IRISH ASSOCIATION FOR EMERGENCY MEDICINE 30

CHY17751 1989-2019

Developing Emergency Medicine in Ireland

Strategic Objectives for the Irish Association for Emergency Medicine

2020 – 2025


EMERGENCY

Foreword

In 2019, the Irish Association for Emergency Medicine (IAEM) celebrated 30 years since its inauguration and in March of that year the Executive decided it needed a document to outline its strategic direction for the next five years. As the first document of its kind, it was decided to review the development of Emergency Medicine as a specialty in Ireland and the critical role played by the Association, describe achievements and challenges for Emergency Medicine and lay out the strategic direction for the Association. During the remainder of 2019, there was extensive consultation with the membership including a detailed on-line survey, a roundtable forum on 28th June 2019 as part of the IAEM30 Celebration Day and detailed structured interviews with members of the Executive. A summary of the findings and plans were presented at the IAEM Annual Scientific Meeting in October 2019.

In the intervening months the COVID-19 pandemic reached Ireland and the attention of IAEM was diverted to managing this unprecedented situation. Thank you to all who have continued to deliver emergency healthcare over these difficult months. Emergency Departments in Ireland remained open to receive patients who needed our care throughout the pandemic. The fact that we would do so, despite immense and ongoing challenges, was never in doubt; this is the core of the Emergency Medicine ethos.

With the clinical and organisational changes and challenges of 2020 the need for IAEM to describe the future of the Association and our view of how Emergency Medicine should be delivered in Ireland is even more important. With the foundations laid down in this document, we will now move to an implementation plan through further engagement with our stakeholders, including patients, to further develop Emergency Medicine as a central component of healthcare in Ireland.

Thank you to all those who gave their time freely, particularly those who helped with the numerous edits.

Emily O'Conor, FRCEM
President Irish Association for Emergency Medicine
October 2020

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Note: Photos used in this document were taken before the COVID-19 pandemic and associated recommendations for Personal Protective Equipment.

"The Irish Association for Emergency Medicine was founded in 1989 as the representative expert body for the medical specialty of Emergency Medicine. It is a charity (CHY 17751) that seeks to ensure that the best possible emergency care is delivered in Emergency Departments across Ireland. Its members are the doctors staffing Ireland's EDs. The Association provides advice and expertise to the public, government and heath service management about all aspects of hospital-based emergency care and is a member of the European Society for Emergency Medicine (EUSEM) and the International Federation for Emergency Medicine (IFEM)."

1. Executive Summary

The Irish Association for Emergency Medicine (IAEM) is the representative body for Emergency Medicine (EM) in Ireland. It is an association of doctors of all levels (Consultants, Doctors in Specialist Training and other clinicians) with expertise in treatment of acute illness and injury. They work in Emergency Departments but also in the pre-hospital area and other units within evolving Emergency Care Networks (ECNs). Based on specialty training, international and local experience, IAEM members deliver emergency medical care, set clinical standards, promote and conduct research and deliver specialty training in EM in Ireland. As a charity (CHY 17751), IAEM seeks to ensure that the best possible emergency care is delivered to people in Ireland and provides advice and expertise to the public, government and health service management about all aspects of EM.

To mark 30 years since the establishment of the association, a review was carried out with members to evaluate achievements to date and agree priorities for the future. This review, as the first of its kind, covers both EM in Ireland and the role of IAEM.

Key themes from this review included the desire to improve awareness of the function and role of EM in Ireland; to continue to advocate for improvements in patient care and to continue to train and support the staff who deliver emergency care. Another key theme was the role of IAEM in connecting the various committees and bodies involved in Irish EM so that further development of the specialty can be coherent and co-ordinated. Critical links included those with the Royal College of Emergency Medicine (RCEM) and the Royal College of Surgeons in Ireland (RCSI), currently the recognised training body for EM.

Based on analysis of the findings, the values of IAEM and the context of the health service in Ireland, a number of Strategic Objectives were developed for IAEM for the next five years:

Strategic Objective 1

COMMUNICATE with patients and the general public about what to expect from Emergency Medicine

Strategic Objective 2

DESCRIBE a system of Emergency Medicine in Ireland that ensures every person has timely access to quality emergency medical care.

Strategic Objective 3

ADVOCATE for patients by highlighting the adverse impact of inadequate resources.

Strategic Objective 4

Further **DEVELOP** training and research in Emergency Medicine

Strategic Objective 5

STRENGTHEN both internal IAEM structures and relationships with other bodies that have a role in Irish Emergency Medicine.

Strategic Objective 1

COMMUNICATE

with patients and the general public about what to expect from Emergency Medicine

Promote an understanding of the specialty of Emergency Medicine and the key role it plays in enabling the health service to meet the increasing needs of Ireland's population.

Explain how best to use the unique skill set that clinicians in Emergency Medicine bring to Irish healthcare.

Describe the many good outcomes and positive patient experiences that occur every day in Emergency Departments.

Highlight the passion and dedication of staff who work in Emergency Medicine and describe what motivates them.

Strategic Objective 2

DESCRIBE

a system of Emergency Medicine in Ireland that ensures every person has timely access to quality emergency medical care.

Describe a system in which all Emergency Medicine care in Ireland is under the supervision of a fully-trained Consultant in Emergency Medicine.

Ensure recognition of intensity of the work carried out by staff in Emergency Departments and describe the structure that would enable a focus of expertise on those patients who most need their specialist skills.

Describe the continuing development of subspecialties, such as Paediatric Emergency Medicine, Pre-hospital Emergency Medicine, Geriatric Emergency Medicine and Academic Emergency Medicine.

Describe pathways of care that are efficient and patient-centred, including the further development of Clinical Decision Units led by Consultants in Emergency Medicine.

Identify the number of Consultants in Emergency Medicine needed and the number of specialty trainees required to fill posts in the future.

Work with the Emergency Medicine Programme to describe and support the team the Consultant will lead, including trainees, non-trainee doctors and other healthcare staff.

Strategic Objective 3

ADVOCATE

for patients by highlighting the adverse impact of inadequate resources.

Describe the concerns of members who cannot deliver the quality of patient care they wish.

Explain how inadequate access affects patients, particularly poor access to hospital beds, diagnostics and timely access to specialty clinics.

Collaborate with health service leadership, both within hospital settings and in the wider healthcare environment, to improve clinical outcomes and patient experience and in particular to reduce the mortality and harm associated with prolonged stays in the Emergency Department.

Strategic Objective 4

Further

DEVELOP

training and research in Emergency Medicine

Promote training and research in Emergency Medicine so that talent can be fostered and developed for the delivery of high-quality patient care.

Work with the Irish Committee for Emergency Medicine Training to further support doctors and students through the Irish Emergency Medicine Trainees Association and the Emergency Medicine Students Society of Ireland.

Promote involvement in research, audit and professional development for all members.

Support the development and adoption of evidence-based practice in Emergency Medicine, through the development of clinical guidance and standards of care that reduce variability in care.

Strategic Objective 5

STRENGTHEN

both internal IAEM structures and relationships with other bodies that have a role in Irish Emergency Medicine.

Enable the further development of the specialty in Ireland in a coherent and co-ordinated way by strengthening relationships with the Royal College of Emergency Medicine and the Royal College of Surgeons in Ireland.

Maintain the positive collegiality of IAEM and strengthen relationships with the International Federation for Emergency Medicine and the European Society for Emergency Medicine.

Establish a clear communication structure which maximises the benefit of the association for all members.

Maximise the contribution of doctors in IAEM by investing in administrative supports.

Continue to ensure the association meets the high standards expected of a charity and pursue the priorities set out in this review.

It is anticipated that the IAEM Executive will develop annual operational plans to progress the implementation of these objectives and monitor their progress.

Many thanks to Healthcare Informed who assisted with the survey, roundtable discussions and Executive interviews, Claire Briant, IAEM Administrator, and Breda Naddy who assisted with editing. A very special thanks is extended to the many IAEM members who participated in the process.


INK/RED
PURPLE
YELLOW
WHITE


Paediatric Emergency
Department

2. Introduction

2.1 Introduction to the Irish Association for Emergency Medicine

In 1989, a small number of Consultants in EM in Ireland came together to form a representative expert body for the medical specialty of EM[1]. It is now called the Irish Association for Emergency Medicine and has grown to a membership of over 200. Members are doctors working in EM or Paediatric Emergency Medicine (PEM), in the pre-hospital arena and in Emergency Departments around the country. Doctors registered on the Specialist Division of the Register (hereafter, Specialist Register) in the Division of Emergency Medicine of the Medical Council or holding substantive posts as Consultants in EM or PEM are eligible to become Full Members of the Association. Doctors in training and other doctors working or having an interest in EM may join as Associate Members. Medical students may join as Affiliate Members. Under the provisions of the IAEM Constitution, Full Members who have retired from clinical practice are entitled to Life Membership and IAEM may also bestow Honorary Membership on Consultants in EM from overseas or consultants in other specialties who have made a significant contribution to the development or advancement of the specialty of EM in Ireland or internationally. Nursing and other healthcare professionals who work closely with doctors in the provision of emergency care are increasingly involved in the IAEM Annual Scientific Meeting.

In September 2020 there were 100 Full Members, 19 Honorary/Life Members and 139 Associate/Affiliate Members in the organisation.

The Officers (President, Treasurer and Honorary Secretary), Committee chairs and ordinary members of the Executive and IAEM committees carry out their duties on a voluntary basis and IAEM funds part-time administrative support sourced from the EM Training Office of RCSI. In addition to the Executive Committee, there are several IAEM standing committees including the Academic and Research Committee, the Clinical Guidelines Committee and the Point-of-Care Ultrasound Committee.

1 The specialty was then known as Accident & Emergency Medicine and Consultants in the specialty as Consultants in Accident & Emergency Medicine. The name of the specialty was changed to Emergency Medicine in 2000 which is the internationally used name.

2.2 Introduction to the specialty of Emergency Medicine

EM is defined by the International Federation for Emergency Medicine (IFEM) as:

a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioural disorders; it further encompasses an understanding of the development of prehospital and inhospital emergency medical systems and the skills necessary for this development.

Consultants in EM treat patients across the full spectrum of acute healthcare needs: from those newly born to those at end-of-life; those needing resuscitation for major illness or injury to those with more minor, but still urgent, needs; those with straightforward needs and those with very complex needs; those patients who need emergency care once in a lifetime and those who need emergency expertise more frequently, at any hour of day and night as the need arises.

The specialty of EM developed in many areas of the world in the mid-20th century in response to patient need. The need for a specialty of 'Accident and Emergency Medicine' was first mooted in the UK in the Platt Report in 1962. Ireland followed suit some years later. Since 2000 the specialty in Ireland has been called Emergency Medicine in line with international nomenclature.

In 2017, the UK-based RCEM marked 50 years since the first meeting of doctors working in the then nascent specialty in 1967. Similarly, the American College of Emergency Physicians celebrated 50 years of the specialty in 2019. Irish EM (and EM in Canada and Australasia) developed in parallel to developments in these countries. The first Consultant in EM in Ireland was appointed in 1974 and Irish consultants were among the founding members of the forerunners of the RCEM. Today, Ireland has a seat on RCEM Council (through IAEM) and although we deliver health care in different jurisdictions, IAEM and RCEM continue to share both standards and goals. RCEM representation in Northern Ireland is a National Board in line with arrangements in other devolved nations of the UK.

Ireland has been a full member of the International Federation of Emergency Medicine since 1991. EM on mainland Europe is developing rapidly and IAEM contributes to the activities of the European Society for Emergency Medicine (EuSEM) and Union Européenne des Médecins Spécialistes (UEMS).

The different components of the Fellowship of RCEM (FRCEM) are the specialty exams for doctors undergoing specialist training in EM in Ireland. Fellowship of RCEM is the exit exam required to complete advanced specialty training to be eligible for the Specialist Register and thus a post as a Consultant in EM. In recent years, a number of Irish doctors have completed training in Australasia and obtained the Fellowship of the Australasian College of EM (FACEM) which is recognised as equivalent to FRCEM. RCSI is currently the body recognised by the Medical Council for EM training in Ireland (and for the EM Professional Competence Scheme) and the training programmes are overseen by the Irish Committee on Emergency Medicine Training (ICEMT) on RCSI's behalf (see Section 3.2.1). Whereas the early Consultants in EM in Ireland were obliged to travel abroad for specialist training, doctors wishing to train as a Consultant in EM have been able to complete both Core and Advanced specialist training in EM in Ireland since 2011, allowing them to sit the FRCEM, receive a Certificate of Satisfactory Completion of Specialist Training (CSCST) and become eligible for entry onto the Specialist Register in the division of EM. There are over 70 doctors currently in core specialty training in EM in Ireland, and more than 50 advanced trainees.

From the survey it was clear that there was interest from the membership in moving towards an Irish College of Emergency Medicine with the development of a Faculty of EM in Ireland as an interim step. One of the outputs of this strategic document is the mandate for IAEM to describe and develop the structures to achieve this while optimising the relationship between IAEM and both RCEM and RCSI, so that EM in Ireland can be best delivered for both providers and their patients alike.

2.3 Emergency Medicine in Ireland

There were over 1.3 million attendances at Emergency Departments (EDs) and Injury Units in Ireland in 2019 and the number and complexity of presentations continues to rise year on year. International experience demonstrates that, despite healthcare systems developing alternatives to attendance at an ED for unexpected urgent health needs, the number of patients attending EDs does not decrease. Ireland is no different in this regard, and the reasons for this paradox are complex[2,3].

2 Coleman P, Irons R, Nicholl J (2001). Will alternative immediate care services reduce demands for non-urgent treatment at accident and emergency? Emergency Medicine Journal;18:482-487.

3. Anantharaman V. (2008). Impact of health care system interventions on emergency department utilization and overcrowding in Singapore. International journal of emergency medicine, 1(1), 11–20. https://doi.org/10.1007/s12245-008-0004-8

As of January 2020, there were 29 hospitals in the Republic of Ireland that offered Emergency Department (ED) services on a 24/7 basis. In addition, there are 11 Injury Units (IUs) and together these units make up the infrastructure of EM in Ireland. Currently, nine of the 29 hospitals that offer ED services on a 24/7 basis do so without having a named Consultant in EM available and clinically accountable for the patients registering in the ED at all times of opening, a situation that IAEM has deemed unacceptable. At present, there are over 100 Consultant posts in EM. To deliver safe, quality and efficient emergency care in line with international best practice, the current configuration of 29 Emergency Departments and 11 IUs would need to be staffed by at least 252 Consultants in EM. IAEM is on record as taking the view that Ireland currently has too many EDs and reconfiguration is required.

Patients arrive to the EDs of public hospitals by helicopter, ambulance, public or private vehicle or on foot. They can self refer or be referred by Primary Care or other community services. There is a statutory Government levy charged when attending an ED with some exemptions, including those referred by Primary Care and those with Medical Cards. For patients most critically ill or injured, pre-hospital services will alert ED staff who will be waiting to receive them in the Resuscitation Room. Other patients will be registered and seen initially by a Triage nurse who prioritises patients according to clinical need. Traditionally, clinicians that made treatment decisions for patients in an ED were invariably doctors, but Advanced Nurse Practitioners and Clinical Nurse Specialists in areas such as Minor Injury, Mental Health Liaison, Frailty, Emergency Cardiology etc. are now long established as senior decision makers. Increasingly, groups such as Physiotherapy and other Health and Social Care Professions have joined the blended decision-making team. The majority of patients (typically 70-75%) are discharged home from the ED with the others referred for admission to a hospital bed for further care. Most of these admissions involve transfer of care to a non-EM specialty, but short-stay admission to a Clinical Decision Unit (CDU) under the care of a Consultant in EM is recognised as a safe and efficient pathway for selected patients.

2.4 Current Challenges in Emergency Medicine

Care at EDs in public hospitals is available to everyone and priority for care is based on clinical need alone. Timely access to public healthcare in Ireland is difficult for patients. It is clear that the Emergency Department has become the default option to gain access for urgent hospital treatment, even for patients with differentiated conditions.

For a specialty that is focused on immediate management of acute conditions, a key requirement for successful practice is continuous flow, i.e. the discharge or onward referral of patients once their acute need has been addressed so that space is created for newly-arriving patients. Without flow, there are profound negative effects on the ability to practice EM which can manifest as inefficient practices and suboptimal patient outcomes. Over the last couple

4 Based on Consultant Staffing for Type A, B and C units (see Chapter 13 of the Emergency Medicine Programme Report)

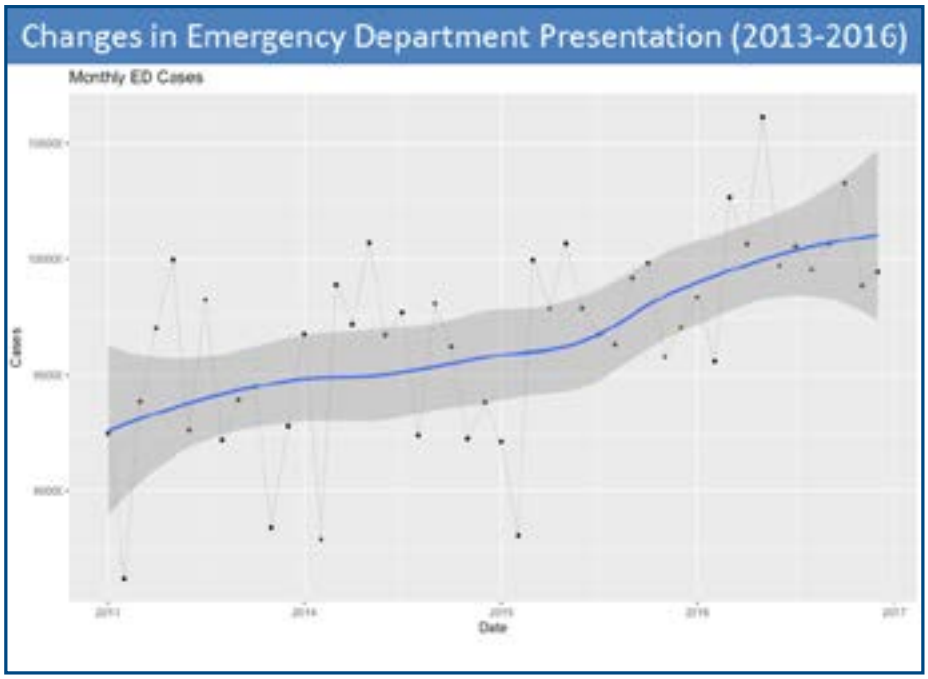
5 https://www.hse.ie/eng/about/who/acute-hospitals-division/patient-care/hospital-charges/

6 Chapter 13 of the Emergency Medicine Programme Report: The Emergency Team and Workforce Planning

of decades, a mismatch between bed capacity and demand has led to the 'normalisation' of poor flow; and this is best seen in the practice of hospitals boarding admitted inpatients in Emergency Departments. This impairs workflow in the ED, sometimes to the point of bringing it to a complete standstill.

There is, perhaps understandably, a misconception that ED crowding is evidence of failure of the EM model because the ED is where the symptoms of problems with system function and capacity have been allowed to manifest. Sadly, much time, energy and analysis has been devoted to dealing with the symptom of ED crowding rather than addressing the systemic issues and particularly the capacity issues at its core.

2.4.1 Increasing demand



Analysis of ED Presentations in Ireland: F. Donohue and G Martin

International experience demonstrates that, despite healthcare systems developing alternatives to attendance at an ED for unexpected urgent health needs, the number of patients attending at ED does not decrease. Ireland is no different in this regard[8] and the reasons for this paradox are complex.

Impacting on the demand for emergency care is the increasing life expectancy in Ireland. We now have an average life expectancy of 80.79 years. The number of people aged over 85 years in Ireland is projected to almost double by 2030[9]. Using current ED attendance figures, weighted for age group, it is estimated that the number of emergency attendances among the 65+ age group will increase to approx. 267,975 by 2026, representing an increase in attendances in this age group of approximately 37% over a 10-year period. Research by QualityWatch in the UK suggests attendances for those aged 85+ have risen 20% more than would be predicted by population growth alone[10].

7 Morley, C., Unwin, M., Peterson, G. M., Stankovich, J., & Kinsman, L. (2018). Emergency department crowding: A systematic review of causes, consequences and solutions. PloS one, 13(8), e0203316. https://doi.org/10.1371/journal.pone.0203316

8 Analysis of ED Presentations in Ireland: F. Donohue and G Martin

9 https://www.esri.ie/news/demand-for-healthcare-projected-to-increase-substantially-with-rapid-growth-and-ageing-of

10 https://www.health.org.uk/sites/default/files/QualityWatch_FocusOnAEAttendances.pdf

2.4.2 Recruitment and Retention

The contract of employment introduced for new Consultants since 2012 has had a significant negative impact on Consultants considering returning to Ireland or taking up a Consultant post from a training post in Ireland. This has led to the unprecedented situation of a widespread failure to recruit to Consultant posts across the country. It is well known that difficult working environments are a significant stressor and this is likely to be a major contributory factor to difficulties in recruiting permanent staff to Emergency Departments[11].

2.4.3 Infrastructure and Resources

There is wide variation in the physical structures of EDs across the country. Many still have poor infrastructure and are poorly resourced. Of the 29 EDs, nine do not have a Consultant in EM on call at all times. The harmful impact of ED crowding on patients and staff is well publicised and compounds the infrastructural difficulties. While there have been improvements in the level of crowding in some hospitals, improvements in many hospitals have been limited and not sustained. There remains a need for the causes of the problem to be better understood by heath service managers and appropriate solutions implemented by health system leaders.

2.5 Current Opportunities in Emergency Medicine

Although a relatively young specialty, the profile of EM is high amongst the public. Providing a 24/7 emergency service that delivers high-quality care for patients at significant and vulnerable times in their lives is a huge responsibility that requires passion and dedication. International experience shows that countries, in which EM did not exist previously are now actively developing the specialty. The need for EM is growing around the world, with the passion, commitment and ethos well described by the International Federation for Emergency Medicine. Irish EM training and practice is well respected internationally and our doctors are highly sought after around the world. Despite deficits in access to publicly-funded healthcare in Ireland, this passion drives the specialty to continuously improve. In addition to general EM training and practice, Ireland has developed subspecialty areas of interest including Paediatric EM, Pre-hospital EM and Geriatric EM.

2.5.1 Paediatric Emergency Medicine

Paediatric Emergency Medicine (PEM) is a well-established, internationally recognised subspecialty of EM. The amalgamation of the three Dublin Paediatric Hospitals into a single legal entity, Children's Health Ireland (CHI) in January 2019, along with the ongoing construction of the new National Children's Hospital, offers huge promise for the improvement in care for the children of Ireland and the parallel expansion of PEM in Ireland. The first step in implementing a new model of care in the delivery of PEM was the opening of the Urgent Care Centre (UCC) in Blanchardstown in July 2019. This is to be followed by the opening of a second UCC in Tallaght, and the opening of the National Children's Hospital on the St James's Hospital site in 2023. It is anticipated that in excess of 120,000 children will be treated annually between the three sites.

11 See research publication on Why our doctors are leaving Irish emergency medicine training (Feb 2019) and Hospital doctors in Ireland and the struggle for work-life balance (Sept 2020)

Included within the model of care for PEM is the further development of emergency care for children outside Dublin and a national trauma network for paediatrics.

Consultants in PEM can train in General Paediatrics with additional time in EM or train in EM with additional time in General Paediatrics. In recent years, a fellowship programme has been developed for trainees who have achieved a Certificate of CSCST in EM and wish to subspecialise in PEM. This programme is available through the CHI under the auspices of ICEMT.

2.5.2 Geriatric Emergency Medicine

An increasing number of older people are attending Emergency Departments. This is related to the demographic shift that has resulted in a rapid increase in the number of older people. Over the years 2015 – 2030, the share of population aged 65 and over is projected to increase from one in eight to one in six and the number of people aged 85 and over is projected to almost double[12]. Older patients who attend the ED present unique challenges and have a higher likelihood of admission, followed by a longer length of stay, compared to other patient groups. Implementation of improved care for increasingly frail, older people requires a whole-system approach but there is currently a pressing need to change how emergency care is delivered to improve quality, outcomes and efficiency. Geriatric EM specialises in managing common frailty syndromes, such as confusion, trauma, falls and polypharmacy as well as issues such as cognitive impairment, functional impairment and end-of-life care.

2.5.3 Pre-Hospital Emergency Medicine

Pre-hospital Emergency Medicine (PHEM) is a relatively new subspecialty area of medical practice focusing on the specialist provision of on-scene and in-transit critical care, including: provision of critical care for seriously ill or injured patients before they reach hospital (on-scene) or during emergency transfer to or between hospitals (in-transit). This represents a unique area of medical practice which requires the focused application of a defined range of knowledge and skills to a level not normally available outside hospital. In the UK, this is now a recognised subspecialty of EM, Anaesthesia, Acute Medicine and Intensive Care Medicine[13].

In Ireland, pre-hospital care at a PHEM level is currently provided by a small group of doctors on a voluntary basis on behalf of the National Ambulance Service. These doctors currently respond to approximately 800 patients per annum. PHEM doctors have a wide scope of critical care practice including pre-hospital emergency anaesthesia, resuscitative thoracotomy, mass casualty incident response and, most recently, pre-hospital blood and plasma transfusion. A pilot post-CSCST fellowship in PHEM was supported by ICEMT in 2018-2019 and completed

12 https://www.esri.ie/news/demand-for-healthcare-projected-to-increase-substantially-with-rapid-growth-and-ageing-of

13 Ref: http://www.ibtphem.org.uk/media/1039/sub-specialty-training-in-phem-curriculum-assessment-system-edition-2-2015.pdf

by an Advanced Trainee in EM.

There is a wider group of doctors, volunteers and off-duty responders who also contribute significantly to pre-hospital care at different clinical levels. The Irish Society for Pre-hospital Emergency Medicine was recently formed to promote the development and role of the specialty of PHEM in Ireland.

IAEM supports the development of PHEM in Ireland to become a formal medical subspecialty, with a dedicated training pathway.

3. IAEM Strategy Development

3.1 Background

In keeping with IAEM's focus on advocating for the provision of the highest quality of service, the Association decided to undertake a strategic review in conjunction with its 30th Anniversary. To ensure the strategy was reflective of the needs and aspirations of its membership, a number of methods were used to facilitate and gather feedback from members. These included a survey questionnaire, one-to-one interviews with members of the IAEM Executive and a roundtable discussion forum to which all members were invited.

The aim of IAEM is to represent the medical specialty of EM and to advocate for the patients we treat. Over the last 30 years, IAEM has succeeded in highlighting the importance of the specialty, the unique needs of the patient population it serves and the challenges in delivering high-quality EM care in the current environment. This strategy outlines a clear pathway for IAEM to continue to support and develop the specialty of EM into the future.

3.2 IAEM's Achievements to Date

IAEM has had considerable success in advocating for the specialty of EM, its members and its patients. In the 30 years since its inception, IAEM has succeeded in having EM recognised by the Medical Council as a distinct medical specialty at the time of the creation of the Specialist Register in 1991. EM has developed the associated career structure of specialty roles – from medical student to intern, to trainee and, ultimately, to Consultant.

IAEM is now the point of contact for the media and healthcare leaders on EM/ED related issues. To support its members, IAEM hosts an Annual Scientific Meeting, develops Clinical Guidelines and awards bursaries and prizes. IAEM has also spent a decade advocating for patients by highlighting the adverse impact that ED crowding has on patients and by involvement in road safety and other public safety campaigns.

Below is a list of some of IAEM's successes across a broad range of areas:

3.2.1 EM Specialty Training Programme

There is now a comprehensive training programme for EM extending from an undergraduate curriculum through Core to Advanced Training Schemes. IAEM was integral to the establishment of the National Emergency Medicine Training Programme. This programme is supervised by the ICEMT and consists of Core (Basic) Specialist Training in Emergency Medicine (CSTEM) and Advanced (Higher) Specialist Training in Emergency Medicine (ASTEM). To successfully complete the ASTEM programme, trainees are required to pass the FRCEM examination. On completion of the Training Programme, doctors receive a CSCST and are eligible for inclusion in the Specialist Register in the division of EM. They are then deemed to be a fully-trained specialist in EM and are eligible to apply for Consultant posts.

3.2.2 Creating Better Understanding of the Causes of and Solutions to ED Crowding

ED crowding with admitted inpatients is well documented and well publicised. IAEM has worked consistently to highlight the issue of crowding and the proven association with increased mortality and morbidity; the adverse patient experience and the negative impact on the multidisciplinary teams that work in EDs. IAEM seeks to educate the public and the healthcare sector that the solution to crowding, although multifaceted, generally lies outside the ED. ED crowding is very much a symptom of malfunction in the wider healthcare system and is strongly related to Ireland's inadequate bed capacity (Health Service Capacity Review, 2018). This message has been communicated by IAEM through representation on various national and local media as well as direct work with healthcare leaders. It is now generally accepted that ED crowding is damaging to both patients and staff and that the health sector must consider a wide range of issues outside of the ED in attempting to resolve the issue. A selection of IAEM's press releases can be found here and the text of a presentation to members of the Oireachtas here.

3.2.3 Hosting ICEM 2012

IAEM hosted the International Conference on Emergency Medicine (ICEM) in Ireland in 2012. This was a hugely successful event, attended by specialists in Emergency Medicine from across the world. The conference set new records for an ICEM meeting with 2,200 delegates attending and over 1,100 abstract submissions received. IAEM achieved this with the smallest membership of any of the organisations that have hosted the event either before or since, entirely through voluntary work by the Association's membership.

3.2.4 Emergency Medicine Programme - Model of Care 2012

The National Emergency Medicine Programme (EMP) was established in July 2010 following intensive lobbying by IAEM. The HSE had created a number of Clinical Programmes, including ones to design Models of Care for chronic diseases and Unscheduled Care Access in the Health Service (Critical Care, Acute Medicine, etc.) and IAEM successfully argued that the lack of a similar programme dealing with EM was a major deficit, particularly as the majority of Irish

patients were admitted to hospital through the ED. The EMP National Report was launched in 2012 and contained an agreed expert vision for how access, quality and cost might be improved in EDs throughout Ireland. Significant enhancements to the services provided at EDs have been implemented as a result of the programme. These include support for the optimisation of internal ED processes, increased numbers of Consultant and other posts (e.g. Advanced Nurse Practitioners), standardisation of triage, introduction of the Irish Children's Triage System, standardisation of ambulance patient handover, Mental Health Triage, improved team communication, audio-visual separation of children from adults and other quality improvement measures. The Clinical Microsystems Quality Improvement methodology has been introduced into many EDs and is now being considered for development elsewhere in the hospital system. IAEM is the clinical advisory group for the EMP. IAEM/EMP has facilitated EM being at the heart of many recent developments in healthcare delivery, including the governance of Injury Units, development of the National Trauma Strategy, planning for the management of mass casualty incidents, Activity Based Funding, recognition and management of frailty, palliative and end-of-life care. Public Health initiatives, research into the effect of interventions in the ED (e.g. frailty assessment and management), the development of shared records and the Electronic Health Record have also been actively supported. IAEM supports EMP in advocating for the establishment of Emergency Care Networks, one benefit of which will be the appointment of at least one Consultant in PEM in each network.

3.2.5 Annual Scientific Meetings

Over the past 20 years, IAEM has developed and enhanced its Annual Scientific Meeting (ASM). The ASM is an educational opportunity for EM trainees and Consultants, ED nurses and the other Health and Social Care Professionals (HSCPs) who contribute to patient care in the ED, including pre-hospital care practitioners. The format includes pre-conference workshops, educational presentations, international guest lectures and opportunities to present research by either poster or oral presentation. Feedback from participants is positive both in relation to the content delivered and also the opportunity to engage with their colleagues in EM. The ASM also provides an opportunity to meet Continuous Professional Development (CPD) requirements.

3.2.6 IAEM Clinical Guidelines

The Clinical Guidelines Committee (CGC) was established in 2014 to develop high quality, evidence-based and ED-specific clinical guidelines. Additionally, the CGC endorses evidence-based guidelines developed in other countries, if these are applicable to the Irish context. To date, a total of 26 Clinical Guidelines have been developed encompassing both adult and paediatric care and a significant number of additional guidelines are currently in development. The CGC uses a robust and transparent process to ensure the clinical guidelines are evidence-based and of high quality.

3.2.7 IAEM Website

The aim of the IAEM website is multifaceted. The Association has developed a website that many individuals and/or organisations often visit to access up-to-date information about the specialty of EM and the functioning of EDs. For the public, this includes details of what to expect when they visit the ED. The website also provides information to EM trainees and Consultants in the form of Clinical Guidelines and information about the activities of IAEM. The website has increased in popularity year-on-year since its introduction and recent re-design, with some 17,000 users visiting the site in 2020.

3.2.8 Podcast

To mark the IAEM 30 celebrations in 2019, six audio podcasts were recorded. The podcasts feature medical voices from the past, present and future of EM in Ireland to mark the Association's progression over three decades. These podcasts are hosted on the IAEM website.

3.2.9 Point-of-Care Ultrasound

Point-of-care ultrasound (POCUS) has become the standard of care for the sickest patients in our Emergency Departments. EM training in Ireland has facilitated level 1 RCEM sign off. The IAEM POCUS Committee was formed to encourage novel POCUS educational events for all EM-affiliated training groups – students, doctors in training and Consultant mentors.

3.2.10 Outreach

Many members of IAEM work voluntarily with their local communities in public education and engagement. Members have contributed to local and national Road Safety Authority campaigns, Community First Responder Groups, Voluntary Ambulance services and numerous other voluntary activities. Consultants in EM are in demand to speak at public meetings on issues such as CPR, accident prevention, and other topics relevant to EM.

3.2.11 Academic and Research Committee

The IAEM Academic and Research Committee aims to encourage, facilitate and promote the development of academic EM through the provision of research skills workshops and the production and dissemination of research and scholarly work in the field of EM in Ireland. The committee represents the interests of IAEM at national and international research fora and is a resource for those wishing to develop research projects in EM or in EDs in Ireland, reviewing and advising on multicentre ED based research proposals including surveys. The committee evaluates research abstracts for the ASM, including the awarding of the Professor Conor Egleston prize. The Bayer Travel Bursary and the IAEM Research Award are both administered and adjudicated on behalf of IAEM through this committee annually.

3.3 Committees / Bodies involved in EM in Ireland

IAEM is a registered charity which promotes the highest standard of emergency care for all citizens and visitors to Ireland through education, advocacy, research, training and the provision of advice and guidance to government, health service management and others.

IAEM works closely with several other bodies.

3.3.1 Royal College of Emergency Medicine

RCEM is based in the United Kingdom, has over 6,000 registered Fellows and Members internationally and works to represent both its members and the interests of patients. Irish Consultants in EM were founding members of RCEM and IAEM is represented on RCEM Council by its President. The RCEM curriculum and postgraduate examinations (MRCEM/FRCEM) for specialty training to Consultant level are those used in Ireland and Irish Consultants in EM examine at both levels. MRCEM or Intermediate FRCEM is required to progress from Core to Advanced specialty training and FRCEM or equivalent, e.g. FACEM is required for successful completion of Specialist Training in EM in Ireland. In interviews and discussions for this strategy, members indicated that they would like to strengthen the link with RCEM.

3.3.2 Royal College of Surgeons in Ireland and Irish Committee on Emergency Medicine Training

The Irish Surgical Postgraduate Training Committee (ISPTC) of RCSI is the training body recognised under the Medical Practitioners Act 2007 under whose auspices training in EM currently falls. ICEMT oversees EM training in Ireland on behalf of ISPTC, of which it is a subcommittee, and to which it reports. Members have indicated they would like to strengthen links between IAEM and RCSI.

3.3.3 Irish Emergency Medicine Trainees Association (IEMTA)

IEMTA is the national representative organisation for EM trainees in Ireland. Since 2011, IEMTA has been a subgroup of IAEM. IEMTA receives its funding from IAEM and is governed by its constitution. Medical student or Non-Consultant Hospital Doctor (NCHD) members of IAEM are automatically members of IEMTA.

3.3.4 Emergency Medicine Student Society of Ireland (EMSSI)

The Emergency Medicine Student Society of Ireland (EMSSI) is composed of health science students from Trinity College Dublin (TCD), University College Dublin (UCD), University College Cork (UCC), University of Limerick (UL), RCSI and National University of Ireland, Galway (NUIG) with an interest in EM and emergency care. There are EMSSI chapters in each of the six medical schools in Ireland and a partnership has been forged with its sister society in Queens University, Belfast. EMSSI fosters opportunities for networking, runs emergency skills workshops as well as offering wilderness medicine trips in the field.

3.3.5 Emergency Medicine Programme

The Emergency Medicine Programme (EMP) is one of a suite of National Clinical Programmes (NCPs) established by the HSE as a joint venture with the relevant Medical Colleges, Nursing Bodies and other Paramedical Training and Standard setting bodies. Each NCP was initially tasked with designing the optimum Model of Care for their particular area of expertise. The EMP is led by a multidisciplinary working group that includes Consultants in EM (including PEM), Emergency Nurses, representatives of Pre-hospital Care and other Health and Social Care Professionals.

4. IAEM Member Consultation and Findings

4.1 Overview of Methodology

To ensure the strategy of IAEM was representative of the breadth of its membership, consultation was undertaken through a number of mechanisms. These included a survey questionnaire, a roundtable forum and interviews with members of the IAEM Executive. There was a positive response, with a high rate of uptake for the survey and enthusiastic levels of participation at the roundtable forum and Interviews.

The survey was undertaken via circulation of an electronic questionnaire to all IAEM Members in June 2019. Participants were asked to complete the survey and to forward it to any other interested parties. It covered a wide range of topics in relation to the current status of EM and potential developments for the future. 148 responses were received, which included 75% of all Full Members, 45% of all Associate Members and 52 others:

> The IAEM Constitution states ***Full Membership*** applies to a doctor who holds a substantive post as a Consultant in either Emergency Medicine or Paediatric Emergency Medicine, in either a public or private hospital in Ireland; to a doctor who is listed on the Medical Council (Ireland) Specialist Register in the division of Emergency Medicine; or to a doctor who is listed on the Medical Council (Ireland) Specialist Register in the division of Paediatrics and is working in the field of Paediatric Emergency Medicine.
>
> ***Associate Membership*** applies to a Non-Consultant Hospital Doctor, such as an Associate Specialist; Associate Emergency Physician; Staff Grade; Specialist Registrar; Registrar; Senior House Officer; Intern or equivalent, working in or having an interest in Emergency Medicine

Results from the survey were analysed and stratified and discussed by the IAEM Executive. To facilitate further analysis, there was an agreement to use the findings of the survey to direct the conversations at the roundtable forum and interviews, under the following three broad headings, each of which contained a number of relevant subheadings:

- Role of Emergency Medicine
- Role of the Consultant in Emergency Medicine
- The role, structure and relationships of IAEM in the future

The roundtable forum discussion was held on 28th June 2019 and involved over 50 members with varying levels of experience in EM. Groups were structured to ensure a mix of expertise and to ensure representatives from the IAEM Executive and trainees had an opportunity to discuss key issues as a team. Themes identified from the survey questionnaire were presented to the groups, who discussed and reflected on the issues and provided combined feedback. The discussions predominantly reinforced the findings from the survey and provided additional detail and clarity on the topics.

One-to-one interviews were undertaken with the following IAEM Executive Committee members:

Dr Emily O'Conor	President
Dr Sinead O'Gorman	Honorary Treasurer
Mr Fergal Hickey	Communications Officer
Dr Gareth Quin	Dean of Postgraduate EM Training/Chair of ICEMT
Dr Etimbuk Umana	President, IEMTA
Mr Gerry McCarthy	National Clinical Lead, EMP
Dr Conor Deasy	Chair, Academic and Research Committee
Dr Laura Melody	Paediatric EM Representative
Dr Alan Watts	Executive Committee Member

These interviews enabled an in-depth discussion of the findings from the roundtable forum. They also facilitated any new or prominent issues to be highlighted.

Some of the findings from the survey questionnaire, roundtable forum and one-to-one interviews are detailed below. Findings are broadly presented in line with the three categories identified by the Executive - Role of Emergency Medicine, Role of the Consultant in Emergency Medicine and Role of IAEM in the future.

4.2 General Comments from Members

The survey covered a wide range of topics in relation to the current status of EM and potential developments for the future. It is a valuable resource for further study. Not all findings are reported, but those outlined below are reflective of members' responses and give insight into their views on issues that are topical in EM. Results are stratified with 'FM' denoting Full Members and 'AM' denoting Associate Members of IAEM.

When asked for **their reason for choosing a career in EM,** members responded as follows:

1	Variety of Clinical Presentations	(94% FM and 97% AM)
2	Team Working	(57% FM and 79% AM)
3	Rapid Decision Making	(56% FM and 78% AM)
4	Excitement	(62% FM and 76% AM)

Table 1: Reasons for choosing a career in EM

Other responses included **'Societal Good' (33%** both **FM** and **AM), 'Defined training programme' (18% AM), 'Inspired by someone I worked with' (35% FM** and **39% AM), 'Procedures' (57% FM** and **67% AM)** and **'Rapid Impact' (48% FM** and **49% AM)**

The **aspects of EM enjoyed most** were **'Resuscitation' (88% FM and 97% AM)** and **'Musculoskeletal' (63% FM** and **33% AM**). Members also enjoyed Paediatric and Geriatric Emergency Medicine, Pre-hospital and Major Incident roles, EM research and education, clinical guideline & policy development, quality & patient safety, and wellbeing & workforce sustainability.

When asked about involvement in **training** within the last year, members responded that:

88% FM and **94% AM** were involved in **Simulation Training**

58% FM and **91% AM** were involved in **POCUS Training**

61% FM and **47% AM** were involved in **Original Research**

93% FM and **91% AM** were involved in **audit of EM Practice**

4.3 Role of Emergency Medicine

This section deals with members' views on caring for patients including access to care, challenges in delivering care and opinions on improving care.

4.3.1 Who Should Deliver Care?

More than 96% of members agreed that **patient care should be delivered by a medical team** including:

- Consultants (on the Specialist Register)
- Doctors in Training
- Advanced Nurse Practitioners

At the roundtable discussion, the need for additional Specialist Registrar posts was highlighted. The Executive interviews also reiterated the need for additional numbers of trainee and Consultant appointments. Over 90% agreed that this team should include permanent, non-training grade, doctors, i.e. NCHDs who are experienced in EM but do not have a formal higher specialty qualification, or are not on a formal training scheme, with the caveat that this should not reduce the numbers of training posts available. The role of these doctors needs to be planned and managed. 73% agreed that the team should include Advanced Care Practitioners such as Physician Associates (PAs). There was positivity in relation to the role of the PA in the ED but training for doctors would need to be protected.

In discussion with members, many specialties and disciplines were identified as being of benefit to the ED team. The different approaches to GP involvement in EDs were discussed, including a full-time GP, a sessional GP or an out-of-hours GP located close to the ED. The positive relationships resulting from enhanced GP-ED collaboration were noted. In addition, it was felt that inpatient on-call teams should be part of the ED team without other competing commitments. Teamwork and inclusive handovers were highlighted as essential at the roundtable discussion. The Executive noted in their interviews the changing outlook of the cohorts of EM trainees and Consultants, whereby there is an expectation now that new graduates will be operating as part of a team and not in isolation.

Experience of Compromised Care

Members were asked if they had seen patient care compromised while working.

38% FM and **48% AM** said that they had seen patient care being compromised on every shift by having too few EM doctors on shift; **38% FM** and **52% AM** said that they had seen patient care being compromised on every shift by having too few EM nurses on shift. 99% of respondents said that on 'every shift' or 'most shifts' lack of access to a bed on the ward compromised patient care. 66% of respondents felt that lack of responsiveness from other specialities onsite resulted in patient care being compromised.

4.3.2 Patient Flow and Access to the ED

Usefulness of alternative patient pathways, other than attending at ED

The following question on the usefulness of alternatives was asked of members: *'It has been well flagged that access to public health services is a problem for patients in Ireland. Some patients attend the ED with healthcare problems that could be dealt with in another setting if available. In your experience over the past year, how useful do you believe your patients would find the services below as an alternative to attending at ED?'*

Question	Always Useful	Frequently Useful	Occasionally Useful	Not Useful
GP: Monday–Friday 09:00–17:00	32%	34%	25%	9%
GP: Outside of these hours	28%	33%	33%	6%
Timely access to diagnostics for GP referrals	62%	25%	12%	1%
Timely access to outpatients for GP referrals	80%	13%	6%	1%
Access to telephone advice line	19%	25%	25%	30%
Timely access to community mental health	47%	33%	17%	4%
Timely access to community HSCP	35%	26%	28%	4%
Timely access to support for frail elderly outside the hospital setting	70%	23%	6%	1%
Injury units	40%	29%	24%	6%

Table 2: Potential usefulness of alternatives to attendance at ED

Timely access to diagnostics and to outpatients for GP referrals scored highly as did timely access to support for frail elderly patients outside the hospital setting. Timely access to community mental health was also significant.

Prevention of Hospital Admission

Once a patient was in the ED, respondents were asked to identify which **type of diagnostics could have prevented hospital admission or enabled an earlier discharge.** Over 90% stated that access to the following were 'always useful' or 'frequently useful' in this regard:

Rapid Access to **CT** (Monday–Friday, 09:00–17:00)

Rapid access to **CT** (outside of these hours)

Rapid access to **Ultrasound** (Monday–Friday, 09:00–17:00)

Rapid access to **specialty outpatient clinics** for follow-up referral from EM

Rapid access to **community multidisciplinary team** follow-up

Better access to **alternatives to acute hospital beds for frail older patients** (Monday – Friday, daytime)

Less benefit was noted for **Rapid access to ultrasound outside of the hours of Monday–Friday 09:00–17:00; 31% FM** and **23% AM** stated that was ***'occasionally useful'*** or ***'not useful'.***

From the roundtable discussion, it was felt that the current binary options of 'admit or discharge' should be supplemented by rapid-access clinics to enhance patient flow. Early streaming of patients into appropriate areas or teams was beneficial (for example the use of rapid access team, or other triage related teams such as frailty intervention teams). Participants felt that it was important to establish an environment where the ED and the remainder of the hospital worked together.

Clinical Decision Units (CDUs)

A Clinical Decision Unit is a mechanism to optimise the flow of appropriate patients who need some diagnostic or treatment interventions, or a period of observation, prior to safe discharge. Rather than referring a patient to another specialty for further care, patients are admitted under the care of a Consultant in EM for short-stay treatment. Such units have been well shown to provide quality care with optimum access in a cost-effective fashion[14].

Members noted CDUs were of benefit when supported by relevant and appropriate structures and processes. This includes standalone beds, ensuring availability of the appropriate staff mix to provide care and adequate funding.

82% FM and **71% AM had worked in a CDU.**

76% FM and **68% AM believed that CDU improves patient care in ED (7%** and **26%** 'don't know', respectively).

53% believe that a **CDU should be available in all EDs;** and **27%** believe that **it should only be available in EDs with greater than 30,000 attendances.**

Comments were raised in response to this question, some examples of both positive and negative comments are outlined below:

'Optimises senior clinical input and timely access to investigations.'

'More efficient, empathic care with very rapid safe turnover of patients. When they work well, they are labour intensive but excellent safety valves for ED patients (and staff).'

'For a focused group of patients but it needs to be funded properly and is difficult to achieve whilst also running a full ED.'

'It fills with admitted patients…Used to game system/numbers by management.'

Performance Indicators

There was mixed feedback in relation to whether performance indicators were found to be useful to the respondents' work.

'Admission Rate' was noted to be **'always useful'** for **23%** or **'sometimes useful'** for **43%**.

'Left before completion of care' was found to be **'always useful'** for **20%** or **'sometimes useful'** by **38%.**

14 Described in Chapter 8 of the EMP Programme Report

Suggestions for other performance indicators included patient feedback, percentage capacity within departments (rather than raw numbers) and times to specific points in the patient care journey e.g. time to triage, time to first clinician encounter and time from specialty referral to assessment.

4.4 Role of the Consultant in EM

This section covers some of IAEM members' views about the role of a Consultant in EM in Ireland, particularly issues related to recruitment, retention and wellbeing.

4.4.1 Priorities for Consultants in EM

Survey participants were asked: *If you are planning a career as a Consultant in Emergency Medicine in Ireland or currently working as a Consultant in Emergency Medicine in Ireland, please rate the importance of each of the following.'* Responses are shown below.

Question	FM/AM	Essential	Quite Important	Somewhat Important	Not Important	Prefer not to Say
Abolition of new Consultant pay disparity	FM	85%	10%	5%	0%	0%
	AM	61%	30%	9%	0%	0%
Increased remuneration for all doctors	FM	25%	30%	33%	12%	0%
	AM	42%	36%	15%	6%	0%
Increased remuneration for consultants	FM	38%	25%	27%	11%	0%
	AM	42%	30%	21%	6%	0%
Improved working conditions within the EDs of public hospitals	FM	95%	5%	0%	0%	0%
	AM	85%	15%	0%	0%	0%
Recognition of work intensity	FM	86%	12%	0%	2%	0%
	AM	79%	18%	3%	0%	0%
The ability to care for patients properly	FM	90%	10%	0%	0%	0%
	AM	82%	15%	3%	0%	0%
More time for professional development	FM	33%	57%	10%	0%	0%
	AM	52%	39%	9%	0%	0%
More funding for professional development	FM	26%	45%	28%	2%	0%
	AM	51%	30%	12%	6%	0%
Access to private practice	FM	14%	22%	28%	35%	2%
	AM	0%	24%	35%	36%	3%

Table 3: Priorities for Consultants in EM

Comments included: *'Recognition of portfolio careers e.g. education', 'new investment in staffing and reconfiguration of services' and 'access to private practice only necessary as long as remuneration stays as it currently stands'.*

At the roundtable discussion, the vision for the role of the Consultant in EM included a balance between clinical and non-clinical responsibilities and using a shift work pattern (which may include shift weighting), rather than the current on-call approach. Self-rostering was also suggested. Age-appropriate work intensity was considered important so that as a consultant

gets older, the less onerous the role becomes. Interviews with the IAEM Executive echoed the need to recognise the intensity of the role, the need for sustainable work practices, self-rostering and subspecialisation. The Executive acknowledged that the current generation are at a financial disadvantage relative to previous generations and emphasised the need for economic remuneration and terms and conditions reflective of the unsocial hours. It was noted by the Executive that IAEM has a role in educating and informing the healthcare system on how this model could work and the benefits that this would bring to patients who access the service out of hours.

4.4.2 Priorities for Future Employment Options in EM

Participants were asked: 'Assuming adequate numbers of Consultants and adequate terms and conditions of employment, please indicate your support for the following.'
Responses are shown below.

Question	FM/AM	Strongly Support	Somewhat Support	Don't Support at All
Consultants working across different sites within a network	FM	49%	38%	13%
	AM	32%	39%	29%
A Consultant rota which includes late evening and weekend work onsite on a regular basis	FM	55%	40%	5%
	AM	52%	39%	10%
A Consultant rota which changes for older Consultants	FM	89%	9%	2%
	AM	61%	36%	3%
A Consultant job description which includes recognition of job intensity	FM	98%	2%	0%
	AM	97%	3%	0%

Table 4: Priorities for Future Employment Options

Protected time for education and research was seen as important as well as career progression to roles such as Clinical Directorships. Consultant performance management was welcomed.

4.4.3 Dealing with Work Pressures in EM

56% AM reported feeling **overwhelmed 'every shift** 'or **'most shifts'.**

When asked to indicate *'what assists you when feeling overwhelmed'* the responses were as follows (please note respondents may have selected a number of responses):

Response	FM	AM
The Clinical Team on shift with me	55%	74%
Medical Colleagues senior to me	13%	32%
Occupational Health	0%	3%
Human Resources Department	4%	3%
HSE Support Line	0%	0%
Non-Clinical Activity (e.g. teaching, training activity, conference)	27%	23%
Wellbeing / Sustainability / Education	7%	3%
Nothing at Work Helped Me	32%	23%
Other	5%	10%

Table 5: What helps when feeling overwhelmed?

Discussion at the roundtable supported subspecialty development and the ability to utilise subspecialisation to aid resilience. Wellness was noted as a significant issue, particularly in relation to facilitating doctors to come back to work, supporting education, leave and protected breaks. During the working day, the importance of adequate food and staff rooms was highlighted (e.g. staff rooms where informal clinical discussions can occur without fear of confidentiality breach as might occur in hospital coffee shops).

4.5 Role of IAEM in the Future

This section details members' opinions about the current and possible future role of the Association.

4.5.1 Promoting Awareness of the Specialty

The **role of IAEM as raising awareness** about the **Specialty of EM** was demonstrated in the responses:

91% FM and **90% AM** stated that *'representing the specialty of EM'* was *'essential'* or *'very important'*

88% FM and **71% AM** stated that *'advocating on behalf of patients'* was *'essential'* or *'very important'*

90% FM and **87% AM** stated that *'advocating on behalf of members'* was *'essential'* or *'very important'*

88% FM and **84% AM** stated that *'educating the public about EM'* was *'essential'* or *'very important'*

93% FM and **90% AM** stated that *'educating other stakeholders about EM'* was *'essential'* or *'very important'*

Promoting positive developments in the specialty of EM and advocacy for patients and

members was mentioned at the roundtable discussion (e.g. medical student members of EMSSI delivering CPR or First Aid training in schools). Executive interviews drew attention to the possibility that IAEM's role in highlighting the challenges facing the specialty of EM and the issues of patient flow may result in the organisation appearing disgruntled, in spite of the fact that the speciality is a very positive and proactive one. They said it was timely to project a positive image of the specialty and focus on the positive stories from individual departments. Interdepartmental and interorganizational working were seen as particularly important.

4.5.2 Standards and Research

Development of **'Standards of Practice'** (roles of various team members, policies and procedures around the mechanics of EM practice as distinct from clinical guidelines solely) was discussed and deemed important.

In the survey:

66% FM and **90% AM** stated *'setting standards for EM'* was *'essential'* or *'very important'* for IAEM to be involved in.

67% FM and **77% AM** stated *'Developing EM Research in Ireland'* was *'essential'* or *'very important' for IAEM to be involved in.*

Within their current employment, **61% FM** and **47% AM** were involved in original research and **93% FM** and **91% AM** were involved in audit involving EM practice.

4.5.3 Education and Training

67% FM and **81% AM** responded *'developing extra training for Doctors, Students, Others interested in EM'* was *'essential'* or *'very important'.*

42% FM and **65% AM** found the *'Free Open Access Medical Education (FOAMed) community and resources' 'extremely useful'.*

41% FM and ***53% AM*** found online resources *'extremely useful'*. One comment noted that the 'Rise of FOAMed has rejuvenated EM internationally'.

At the roundtable, providing bursaries and supporting training opportunities abroad were mentioned as roles of IAEM. There was also a suggestion that extra training relating to media, CV training, interview skills, medicolegal matters etc. would be useful. Other examples of what members would like included: support for trainees to attend international conferences, access to masterclasses and guest speakers at the IEMTA training days. Developing CPD-approved courses was also suggested. Exceptional EM practices are rarely recognised and this could be developed through IAEM awards. The Executive also reported a need for additional support for doctors working in EM who are not on training schemes. Creating bursaries that are inclusive of nontrainees was proposed. Support for developments such as the recent Traumadoc was seen as something that could be replicated.

In response to *'Which aspects of your professional development would you like to improve over the coming year?'* the top three areas were: POCUS, leadership skills and management. Additional areas included *'human factors', 'research', 'Clinical Director role' 'educational skills' and 'academic'*. Over 80% of all respondents funded some, or all, of their professional development personally within the last year.

4.5.4 IAEM structures

Future development of IAEM Structures should include consideration of broadening the focus to include nursing staff working in EM and developing the Faculty of EM in the future. While the concept of the Faculty was popular and seen by some as a method of moving to the next step, the operational aspects were unclear. Many interviewees spoke of the benefits of the Faculty in terms of increased profile and status, particularly now that the number of people in the speciality is such that it would warrant a Faculty. Feedback at the roundtable indicated members' support for investment in a 'home' for Irish EM and for development of the administrative structures required to further develop IAEM. Challenges noted included a lack of awareness of what is involved, and what might be lost, in development. It would also have an impact on the role of IAEM and interviewees were not clear on what this impact might be. It was proposed at the roundtable that there should be a role funded part-time to lead out on Faculty development.

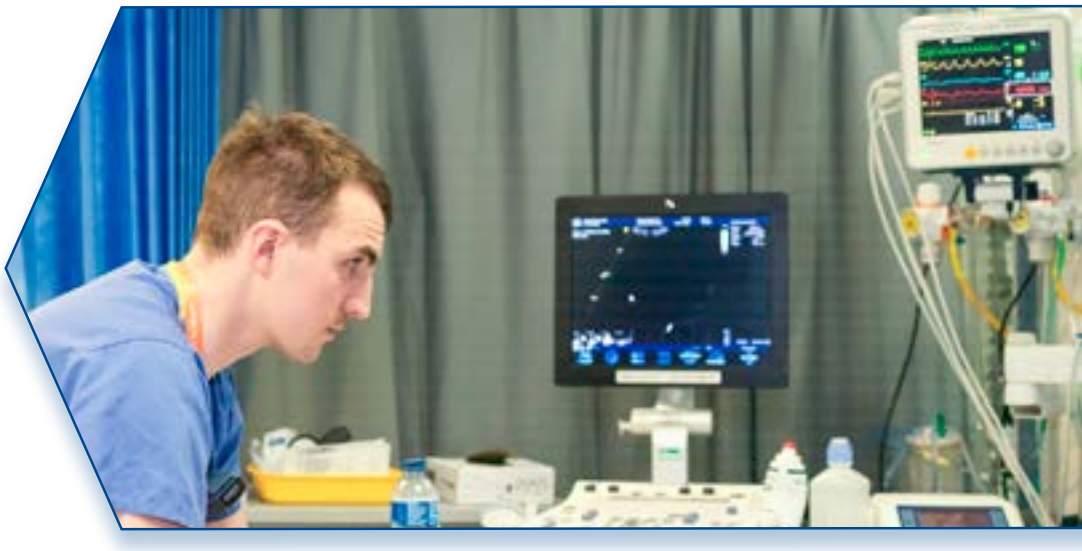
Strengthening the link with RCEM came out as a strong theme in the survey, roundtable discussion and interviews with members of the Executive.

From the survey:

79% FM and **84% AM** viewed as *'essential'* or *'very important'* the role of IAEM in linking with other professional bodies in Ireland and international EM.

70% FM and **65% AM** responded *'definitely yes'* when asked if they would like to see links with RCSI strengthened.

79% FM and **65% AM** said *'yes'* when asked *'Would you like to see the development of a Faculty of EM in Ireland affiliated to RCSI'*.



5. Strategic Objectives

5.1 Key Themes from Consultation

As a result of the consultation and feedback, key themes and trends emerged. These themes included:

- The need to efficiently deliver patient care and improve the current service. Key enablers include adequate numbers of senior decision makers, sustainable career paths and improved working conditions for staff in EDs. Further development of training, standards of care and clinical guidelines are also key enablers for improved patient care.

- Support for the work of IAEM in promoting awareness of the specialty and highlighting the needs of patients to all those with a role in delivering healthcare in Ireland. Communicating with patients about what to expect from their emergency service is also part of this work. There is strong demand to continue this work. Members would also like an increased focus on positive aspects of the specialty.

- The role of IAEM in connecting the various committees and bodies involved in Irish EM so the development of the specialty can be coherent and co-ordinated. Members showed strong enthusiasm for building all connections and, in particular, for strengthening the link with the RCEM and RCSI.

These themes were considered in the context of the current challenges to the provision of EM in Ireland and the achievements of IAEM to date. Strategic Objectives were identified which focus on the priority areas for IAEM in the future.

5.2 Strategic Objectives

The Irish Association for Emergency Medicine will:

Strategic Objective 1

COMMUNICATE

with patients and the general public about what to expect from Emergency Medicine.

Promote an understanding of the specialty of Emergency Medicine and the key role it plays in enabling the health service to meet the increasing needs of Ireland's population.

Explain how best to use the unique skill set that clinicians in Emergency Medicine bring to Irish healthcare.

Describe the many good outcomes and positive patient experiences that occur every day in Emergency Departments.

Highlight the passion and dedication of staff who work in Emergency Medicine and describe what motivates them.

Strategic Objective 2

DESCRIBE

a system of Emergency Medicine in Ireland that ensures every person has timely access to quality emergency medical care.

Describe a system in which all Emergency Medicine care in Ireland is under the supervision of a fully-trained Consultant in Emergency Medicine.

Ensure recognition of intensity of the work carried out by staff in Emergency Departments and describe the structure that would enable a focus of expertise on those patients who most need their specialist skills.

Describe the continuing development of subspecialties, such as Paediatric Emergency Medicine, Pre-hospital Emergency Medicine, Geriatric Emergency Medicine and Academic Emergency Medicine.

Describe pathways of care that are efficient and patient-centred, including the further development of Clinical Decision Units led by Consultants in Emergency Medicine.

Identify the number of Consultants in Emergency Medicine needed and the number of specialty trainees required to fill posts in the future.

Work with the Emergency Medicine Programme to describe and support the team the Consultant will lead, including trainees, non-trainee doctors and other healthcare staff.

Strategic Objective 3

ADVOCATE

for patients by highlighting the adverse impact of inadequate resources.

Describe the concerns of members who cannot deliver the quality of patient care they wish.

Explain how inadequate access affects patients, particularly poor access to hospital beds, diagnostics and timely access to specialty clinics.

Collaborate with health service leadership, both within hospital settings and in the wider healthcare environment, to improve clinical outcomes and patient experience and in particular to reduce the mortality and harm associated with prolonged stays in the Emergency Department.

Strategic Objective 4

Further

DEVELOP

training and research in Emergency Medicine

Promote training and research in Emergency Medicine so that talent can be fostered and developed for the delivery of high-quality patient care.

Work with the Irish Committee for Emergency Medicine Training to further support doctors and students through the Irish Emergency Medicine Trainees Association and the Emergency Medicine Students Society of Ireland.

Promote involvement in research, audit and professional development for all members.

Support the development and adoption of evidence-based practice in Emergency Medicine, through the development of clinical guidance and standards of care that reduce variability in care.

Strategic Objective 5

STRENGTHEN

both internal IAEM structures and relationships with other bodies that have a role in Irish Emergency Medicine.

Enable the further development of the specialty in Ireland in a coherent and co-ordinated way by strengthening relationships with the Royal College of Emergency Medicine and the Royal College of Surgeons in Ireland.

Maintain the positive collegiality of IAEM and strengthen relationships with the International Federation for Emergency Medicine and the European Society for Emergency Medicine.

Establish a clear communication structure which maximises the benefit of the association for all members.

Maximise the contribution of doctors in IAEM by investing in administrative supports.

Continue to ensure the association meets the high standards expected of a charity and pursue the priorities set out in this review.

Conclusion

This document has outlined the development of Emergency Medicine as a distinct medical specialty in Ireland and the central role of IAEM as the expert professional group of doctors delivering this care. The consultation described in this document is the first of its kind in Ireland and represents the consensus of IAEM members, the current and future Consultants in EM. This consensus has allowed the development of five Strategic Objectives that are key to further improvement in the delivery of high-quality, accessible emergency healthcare in Ireland.

In June 2020, IAEM published a document 'Resetting Care in Ireland's Emergency Departments' which described the steps to be taken by those working in Emergency Medicine and the many other stakeholders involved in emergency care as we move through and beyond the Covid-19 pandemic. With the publication of this document 'Developing Emergency Medicine in Ireland' and 5 Strategic Objectives, IAEM looks forward to working with patients, government, HSE and our professional colleagues to improve emergency care in Ireland. We look forward to using 'Developing EM in Ireland' as a template for engaging with patients, the HSE, the Department of Health and other professional organisations.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