



The Royal College of
Emergency Medicine

NHS

Improvement

Creating workforce stability in emergency care

Expected good practice

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This report was written by NHS Improvement and Royal College of Emergency Medicine.

Contents

Introduction	3
1. Creating a better working environment.....	4
1.1 Annualised/self-rostered rota	4
2. Offering incentives for people to work in the department.....	7
2.1 CESR schemes.....	7
3. Broadening the pool of staff.....	10
3.1 ACPs and PAs	10
3.2 Clinical fellows.....	12
3.3 Overseas doctors	12
3.4 Engaging other specialties and teams in the emergency department	15
4. Factors for trusts to consider in case for change	17

Introduction

The emergency care workforce is under significant pressure, with increasing demand, rota gaps, trainee attrition and workforce burnout all contributing to an environment where achieving stability is increasingly difficult. NHS Improvement is working with Health Education England, NHS England, The Royal College of Emergency Medicine (RCEM) as well as the Department of Health and Social Care to try and resolve these problems in the long-term.

In October 2017 we published *Securing the future workforce of emergency departments in England*, our shared vision to ensure that in the medium and long term we meet today's workforce challenges and therefore future demand on the service.

We know that trusts are working extremely hard to achieve workforce stability. There is a lot of good practice that can be applied across providers. This document sets out measures that providers have successfully put in place to achieve some stability in their workforce in difficult circumstances. We would expect all providers facing workforce challenges to consider their application.

Our intention is not to downplay the pressures facing the workforce or to suggest that implementing one or more of these measures will resolve all the emergency care workforce pressures facing trusts, but doing so could help stabilise your emergency care workforce.

The measures generally can be grouped into three themes:



For each of these three themes we detail the potential measure you could take and the benefits of implementing them, with case studies showing specifically what trusts did and why. In addition, because emergency departments (EDs) and trusts as a whole often make changes in conjunction, we include some factors for trusts to consider when looking at the case for change.

Underpinning each of these themes is the need for strong leadership to enable successful delivery. The team at the core of the often intense ED environment needs clear direction and motivation, especially when the system is under heightened and prolonged pressure, to drive the implementation of novel initiatives. Moreover, the

ED leadership team must reach beyond the department itself, to ensure culture and goals are aligned with the executive team and of course the wider trust.

1. Creating a better working environment

1.1 Annualised/self-rostered rota

Problems being solved:

- burnout and lack of work–life balance due to standard rotas not adequately factoring in staff needs and preferences
- annual leave, study leave and non-clinical programmed activity not being taken as these were not built into standard rotas
- patient demand and needs being met suboptimally given the resources available.

Annualised/self-rostered rotas help to resolve these problems by organising rotas around staff preferences and patient demand. Leave, bank holidays and non-clinical time are built into the rota before allocations begin.

Benefits:

- ✓ rotas are organised around staff preferences
- ✓ rotas are more flexible and so can respond better to changes in patient demand: staff supply meets demand rather than staff being a ‘slave to the rota’
- ✓ clinicians enjoy a better work–life balance and patients better care as appropriate staffing to meet their needs is more likely
- ✓ the better work environment for staff makes the ED a more attractive place to work, improving recruitment and retention.

“Self-rostering made swaps so easy. This has revolutionised consultant work–life balance and created a growing and sustainable workforce. The single most important change to safety of our patients over the last five years.”

Brighton and Sussex University Hospitals NHS Trust

Common features of measure

- Rotas worked out on an annual rather than a weekly basis. The total number of working hours per year is calculated and from that the required number of clinical programmed activities is deduced.
- The annual rota takes account of annual leave, study leave, professional leave and bank holidays. This may mean, for example, using 42 of the 52 weeks in a year as the basis for the total number of hours annually.
- A system allows staff to choose (at least to a large extent) which shifts they work – for example, staff could state which shifts they want to work at a rota planning meeting.
- This system then ensures that demand can be met by staff working their preferred shifts. If it cannot, the system allocates staff to unfilled shifts or staff decide between themselves how the unfilled shifts will be covered.
- An online or spreadsheet-based system is usually used to plan the rota.
- The department decides how far the rota applies to different staff groups (eg consultants, middle grade, etc).
- Staff are remunerated according to the number of shifts and time pattern worked.

Case study: Brighton and Sussex University Hospitals NHS Trust

The main drivers for moving to an annualised, self-rostered rota were staff burnout and inability to achieve a sensible work–life balance. Brighton had a demoralised junior workforce, a large locum spend and patient care was suffering.

Main features of the scheme

- Annualised rota for consultants and middle-grade doctors, meaning guaranteed leave and bank holidays.
- Ensures optimum number of staff on shift at all times; never a surplus requirement of staff.
- Calculates the number of shifts/programmed activities (PAs) each employee can do over the year, and determines how best to use this available time, ensuring the most efficient use of staff.
- Allows immediate change to rostering schedules to meet patient needs.
- Rota meeting used for self-rostering (weekends pre-allocated); staff shout out when they want to work.

Outcomes

- Reduced burnout among staff and better work–life balance; this has facilitated part-time working and family-friendly working patterns.
- Helped the ED move towards 24/7 working.
- Reduced locum costs.
- Great satisfaction with the rota among staff.
- Helped the ED to increase consultant numbers from 8 to 20 in four years; likewise, the number of registrars has gone from 7 to 24.
- Portfolio careers as the system allows staff to go up or down in number of PAs without impacting on the rota.
- Sickness and other leave easily covered.

“Traditional staffing roster management systems are designed to ensure that all employees work their required hours. But more is needed for our patients – a move away from a traditional 9 to 5 pattern and annual leave model, to one that is responsive to patient needs. We need to ensure that there is always the optimum number of people on shift but never a surplus, while also giving employees sustainable and flexible working conditions. Annualised semi self-rostering systems provide this. It flips the thinking of rostering on its head.

The organisation benefits as it is 100% transparent, utilises staff in the most efficient way and thus cuts down on locum costs. It allows internal cover for sickness, paternity leave, etc and easy take on of shifts that others can't do due to short notice commitments.”

Contact: drroballoway@gmail.com for more information.

2. Offering incentives for people to work in the department

2.1 CESR schemes

Certificate of Eligibility for Specialist Registration (CESR) schemes help doctors who have not followed an approved training programme to get on to the specialist register.

Problems being solved:

- the lack of opportunities for career progression for middle-grade doctors reduces their incentive to work substantively
- this fosters a shortage of doctors who want to work substantively, resulting in less stability in the workforce, rota gaps and a high locum agency bill
- need for clearer guidance and support for individual doctors completing the CESR process.

CESR schemes help to resolve these problems by providing career progression opportunities and incentives to doctors working as locums, making substantive work more attractive to them.

Common features of measure

- EDs provide help with the CESR process for substantive staff wishing to pursue it. This makes applying for substantive work less off-putting to the doctor (good for the ED) and helps the doctor with their career (good for the doctor).
- Help for doctors by offering them the education and training they need for this process.
- Offer of secondments in relevant specialties to allow doctors to build competencies for the CESR.
- Support with the more bureaucratic elements of the process such as form filling.

Benefits:

- ✓ makes ED roles more attractive to substantive staff, helping to improve workforce stability
- ✓ increases number of ED consultants in the workforce
- ✓ staff get broader experience in different specialties, which helps to improve generalist care in EDs.

Case study: Derby Teaching Hospitals NHS Foundation Trust

The trust had an unsustainable rota, with only 4.8 whole time equivalent (WTE) trust-employed specialty and associate specialist (SAS) doctors available overnight and frequent rota gaps filled by consultants covering night shifts.

It designed an innovative training programme to offer emergency medicine SAS doctors tailor-made rotations. The aim was to give successful applicants the opportunity to obtain additional skills in relevant specialties, to provide a bespoke learning environment in emergency medicine and to help those doctors who wish to pursue a CESR application.

Main features of the scheme

- Ethos of supporting every doctor to get to where they wish to be in their career by offering the required education, training and support.
- Three-month secondments in all relevant specialties to obtain the competencies. Secondments include anaesthetics, intensive care, acute medicine and paediatrics. There is some flexibility for individuals to pursue other areas of interest (these have included teaching, ultrasound and public health).
- A bespoke education programme with protected teaching time for doctors on the rotation. Teaching sessions are every two weeks and follow the curriculum for the Fellowship of the Royal College of Emergency Medicine (FRCEM) examination.
- All successful applicants are allocated a consultant mentor with whom they have regular meetings and yearly appraisals, and from whom they get the support they need to meet their personal development plan.
- A bespoke portfolio provides doctors with a framework for compiling their evidence for both CESR applications and revalidation. These portfolios include the General Medical Council (GMC) and RCEM requirements for a successful CESR application.

Outcomes

- Successful recruitment: increase from 4.8 WTE trust-employed SAS doctors to 21 WTE CESR/SAS doctors.
- Savings of £900,000 by converting locum expenditure to PAYE for trust-employed doctors.
- A higher proportion of senior doctors treating patients.
- More highly trained doctors with a broader range of skills.
- Much better retention.
- Reduction in sickness.
- Future successful CESR applications from this cohort of doctors will help increase consultant numbers in the ED.
- Reduction in night-time breaches attributed to increased senior staffing.
- Has contributed to a significantly improved performance against the four-hour target.

Contact: dan.boden1@nhs.net for more information.

2.2 Sensitivity to staff needs and team building

A common and fairly simple but sometimes difficult to achieve sentiment is catering better for individual staff needs – treating staff as individuals rather than as service providers.

Problems being solved:

- need to take account of individual staff needs to create incentives for staff to join and continue to work for the trust, and a better working environment – this is often difficult to do when a system is under pressure
- need to demonstrate commitment from the leadership team to improving working environment, ultimately to foster a stronger team culture in the department.

Common features of measure

- Increased flexibility (eg in terms of hours/shifts) to give staff a better work–life balance.
- Attention to people’s career goals and building training and development around them.
- Formalising these things in job plans and increasing staff time spent on continuous professional development (CPD), training and research.

Benefit:

- ✓ improves recruitment and retention as the ED is seen as a nicer place to work and burnout is reduced.

3. Broadening the pool of staff

Given the shortage of available doctors, some trusts are supplementing their workforce with additional roles that support the ED team. These do not replace the job of a doctor but do add depth to the team. They can free up time for the senior decision-makers in the ED – the consultants and SAS doctors – to concentrate on this senior role, while lending a range of skills to providing patient care and managing patient flow.

3.1 ACPs and PAs

Development of the following professional groups (through robust training programmes) has presented emergency medicine with a real opportunity to truly add to the workforce. At the time of publishing this document (June 2018), 660 PAs have qualified in England and a significant number work in emergency medicine across the country.

- An **advanced clinical/nurse practitioner (ACP)** is a registered nurse or paramedic who has acquired further expert knowledge, complex decision-making skills and competencies to deliver practice beyond that traditionally expected of staff in their role.
- A **physician associate (PA)** works under the supervision of a doctor, supporting them to manage patients and performing tasks such as examinations, analysis of test results and development of management plans.

Case study: Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield's ED sees over 30,000 patients a year. Many of the practitioners had started a Masters level programme which enabled them to assess, diagnose and treat patients with a range of conditions. However, frequent gaps in the junior doctor rota had led to a reliance on locum cover.

A natural progression seemed to be the development of some of the existing large emergency nurse practitioner workforce into ACPs. These nurses were enrolled on a two-year, non-rostered programme at Sheffield Hallam University and completed a portfolio of competence with the aim of credentialing with the RCEM. The programme was funded by Health Education England Yorkshire and the Humber.

Eight ACPs have completed the programme and together provide 24-hour cover to the ED. This development opens up career progression with a clinical focus to senior ACP band 8a.

Main features of the scheme

- Offers a well-educated, clinically competent and stable workforce. The ACPs can deliver high quality care to patients 24 hours a day.
- Enables career progression for healthcare professionals who wish to remain in a clinical setting.
- Consists of a Masters programme with medical consultant support in the workplace setting. Each ACP has a consultant supervisor. There are placements in other clinical specialties also, eg critical care, cardiology, respiratory medicine. All ACPs work towards RCEM credentialing, supported by collaborative teaching with the emergency medicine trainees.
- All ACPs undergo work-based assessments and these are documented in the portfolio.
- The ACPs provide a resource for junior members of the ED nursing and medical team.

Outcomes

- Eight qualified ACPs together provide a high standard of 24-hour cover for care in the ED.
- Agreement from the trust executive group to increase the team from 8 to 14 ACPs.
- An increase in availability of senior decision-making clinicians over 24 hours.
- More opportunity to teach in the clinical setting, eg ultrasound-guided procedures, to increase the skill set of existing staff.
- Reduction in sickness.
- By offering attractive opportunities Sheffield is increasingly becoming an employer of choice.

Contact: Kirsten.clinton@sth.nhs.uk or Julie.perrin@sth.nhs.uk for more information.

Problem being solved:

- senior decision-makers in EDs need more support, especially as there are shortages among them.

Employing additional ACPs and PAs in EDs adds support and depth to the team. In some areas, ACPs and PAs are more readily available than doctors. The shorter training for these roles means they can be trained more quickly to meet demand.

Benefits:

- ✓ provides much needed additional resource and ‘hands on deck’ to the ED team
- ✓ brings a wider range of skills and experiences to the team, improving patient care
- ✓ can free up consultants for their core senior decision-maker role.

3.2 Clinical fellows

A clinical fellow post allows doctors to combine academic work/training with clinical care – these posts can be held pre or post Certificate of Completion of Training (CCT).

Problem being solved:

- helps address staff shortages faced by some EDs: these roles give doctors who have a particular interest outside of clinical duties (eg research, academia, training) an incentive to work in emergency care.

Benefits:

- ✓ post may be more attractive to some doctors than a standard post in ED, allowing the ED to take on additional doctors in this hard to recruit specialty
- ✓ the doctor and the ED benefit from the wider experience gained from the academic training/role
- ✓ less chance of burnout in these roles.

Case study: Leeds Teaching Hospital NHS Trust

Main features of the scheme

- The ED introduced a substantial number of clinical development fellow posts to restrict the level of locum spend. As a result of savings made, the trust has not applied an upper limit on the number of fellowships.
- As of September 2017, the ED has:
 - **6 x senior clinical fellows (5 x adult; 1 x PEM)** (on their own rota):
 - roles are 60% clinical, 40% non-clinical
 - non-clinical roles specialise in the following areas: simulation, education, quality improvement, sepsis and trauma
 - **13–16 x junior clinical fellows:**
 - roles are 80% clinical, 20% non-clinical
 - fill vacancies in the GP VTS rota and FY2 rota
 - non-clinical responsibilities include undergraduate teaching, audit and examinations.

Outcomes

- Sustainable in-situ simulation running twice weekly.
- Fellows run the online induction programme and help organise face-to-face one-day induction.
- Support available for new pathway development and trauma meetings.
- Delivery of undergraduate education.
- Financial savings on more limited recruitment of £190,000 helping towards our CIP.
- Delivery of more timely patient care and reduced variability of locums. Currently, we are at our lowest levels of junior clinical.

3.3 Overseas doctors

Trusts have used overseas doctor programmes as a way of increasing supply of doctors to their trust, given shortages in their area.

Problem being solved:

- lack of available doctors, particularly those who want to work substantively, leads to workforce instability and inflated locum agency bills.

Overseas doctor programmes help to ease this problem by recruiting from a wider pool of staff.

Common features of measure

- Advertising jobs to international doctors, although word of mouth can be as important once the scheme is up and running.
- An induction/training scheme for overseas doctors joining the trust.
- Regular assessments for these doctors.
- Pastoral care such as help with bank accounts and finding accommodation.

Benefits:

- ✓ increased supply of doctors and ability to fill rota gaps
- ✓ less reliance on locums
- ✓ overseas doctors can bring broader experience and knowledge to an ED.

3.4 Engaging other specialties and teams in the emergency department

Some hospital trusts have incorporated acute physicians and other specialty clinicians into their EDs, such as physiotherapists and occupational therapists, to improve patient flow and better match available workforce to demand. These staff do not take on emergency medicine responsibilities and roles – rather, they start the treatment of ‘their’ patients at an earlier stage in the pathway, working alongside emergency care clinicians.

The model for doing this will vary from department to department depending on factors such as size, status of the department (eg major trauma centre) and workforce availability.

Common features of measure

- Assessment of patients at the front door to determine the most appropriate place for them to be treated.
- Principle of patients being seen by the right staff, in the right place at the right time, aiding patient care and patient flow for the hospital.
- Specialty clinicians commonly come from acute medicine, geriatrics, cardiology, respiratory medicine and gastroenterology.
- A separate rota is often used for the additional specialty clinicians.

NHS Improvement published *Allied health professionals supporting patient flow* in April 2018; this describes how patient flow can be unlocked by team working and highlights how the effective use of other professional groups opens opportunities for service redesign.

Case study: Warrington and Halton Hospitals NHS Foundation Trust

Main features of the scheme

- Acute medical take occurs across all admission areas including ED and ambulatory care. Surgeons and other specialties also review patients in the ED but to a lesser extent.
- Ambulatory care is run by emergency medicine clinicians who work alongside acute medical consultants. The ambulatory emergency care (AEC) unit is co-located with the GP/medical assessment unit a short distance away from the ED.
- Acute medicine becomes the default location when waiting for activity. The front door triage of activity is integral to ensuring the right care, in the right place and at the right time.
- Ambulatory care runs seven days a week (9.30 am to 10 pm) and accepts both ED and medical ambulatory patients. Patients deemed too unwell at triage for ambulatory care are streamed to majors or resus under ED and then medicine/critical care.
- When the department becomes congested, a whole hospital approach helps to release capacity downstream from the ED. Every two hours the ED and admission areas are assessed by the medical and nursing co-ordinators, and they define the level of escalation. This in turn determines the stepwise increases in management of the situation to maintain safety, quality and flow.
- During busy periods this typically involves enhanced senior medical and surgical presence within ED, to allow more senior triage and immediate consultant review – this reduces admissions. This is combined with more frequent consultant ward rounds by the physicians (who are not on call) to facilitate beds in support of the demand.

Outcomes

- Sustained compliance against the four-hour target.
- Opportunities for greater team building and learning across teams.
- Minimising inappropriate hospital admissions.
- Optimisation of medical management early in patient admission.
- Greater job satisfaction for clinicians and opportunities to develop operational skills.

4. Factors for trusts to consider in case for change

We asked trusts what overall factors – financial and otherwise – they thought trusts should look at when considering changes such as those outlined here. Common considerations were:

It is much cheaper to employ substantive staff compared to locums

“The organisation benefits as it [annualised, self-rostered rotas] is 100% transparent and utilises staff in the most efficient way. This cuts down on locum costs and allows internal cover for sickness and paternity leave, as well as making it easier for others to take on shifts at short notice if needed to cover others.

In addition the system does this while improving sustainable and flexible working and so helps to recruit and retain staff, especially those who do not want to work full time. The problem [now] is financing all the juniors who want to work for us rather than not being able to fill these posts.”

Brighton and Sussex University

“We have successfully recruited from 4.8 WTE trust-employed SAS doctors to 21 WTE CESR/SAS doctors with:

- no loss of staff during this time
- a reduction in sickness.

Future successful CESR applications from this cohort of doctors will help facilitate consultant expansion in the department. Savings from converting locum spend to substantive posts are calculated to be approximately £900,000 once recruitment to posts is complete.”

**Derby Teaching Hospitals
NHS Foundation Trust**

Linked to the above, many programmes include conversion of locum spend to fund the scheme in their business case for change

“There has been benefit in converting locum spend to permanent staff. Locum cost has dropped by about 25 to 30% over the last 18 months.”

**The Leeds Teaching Hospitals
NHS Trust**

Impact on performance targets (eg the four-hour target) in turn impacts on the trust’s external reputation

“Performance against four-hour target:

- reduction in night-time breaches attributed to increased senior staffing
- [change] has contributed significantly to the improved performance in the trust with respect to the four-hour target.”

**Derby Teaching Hospitals
NHS Foundation Trust**

“It has to be acknowledged that the central driver to obtaining financial support was the four-hour target ...four-hour performance has steadily improved over the past four years.”

**University Hospital Southampton
NHS Foundation Trust**

Quality of care and patient safety

“Driving higher quality patient care:

- more senior-led service with a higher proportion of senior doctors treating patients
- better trained group of doctors with a broader range of skills.”

**Derby Teaching Hospitals
NHS Foundation Trust**

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