Emergency Medicine Workforce "crisis"

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Basic problem



Capacity

Senior Clinical Decision Makers

The problem

- National problem
- Middle grade recruitment tipped the balance
- Increasingly complex attendances
- Senior Clinical Decision Makers
 - A limited resource
 - Essential for complex and grey cases
 - Need to only make the decisions they need to
 - Reduce overload decision making density high
 - A patient safety issue



Approach

- School Board meeting with representation from all Trusts (including non-training Trusts)
- Consultants, Senior nurses, ambulance representation, trainees, SAS and TG doctors
- Look for quick hits
- Aim to provide training against the same competencies for all staff groups

School Board Sept 2012

- Recruitment and retention
- Short and medium term workforce solutions deliverable at School level

Rebalancing the demand on SCDMs



Divert patients away Protocolise the pathway PAs "Level 1 ACP" MAPs Increase the decision breadth/quality Increase the number of SCDMs "Level 2/3 ACPs"

Pragmatics

- Engage experienced clinicians in EM
- Pay them to train so they are not taken off the shop floor (would further reduce the capacity)
- Fund Senior trainers/supervisors
- Could work everywhere (pan Wessex)
- Evaluate impact (where possible a lot is changing in EM at present!)
- Not Southampton-centric

What have we done..

- School Board 18 Sept 2012
- Report to LETB 20 October 2012
 - 3 short term and 5 medium term proposals
- SAS/TG "Night rota competent training"
 - 20 December for 4 months, very well evaluated(participant and Trust)
 - 12 doctors per group, second cohort running
- Top 10 Protocolised pathways Jan Apr 2013
 - Pathway development and Service Improvement training for teams in 7 Trusts

Wessex Bespoke Emergency Care Training programme

- 19 non-medical EM clinicians (17 EM nurses, 2 paramedics)
- Programme manager essential
- Permission from the College of Emergency Medicine to use the ACCS and HST curriculum for training
- Started Sept 2013, runs 6 months
- Training against 5-10 protocolised pathways
- Evaluation in conjunction with University of Southampton

Goleman Leadership Styles

- Pacesetting "Do it my way"
- Commanding/Coercive
 - "Do it because I say so"
- Visionary/Authoritative

"Let's remind ourselves of the larger purpose"

- Affiliative "People first, task second"
- Democratic "Let's work it out together"
- Coaching "Let me help you develop"

Change management

- Education is an easier way to make change
- Introducing a fully formed idea takes much more time and effort
- Protocolised pathways ownership to departments and individuals to develop their solutions, groups of nurses and doctors learning together, "legacy", visionary, coaching
- SAS doctor programme needs analysis (democratic and expert group), then commanding with clear outcomes
- Bespoke EM programme more visionary and affiliative in development

What is happening nationally?

- Run through training
- Increase ACCS entry points
- Defined route of entry
- Looking at Consultant working
- Physicians Assistants currently not fit for purpose for EM, unable to prescribe, regulation. Work in some EDs
- ACPs our MAP programme a stepping stone to this. One Trust investing in ACPs without a MAP workforce

Summary

- People centred we know one another
- EM has always had a strong multiprofessional training ethos – School is building on this
- We have started well but will need to deliver
- The workforce situation is not improving...if anything it is currently getting worse!

References

- Daniel Goleman blog
- http://danielgoleman.info/topics/leadership/
- Leadership styles in Further Education www.comp.lancs.ac.uk/computing/research/cs eg/projects/explicating/Explicatin