Emergency Medicine Workforce “crisis”

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Basic problem

Demand  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
Recruitment and retention
Short and medium term workforce solutions deliverable at School level
Rebalancing the demand on SCDMs

Reduce demand

Increase the capacity of 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”
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
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