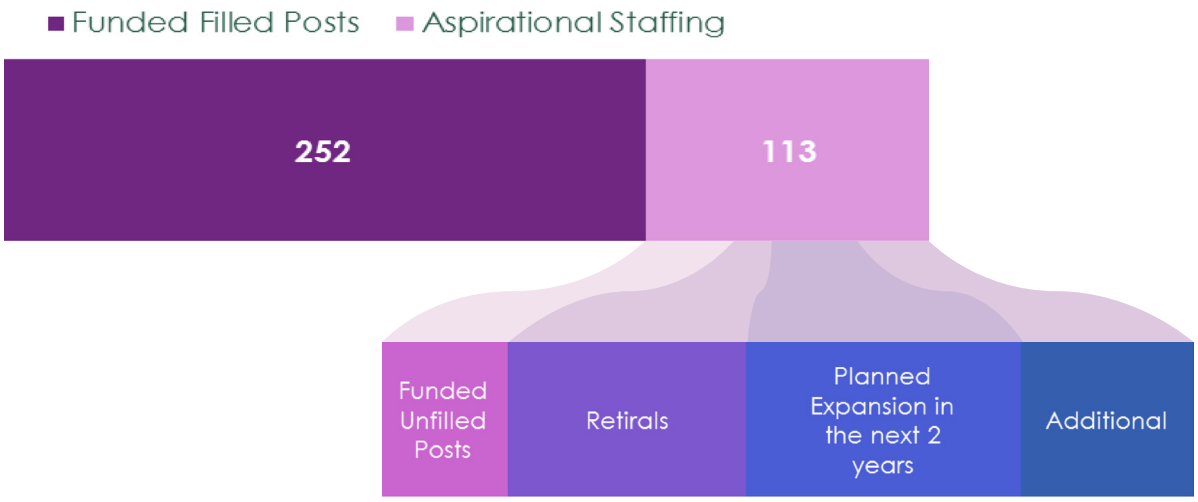
While the aspirational, increase in the non-consultant Senior Decision Maker is not as sizeable as the consultant or Junior Doctor gap, it represents a more complex issue in that this is a role regularly being covered by locums, and in many cases, by consultant locums covering a more junior gap as there is a real lack of suitable individuals to fill these roles. Moving forward, fulfilling this aspiration gap will certainly be a challenge as the career pathway is not as straightforward or easy to forecast as the consultant workforce. Attention must paid to this crucial staff group to ensure that departments are staffed safely.

Table 13. Ideal staffing in EDs by 2026

Staff Group	Ideal Total	Increase from current
Consultant	365	113
Higher Specialist Trainee/Non-Consultant Senior Decision Maker	227	74
Junior Doctor (Non-senior decision maker grade)	340	180
ACP/ANP/PA	120	38
ENP	172	-10

The aspirational total number of consultants was 365 by 2026, a 45% increase compared to the current consultant headcount of 252 - or 113 additional consultants. The diagram below goes into further detail about how the additional 113 WTE consultants might be used given the current landscape.

Figure 11. Breakdown of Ideal Staffing Figures by 2026



As discussed previously in the report, there are currently 18 unfilled funded EM consultant posts, 33 retirals expected by the year 2026, and a planned expansion of 38 EM consultants in the next two years.

If the aspirational additional staffing number of 113 were to be realised it would account for these figures, and there would still need to be an expansion of 74 EM consultants to reach ideal staffing numbers.

If we compare this figure to the120 trainees expected to gain their CCT and be eligible to take up a consultant role, it is clear that despite recent expansion plans in training places, at this rate there will be just enough consultants to reach aspirational consultant staffing figures by 2026. It is important to note that this figure only represents the headcount rather than whole-time equivalent, and it also does not account for demand growth which will further stretch the projected numbers.
While the increase in demand growth has not been consistent over the years, there has been an average of 1% growth year on year. Consequently, we can expect yearly attendances to have reached 1,484,500 by 2026. As mentioned earlier in the report, RCEM recommends that recruitment of Emergency Medicine consultants should be based on one consultant for every 4000 ED attendances to safely staff a department. There would need to be 371 consultants by the year 2026 to achieve this.

It is noteworthy that this figure is remarkably close to the total number of consultants (365) given by departments when asked for their ideal staffing numbers by 2026. This tells us that hearing from those working on the ground is vital when planning workforce appropriately for the future; no one understands the needs of Emergency Departments better than the ED staff who work relentlessly round the clock to care for patients.

The doors are always open, the lights are always on, the future of this extraordinary service must be protected.

Scotland's Emergency Medicine
WORKFORCE CENSUS 2021