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Irish Association for Emergency Medicine

Staffing Needs for Emergency Departments in Ireland

1 Definitions

1.1 Definition of Emergency Medicine

Emergency Medicine involves the diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders (*International Federation for Emergency Medicine*).

1.2 **A Consultant in Emergency Medicine** is a medical practitioner who has undergone training in a recognised training programme and is included on the Specialist Register in the division of Emergency Medicine.

1.3 Emergency Medicine interfaces with Pre-hospital Care, Social Care, Primary Care, Public Health and hospital-based acute specialties. Emergency Medicine is critical to Emergency Planning and National Preparedness for Major Incidents and Disasters.

1.4 Modern Emergency Care is provided by multidisciplinary teams of nurses, Advanced Nurse Practitioners, doctors, care workers and administrative staff. The team is often supported by physiotherapists, occupational therapists and social workers. Emergency Medicine includes Resuscitation, Urgent Care and Ambulatory Care. Consultants in Emergency Medicine may also provide in-patient care in Emergency Observation Units, Clinical Decision Units and Chest Pain Assessment Units.

2. Underlying Principles

Medical Staffing in Irish Emergency Departments should be structured on the following basis:

2.1 All members of our society should have access to the optimum standard of emergency care irrespective of geography and economic status.

2.2 There should be an adequate number of qualified and experienced doctors in Emergency Medicine, appropriately distributed to provide a national emergency service of the highest possible standard.

2.3 In providing an optimal emergency service it must be emphasised that convenience of access must be balanced against the quality of services that can be distributed to meet that convenience.

2.4 Standards of practice will be highest if Consultants in Emergency Medicine directly provide a large proportion of the clinical care. Where this is not possible standards are enhanced by close supervision of junior doctors providing care in Emergency Departments.

2.5 Consultants in Emergency Medicine should have high standards of qualification with an appropriate level of ongoing experience.

2.6 Consultants in Emergency Medicine's work should include clinical and non-clinical work, with a job plan structured to promote career longevity and personal wellbeing.

2.7 Clinical governance in Emergency Medicine should be supported by modern information systems, appropriate management structures and adequate resources.

2.8 Consultants in Emergency Medicine should work as members of well-resourced multi-disciplinary teams in properly equipped Emergency Departments. Such Departments should be designed to a high standard and provide a safe working environment.

3 History

3.1 The first Consultant in Emergency Medicine (then Accident & Emergency) was appointed in Ireland in 1974, two years after the UK pilot of appointing the first tranche of Consultants in Accident & Emergency. It was not until 1999 that the first two-Consultant department was established in the Republic of Ireland and 2003 before the first three-Consultant department was realised.

3.2 The Comhairle na nOspideal *Report on Accident and Emergency Services* was published in February 2003 and the Report of the National Task Force on Medical Staffing (Hanly report) in June 2003. Both recommend significant development of Emergency Medicine nationally but on fewer sites than currently have Emergency (Accident & Emergency) Departments.

3.3 Accident & Emergency Medicine was recognised as a speciality by the Medical Council in 1997 with the instigation of the Specialist Register. The division

was renamed Emergency Medicine in 2000.

3.4 The clinical effectiveness of Irish Emergency Departments has been limited in recent years by departmental overcrowding caused by lack of in-patient bed capacity in the acute hospital sector and underdevelopment of alternative pathways of acute care. This must be addressed by a whole systems approach to Emergency Service development.

4 Current Situation

4.1 Currently there are a variety of Emergency Departments (EDs) countrywide that broadly can be divided into

- Large departments (> 40,000 new attendances)
- Medium (20- 40,000 new attendances)
- Small (< 20,000 new attendances)
- Paediatric departments

There were 1.204 million ED attendances nationally in 2005 (HSE).

At present there are 48 permanent Consultants in Emergency Medicine and 35 hospitals in the Republic of Ireland with "Emergency Departments" (Table 1). Many EDs currently have either a single full time Consultant in Emergency Medicine or sessions covered by one or more Consultants based in Emergency Departments elsewhere. The IAEM believes that no ED in Ireland is currently adequately staffed with Consultants in Emergency Medicine. Furthermore the IAEM believes that the current number of "Emergency Departments" taking emergency ambulance calls is unsustainable and rationalisation needs to occur. Any ED left open following such rationalisation needs to have an acceptable minimum level of staffing if it is to accept undifferentiated emergency ambulance cases.

Table 1 Hospitals in Republic of Ireland with Emergency Departments (including attendances for 2005) *Source HSE "A&E Departments, Background Briefing" May 2006*.

Monaghan General Hospital	11,791	Mercy Hospital, Cork	23,547	Tralee General Hospital	34,859
Roscommon General Hospital	12,410	South Infirmary Victoria Hospital	23,617	St. Vincents University Hospital	36,577
St. Joseph's Hospital, Clonmel	12,689	Naas General Hospital	24,461	Our Lady of Lourdes, Drogheda	38,456
Nenagh General Hospital	13,329	St. Columcille's Hospital	24,529	Mater Misericordiae Hospital	41,000
Portiuncula Hospital	18,237	Midland Regional Hospital, Tullamore	27,065	St. James's Hospital	43,086
Our Lady's General Hospital, Navan	18,620	Mayo General Hospital	28,223	Beaumont Hospital	47,941
St. John's Hospital, Limerick	19,795	Sligo Regional Hospital	29,412	Regional Hospital, Dooradoyle, Limerick	52,617
Cavan General Hospital	20,019	St. Luke's Hospital, Kilkenny	29,967	University College Hospital, Galway	56,041
Louth County Hospital	20,104	Wexford General Hospital	31,063	Waterford Regional Hospital	57,957
Ennis General Hospital	21,345	Connolly Hospital, Blanchardstown	31,434	Cork University Hospital	59,733
Our Lady's Hospital, Cashel	20,592	Midland Regional Hospital, Mullingar	31,383	Tallaght Hospital*	75,392
Midland Regional Hospital, Portlaoise	23,123	Letterkenny General Hospital	31,599	*(includes Adult and Paediatric A&E)*	

The IAEM questions the accuracy of some of the above figures, noting that miscellaneous attendances including attendances for dressings, "routine" outpatient type attendances and direct referrals to inpatient teams are commonly counted in some hospitals' statistics, particularly in Departments which do not have the presence of a fulltime Consultant in Emergency Medicine. The inaccuracy of these figures yet again points to the need for a national standardised minimum data set and appropriate Emergency Department IT systems capable of collecting the information in real time and providing detail on triage categories of patients attending.

Future funding for Emergency Departments is likely to be based upon casemix measures. This will require standardised definitions of casemix measures that accurately reflect case complexity and resource utilisation. Information Management systems in Emergency Medicine need to be reviewed to ensure an equitable system of casemix measurement.

4.2 Current Emergency Medicine training structure

The current Irish model involves

- 1 year Pre-registration Training (Internship)
- 2 years General Professional Training (Senior House Officer posts)
- 5 years Higher Specialist Training (Specialist Registrar post - SpR).

There are currently 16 Higher Specialist Training Posts. The Training System will therefore produce three Consultants on average per year. Given the current shortfall in Consultant numbers the current Training Scheme will not produce sufficient new Consultants to address the deficit.

4.3 Current Emergency Medicine service

Deficiencies in the current service include:

- Overcrowding, particularly as a result of the inappropriate lodging of hospital admissions in the ED after the decision to admit has been made (Inpatient Boarders)
- Prolonged patient waiting times
- Inadequate Consultant numbers
- Most service delivered by relatively inexperienced doctors under variable or inadequate degrees of Consultant supervision.
- Difficulties for Consultants in balancing demands of clinical work, staff training, clinical governance and administrative workload.
- Underdevelopment of academic Emergency Medicine

- Lack of space in poorly designed EDs with out-dated and inadequate facilities
- Staffing structures which do not compare with international best practice – Australia, UK, USA
- Underdevelopment of pre-hospital systems of care

5 Future Service Development:

5.1 Move to a predominantly Consultant provided service

The IAEM recommends that Emergency Care be developed to a service that is predominantly Consultant-provided rather than Consultant-led. Consultant-provided services are recognised internationally as the optimal model for the delivery of Emergency Care.

The benefits of a Consultant-provided service are significant and include:

- improved clinical care with immediate access to senior decision making for all patients
- enhanced training and supervision of staff in training
- less reliance on doctors in training for service provision
- increased support for nursing staff, especially with expanded roles for nurses
- improved risk management in Emergency Medicine
- development of research in Emergency Medicine in Ireland
- increased involvement in pre-hospital care and training of pre-hospital personnel
- increased involvement in preventative Emergency Medicine.
- adequate numbers of experienced staff for responding to Major Incidents
- appropriate Consultant staffing levels will allow for training of increased numbers of Specialist Registrars, who will in time feed the increasing demand for fully trained Consultants.

5.2 International Comparators

5.2.1 Australia

The Australian system of Emergency Health Care is considered to be amongst the best-developed within the International Emergency Medicine community.

Furthermore, many Irish consultants and trainees have worked in the Australian system and many Australian Emergency Departments have similar workloads to Irish departments. It uses a National Triage Scale on which the Manchester Triage System, which is widely used in the UK and Ireland, was based. These triage scales are used as surrogate markers of patient acuity in comparing departmental activity, thus facilitating direct comparison of Australian and Irish departments.

In Australia in 2002, there were 2.5 Emergency Physicians (Consultant in Emergency Medicine equivalents) per 100,000 population or 1 per 40,404 persons. (This equates to 111 Consultants in Emergency Medicine in Ireland compared to the current 48.) Recommended future medical staffing in Australian Emergency Departments is that there should be 11 to 16 "whole-time equivalent" (wte) Emergency Physicians (EPs) in Major Referral Emergency Departments. These Major Departments have extensive out of hours Emergency Physician cover, often 24/7 and 24 hour Higher Specialist Trainee cover. In Urban District hospitals, the Australian system recommends that 8 to 10 wte Consultants (EPs) should be employed, providing extended hours senior cover, ideally 16 hours a day, 7 days a week. Both types of departments will have, in addition, an ED Medical Director who will have only a minimal clinical input.

5.2.2. United Kingdom

The UK is our closest neighbour and has a Health Service comparable to what exists in Ireland. The majority of Consultants in Emergency Medicine working in Emergency Departments in Ireland have trained in the UK and many have spent time in Consultant posts in the British National Health Service (NHS). The College of Emergency Medicine guidelines in the UK recommend that UK departments move towards an increased "shop floor" Consultant presence, 12 hours a day, 7 days a week. Their view is that such a service would require a minimum of 8 wte Consultants to provide. It is further suggested that there should be different types of posts, varying the balance between clinical and other responsibilities. Given the current shortfall in Consultant numbers in the UK, the College would not envisage moving to widespread 24 hour Consultant presence in the short or medium term.

5.2.3 USA

US Emergency Departments have 24 hour Emergency Physician (Consultant) provided services with hospitals employing very large numbers of Emergency Physicians. They have well-funded training programmes and physicians in major centres have significant academic as well as clinical roles. Indeed many have additional roles e.g. as EMS Medical Directors, involvement with Disaster Medicine, Toxicology etc. Medical provision to EDs is organised through staffing structures and finance arrangements that are not currently directly applicable to the Irish health service.

5.3 Implications for Ireland

5.3.1 Given the numbers of Consultants that would be required to move to even a 12 hour, 7 day a week model, it is clear that there will need to a rationalisation of those EDs in Ireland available to receive undifferentiated emergency cases. It would require 8 wte Consultants per ED to provide this level of cover. The current output of the SpR training scheme is clearly insufficient to provide this number of newly trained Consultants.

5.3.2 Under no circumstances should untrained doctors be appointed to Consultant posts in an attempt to deal with the shortfall. Only those on or eligible for inclusion on the Medical Council's Specialist Registrar in the division of Emergency Medicine should be appointable to Consultant posts. The IAEM is increasingly concerned that the Public Appointments Commission has appointed doctors to Consultant posts in Emergency Medicine who are then deemed ineligible for entry to the Specialist Register. This has the effect that such Consultants are unable to have trainees under their supervision. This difficulty can only be avoided by making it a pre-requisite that all applicants for Consultant posts are on or are eligible to be on the Specialist Register in the division of Emergency Medicine, as is the case in the UK.

5.3.3 A 24 hour consultant based service in Ireland would require massive expansion in Consultant numbers of the kind which is unrealistic even in the medium term.

6 How do we calculate staffing needs?

6.1 The concept of "SHO equivalents" has been extensively used in the UK to calculate staffing levels for EDs. While subject to debate it has been used by the British Association for Emergency Medicine in its staffing documents on an ongoing basis. It seems overly simplistic to reduce the professional tasks of an EM doctor to stark numerical terms but this approach does provide a starting point for the calculation of staffing requirements.

There is no high quality data available, on which staffing levels might be more accurately planned or modeled. Processing data, to support analysis of patient throughput versus staffing levels can be provided by contemporary Emergency Department IT systems. Unfortunately, most Irish EDs have out-dated or inadequate Information Management Systems. In addition, there has been a paucity of service-based research into the development and management of Emergency Departments.

The UK model is useful to make "an educated guess" at likely staffing requirements. We propose that the UK "SHO equivalent" should be considered a "service doctor unit". This reflects our belief that SHOs, should not be the primary providers of Emergency Services. We acknowledge that the workload, which has historically been undertaken by an SHO, is a useful

measurement unit in estimating staffing needs, as per the UK model. Also, until such time as there has been a massive expansion in the number of Consultants in Emergency Medicine (of the order of a ten fold increase) the service will continue to be provided by Senior House Officers (SHOs) and Middle Grade Doctors.

6.2 Definition of an SHO equivalent

Experience from EDs in the UK and Ireland reveals that on average, an SHO will see between 2,000 and 3,000 patients per year. This document will use 3,000 patients per year as the *"service doctor unit equivalent"*. This is a fall from historical norms but is based on direct evidence. The reasons for the change are likely be multi-factorial but include a change in ED demographics with more medically ill and elderly patients and less minor injury work, as well as less experienced SHOs being available. These figures can only be used as an approximation as unit size, infrastructure, access to services including diagnostics, department policies, provision of support staff, delays for admission (inpatient boarders) etc will all impact on the rate at which staff can assess and treat patients.

6.2.1

Grade of Staff	Clinical Hours per Week	Casemix	SDU Equivalent
SHO	44	Normal	1.00
SHO	44	Heavy	0.60
SpR	40	Heavy &Supervision	0.50
Middle Grade	40	Heavy & Supervision	0.60

Normal case mix indicates an average ED hospital admission rate of 15-20% with a normal compliment of minor injury and paediatric injury cases. Heavy case mix indicates large numbers of ambulance and trolley cases, more complex moderate illness and less minor injury or paediatric cases. Many departments in Ireland have admission rates approaching 30% and most of the EDs in Dublin do not see children and therefore have a heavier case mix.

Middle grade doctors including Registrars, Specialist Registrars and Associate Emergency Physicians, while being more experienced and generally quicker than SHOs, will generally be involved with the more complex cases and also have a supervisory role. Therefore the total number of patients seen by an individual middle grade doctor will be less than that by an SHO.

6.3 Middle Grade Doctors

These are more experienced doctors who, as well as dealing with the normal work load of EDs, deal with the more complex cases and support and supervise the SHOs. This group encompasses three grades of doctors:

Specialist Registrars, Registrars and Associate Emergency Physicians (See section 11.1 below)

6.3.1 Specialist Registrars
These are doctors on an Emergency Medicine training programme with a view to gaining entry onto the Specialist Register in the division of Emergency Medicine. Service planning must provide for the necessary protected training time for Specialist Registrars.

6.3.2 Registrars
These are doctors with several years' experience (some of which is in Emergency Medicine) who are not on a dedicated training programme. Some of them will be doctors waiting to get onto a Specialist Registrar Training programme.

6.3.3 Associate Emergency Physicians
See section 11.1 below

6.3.4 24 hour cover
It is important that EDs are staffed 24 hours a day 7 days a week with dedicated ED medical staff. The European Working Time Directive limits junior doctors to working a maximum of 48 hours a week as well as imposing restrictions on shift lengths and determining rest periods etc. Allowing 4 hours a week for protected teaching leaves a 44 hr week. The absolute minimum number of doctors needed to cover a 24/7 rota mathematically is 5. While this arguably may be sustainable for very short periods it does not allow for any overlap or flexibility and makes for a very antisocial and family-unfriendly rota. Difficulties may also arise in balancing trainee attendance at mandatory teaching events with service need requirements. A more realistic rota to cover 24 hours requires 7 doctors.

7 Consultant Staffing – 4 Models to be considered:

7.1 The number of Consultants needed for any given Emergency Department will depend on the type of Consultant cover required. In reality, successful Consultants in Emergency Medicine demonstrate complex multi-tasking by moving seamlessly between the following three styles of working, sometimes within the same session. The categorization may be useful in planning Consultant staffing in an ED.

7.1.1 Command and Control
A large part of the job plan involves non-clinical management roles, teaching, audit and research. Clinical roles mainly involve supervision, giving advice or second opinions and involvement in the care of the critically ill patient. This

would be the commonest model in the past and may still be the most cost effective model for many small Emergency Departments.

All EDs need certain fixed amounts of Consultant time to be spent on management, education and audit, irrespective of the size of department. With only 4 Consultants these roles will take up a significant part of the job plan. This will allow Consultant shop floor cover from **09.00-17.00hrs Monday to Friday**.

7.1.2 Extended working week

This model provides the continuous physical presence of a Consultant in Emergency Medicine in a clinical role **12 hours a day 7 days a week** as recommended by the Comhairle Report. The Consultant will be involved in the resuscitation of all critically ill patients and provide direct clinical supervision of junior staff ensuring early senior decision-making. This is closer to the working pattern in EDs internationally and is recommended by the College of Emergency Medicine in the UK. This requires a minimum of 8 wte Consultants.

While Consultant presence will inevitably result in improved service delivery the additional Consultant staffing cannot be included in model calculations as part of service delivery ie Consultant expansion should not be regarded as being a simple replacement of junior doctors.

7.1.3 24 hour Consultant presence

This model is an expansion of the Extended working week model providing a Consultant presence on the shop floor **24 hours a day 7 days a week**. This may not be the best use of a Consultant's skills and may not be economical or clinically justifiable as the numbers of seriously ill patients attending overnight is small. This would require a minimum of 16 Consultants per department. Given the current numbers of Consultants and expected rates of output of the Emergency Medicine Training Scheme this cannot be contemplated in a realistic timeframe.

7.1.4 Consultant delivered service

Using this model all patients attending an ED would be seen by a Consultant in Emergency Medicine. This inevitably would require a further significant multiplication in the number of Consultants. Given the current numbers of Consultants and expected rates of output of the Emergency Medicine Training Scheme it is not possible to envisage such a Consultant delivered service in the short to medium term, although it remains the ideal in terms of quality of patient care. A pragmatic approach towards service development will likely involve a stepwise increase in the proportion of direct patient care delivered by Consultants and increased Consultant supervision of junior staff, as the

service changes from being largely consultant led, to one that is *predominantly* consultant provided.

7.2 Consultant job planning:

The current Common Consultant Contract is for 33 hours per week. A significant proportion of a Consultant's current working week is spent on non-direct clinical activities ie teaching, audit, research, continuous professional development, complaint management, examining, service planning and associated meetings, committee work, providing medicolegal reports for gardai and the courts.

However, ideally, 50% of a Consultant's time should be spent on direct clinical activity. In large multi-consultant departments (ie more than 4 wte Consultants) the proportion of time spent on direct clinical activities may increase to approximately 65%.

Consultants are expected to contribute to training and specialty development activities at regional, national and international level. They may require professional leave to teach on Life Support Courses, be examiners for Undergraduate and Post-graduate exams, or to work with other professional bodies. In addition, evening, night-time and weekend on-call work requires that consultants are allowed rest days to recover. Individual work-plans and departmental schedules must allow for professional leave as well as annual leave and rest days related to the intensity of a consultant's on-call commitment.

8 Examples of Staffing profiles of smaller, medium and larger EDs

There is no one system that fits all. However the following examples, which are similar to international models, offer a baseline from which to start.

8.1 Smaller units (less than 20,000 total attendances per year)

(Assuming average case mix ie 15-20% admissions, 25% paediatric cases, 50% adult minor injury cases).

These units should be incorporated into a hub and spoke model of Emergency Service Provision (as recommended by Hanly), with integrated clinical governance, training and research functions with the base department.

8.1.1 Consultant staffing.

A minimum of four Consultants in Emergency Medicine would provide a "command and control" model. This would enable shop floor cover for 8

hours a day, five days a week. On-call rota of 1 in 4. Locum cover will be required to maintain a 1 in 4 rota.

8.1.2 Middle grade

A minimum of 7 doctors would be needed to provide 24 hour cover. This may not be economical or clinically justifiable as the numbers of patients at night is likely to be small. Four middle grade doctors could provide 16- hour cover.

8.1.3 Service delivery

This is made up of work provided by SHOs and Middle Grade Doctors. Numbers may vary with a skewed case mix.

Middle Grade	4	8,000 patients
Service Doctor Equivalent	5 (for 24 hr cover)	15,000 patients

There is a strong argument for staffing a department of this size entirely with middle grade doctors, as the number of SHOs needed to provide 24 hr cover is high compared to the number of attendances and the training opportunities may be limited.

8.2 Medium units (20,000- 40,000 total attendances per year)

(Assuming average case mix ie 15-20% admissions, 25% paediatric cases, 50% adult minor injury cases)

8.2.1 Consultant staffing

Departments of this size should have a Consultant in Emergency Medicine present in the ED 12 hours a day 7 days a week. A minimum of 8 w.t.e. Consultants are needed to provide this (subject to the necessary contract agreement). Locum cover will be needed to maintain a 1 in 8 rota.

IAEM recognizes that this will require a very significant increase in Consultant numbers. During this period of expansion a hybrid of the command and control and the extended working week models could be developed (subject to provisions of the expected Revised Consultants' Common Contract) to allow some weekend or evening cover.

8.2.2 Middle grade

It is essential that departments of this size have middle grade doctors in the departments 24 hours a day. This requires a minimum of 7 doctors.

8.2.3 Service Delivery

This is made up of work provided by SHOs and Middle Grades. Numbers may vary with skewed case mix

Middle Grade	7	14,000 patients *
Service Doctor Equivalent	5 - 9	10,000- 27,000 patients

*Fewer patients can be seen if SpRs are part of the Middle Grade complement.

8.3 Large units (Over 40,000 total attendances per year)

(Assuming average case mix ie 15-20% admissions, 25% paediatric cases, 50% adult minor injury cases)

8.3.1 Consultant staffing

Departments of this size should have a Consultant in Emergency Medicine present in the ED 12 hours a day 7 days a week. A minimum of 8 w.t.e. Consultants are needed to provide this (subject to the necessary contract agreement). On-call rota 1 in 8. Locum cover will be needed to maintain a 1 in 8 rota.

The volume of serious cases may require double cover on the shop floor for periods of the week. Running a Clinical Decision Unit or a Short Stay/Observation Ward will also require an increased Consultant cohort.

8.3.2 Middle grade

A minimum of 7 doctors would be needed to provide 24 hour cover. However it is likely that the volume of serious cases will require double cover for long periods of the day/evening and thus while 7 is a minimum, 10 is a more likely staffing level needed to provide a quality service.

8.3.3 Service delivery

Middle Grade	10	20,000 patients*
Service doctor equivalent	7- 10	20-30,000 patients

* Fewer patients can be seen if SpRs are part of the Middle Grade complement.

Departments of this size are normally associated with University Teaching Hospitals. The EDs commitment to medical education will require an up lift in staffing levels.

Increased intensity of case-mix will require higher staffing levels.

9 Split site working

Currently many Consultants in Emergency Medicine work across two sites, usually with variable sessional splits. In a number of cases the commitment to one of the hospitals is small and ineffective. Indeed much of this commitment may actually be discharged travelling from and to the major hospital. Such split site working is an inefficient use of a Consultant's time and makes it

difficult to establish good working arrangements both within the EDs and within the hospitals as a whole. IAEM does not support split site working other than the provision of a 2 session commitment to a large ED from a smaller one for professional development or clinical governance reasons.

IAEM is of the opinion that:

- all EDs left open after rationalisation should be fully staffed according to the norms laid down in Section 8.
- all Consultant appointments should have a minimum of 9 sessions at the base hospital.
- Consultants appointed to smaller units may have 2 sessions at a larger (Regional) ED for the purposes of CME and collegiality.
- Consultants are only on call for the hospital where they have their majority commitment.
- Consultants who work across split sites are only clinically responsible for patients while they are physically on site.

10 Impact of Consultant numbers on other medical staff:

As Consultant and middle grade numbers expand and the proportion of direct patient care provided by senior doctors increases, the requirement for service provision by SHOs will decrease. Having more senior decision makers available will improve service efficiency and quality of care. Moreover, increased Consultant numbers will facilitate training and improve the clinical supervision of SHOs and Middle Grade Doctors. This will benefit SHOs aiming to specialise in Emergency Medicine and those rotating through Emergency Medicine as part of their training in Medicine, Surgery and General Practice. Advanced Nurse Practitioner training and ongoing clinical supervision also requires Consultant input. A complex interdependency exists between the staffing requirements for each grade of doctor in Emergency Medicine, but Consultant numbers are the key factor in determining what can be achieved in terms of service delivery, quality of care, training, clinical governance and further service development.

11 Non-consultant career grade doctors

There is a need for permanent, experienced Middle Grade Doctors in many EDs. Many doctors wish to continue to work in hospital medicine but for personal or family reasons do not wish to work fulltime or pursue a Consultant career. Presently although there is no official role for, or recognition of these doctors in Ireland, de facto, many of them are working as "permanent" Registrars in EDs with little support and no hope of professional advancement. Local arrangements have been made to accommodate some such doctors with non-standard titles and conditions of

service although this is inconsistent and unsatisfactory.

IAEM believes that this anomaly must end with the establishment of permanent non-Consultant career grade posts (Associate Emergency Physicians) with appropriate training and entry criteria, and the opportunity to advance to Higher Specialist Training. Such doctors must not be used solely for service provision and must be given support in terms of time and finance for continuing professional development. They must also be paid a salary commensurate with their experience and responsibility. The mistakes made in the operation of the Staff Grade post in the UK with huge variability in the clinical standards amongst post holders must not be repeated in Ireland. Competence Assurance will necessitate that these doctors become registered for professional development and are full participants in clinical governance activities.

11.1 Associate Emergency Physician (AEP)

IAEM has previously proposed the introduction of a new post known as an Associate Emergency Physician (AEP.). Entry to this new grade would be via a structured training programme consisting of four years post-internship experience concluding with an Emergency Medicine examination (Membership of the College of Emergency Medicine -MCEM). Should an AEP subsequently decide to pursue Higher Specialist Training with a view to gaining entry onto the Specialist Register, they will be eligible to apply for entry to a Specialist Registrar (SpR) training programme.

12 Summary

The IAEM is committed to the development of a national system of Emergency Care of the highest standard. All members of our society should have access to the optimum standard of emergency care irrespective of geography and economic status. This will require adequate numbers of Consultants in Emergency Medicine working in well resourced departments, providing a large proportion of direct clinical care, supervising junior doctors and engaging in clinical governance activities. Clinical and systems-based research is needed to support the development of Irish Emergency Medicine. Significant expansion in Emergency Medicine staffing with high level service planning is required to ensure that such a system of care can be provided in an equitable, consistent and sustainable manner.

The proposals outlined in this document represent the views of Consultants in Emergency Medicine working in hospitals throughout Ireland. We believe that these staffing recommendations, if implemented, will form the cornerstone on which a world-class Irish Emergency System of care can be built. We look forward to working with patients, healthcare colleagues, the HSE and the Department of Health and Children in developing such a service. Our patients expect and deserve nothing less than the highest standard of

care when they attend Emergency Departments - our aim is to deliver excellence in Irish Emergency Care.

13 References

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