



Careers, the New Deal and the European Working Time Directive (EWTD). These have impacted as follows:

- Reduction in hours of work (EWTD) and reduced flexibility of shift patterns (New Deal).
- Reduced availability for service commitments from doctors in training due to the increased burden of competency based training.
- Reduction in skill mix of doctors in training with few junior doctors having wide experience of several specialties prior to choosing their final career options.

At a national level, the specialty of Emergency Medicine is also due to experience a substantial reduction in the number of doctors in training, which will impact mostly on the availability of the more experienced middle grade doctors. These doctors have previously been the cornerstone of the provision of out of hour's services in the Emergency Departments. Doctors who are able to work at this level have at least 3 years of experience of Emergency Medicine with additional experience of at least 6 months in paediatric emergency medicine and 6 months in Anaesthetics / Critical Care. This additional training allows them to be competent to provide first line treatment for any patient presenting to the Emergency Department with any combination of minor / major illness and across all age ranges and all medical / surgical disciplines. Whilst they are not 'expert' in all of these areas, they have sufficient experience and expertise across a wide range of areas to treat what must be treated immediately and recognise what requires senior expert advice or assistance.

These changes have occurred at the same time as similar changes have affected the other medical and surgical specialties that provide the core resident emergency services to the acute hospitals (general medical and surgical receiving, trauma & orthopaedics, anaesthetics / critical care and in the case of Wishaw Hospital, obstetrics / gynaecology and paediatrics including neonates). The participants of the Hospital Emergency Care Team (HECT) have remained the same numerically, but each participating specialty has seen a drop in skill mix which can result in very junior medical cover over night if all specialties have their most junior staff rostered for the same shift as a consequence of availability, leave or other forms of absence of more senior staff.

Without a 'senior decision maker,' both the Emergency Department and the rest of the hospital are vulnerable as the team may lack the necessary practical skills and experience and even the most conscientious junior doctor may not recognise when expert help is required.

## **Recruitment**

Recruitment of overseas doctors was considered as a possible option based on reported experience from Wales. On further exploration, it was considered to be non-viable as an option. The intelligence from Wales indicated a high financial outlay which produced a reasonable level of interest which translated into 7 individuals

taking up appointment. In addition, the limited recruitment which took place appeared to be heavily reliant on local contacts.

Borders and Immigration have capped individual Boards freedom to target international recruitment under its Tier 2 facility. NHS Lanarkshire has been capped at 6 applications and we have already used 5 of this limit for middle grade and junior doctor appointments.

NHS Lanarkshire continues to make concerted efforts in the recruitment of a range of medical staff. A recent recruitment campaign targeted at middle grade medical staff for Emergency Medicine has resulted in two expressions of interest from candidates deemed suitable for shortlisting. Both applicants are currently overseas and discussions are ongoing with both with a view to assessment for appointment. Both will be subject to the Tier 2 Certificate of Sponsorship arrangements and only one certificate remains available to NHS Lanarkshire at this time. The Borders and Immigration capping levels are being challenged nationally by representatives from the NHS in Scotland.

In addition, the HR Directorate have been reviewing the approach to recruitment and advertising and associate literature. A short-life working group will conclude this work in the very near future and this will be shared widely with stakeholders.

Contact has been made through the Postgraduate Deanery on NHS Lanarkshire's behalf with the known group of specialty trainees due to gain their CCT in Emergency Medicine in July 2011. We have indicated that NHS Lanarkshire is currently considering implementation of a new medical model for Emergency Medicine and that this may result in future employment opportunities. Advance notice has been given of the intention to organise an informal event to raise awareness and provide details of our proposed future model for Emergency Medicine. There will be an opportunity to meet key clinical and managerial staff. Initial feedback has been positive and provisional arrangements are being made to hold the event in late October/early November 2010 to coincide with the timetable for beginning the formal recruitment process.

### **Current Position**

Each department has different strengths and weaknesses with regards to medical staff. Therefore, the definite staffing model for the 3 sites will emerge over the next couple of months. However, the aspiration is to provide a safe service and cope with the demands. To do this we are currently working to define the core business of an Emergency Department and developing detailed rotas supported by a trained doctor 24/7 as well as other professionals.

## Staffing - August 2010

	<u>Funded Establishment @ Aug 2010</u>	<u>In Post @ Aug 2010</u>	<u>Total Vacancies wte</u>	
<b><u>Hairmyres</u></b>				
Consultants	7.75	7.65	0.10	
Specialty Drs	0.90	0.35	0.55	
Junior Medical Staffing	10.00	10.00	0	(7:3 junior : middle)
	<u>18.65</u>	<u>18.00</u>	<u>0.65</u>	
<b><u>Monklands</u></b>				
Consultants	6.00	4.60	1.40	
Specialty Drs	3.00	0.00	3.00	
Junior Medical Staffing	14.00	14.00	0	(11:3 junior : middle)
	<u>23.00</u>	<u>18.60</u>	<u>4.40</u>	
<b><u>Wishaw</u></b>				
Consultants	5.00	3.00	2.00	
Associate Specialist	1.00	1.00	0	
Specialty Drs	7.60	4.60	3.00	
Junior Medical Staffing	8.00	8.00	0	(7:1 junior : middle)
	<u>21.60</u>	<u>16.60</u>	<u>2.00</u>	

Hairmyres Emergency Department has continued to be able to recruit consultant staff but not Specialty Doctors. This has prompted the transition to an increase in the consultant input in the evenings and weekends to compensate for the lack of middle grade staff. Despite this, the department remains without senior on site cover 4 nights per week from 2am to 8am.

Whereas Wishaw Emergency Medicine Department has only 3 consultants, with 2 new appointees starting in September 2010 and January 2011, supported by few doctors in training, but an establishment of 7 staff grade doctors. This later group have been hard to recruit to because of availability and the rota commitments.

Monklands has 4.6 WTE consultants and up until recently a full compliment of middle grade staff.

### Proposed Solution

Proposed solutions for employing doctors who have completed CCT have been commenced for all 3 sites, with description of rota arrangements and initial indicative costings for these roles. Funding available from current unfilled posts and released as a consequence of the reduction in trainee numbers is being quantified to offset the cost of additional recruitment.

Initial papers suggest:

Hairmyres would look to recruit 2 to 3 WTE additional trained doctors at an additional cost of between £187,000 and £325,000 to deliver a mixed economy of resident on-call consultant or full shift middle grade doctors 24/7.

Wishaw would similarly look to recruit 2-3 additional trained doctors, with indicative costings to be supplied by next meeting of workstream. There is also a need to fill the current 2 vacant staff grade / specialty doctor posts.

Monklands are currently developing their proposal, but their solution is likely to be along similar lines of 2-3 additional WTE trained doctors. These numbers are based on current level of middle grade staff, however, it is likely that trainee numbers may reduce further in the next 2 years.

The total net cost of additional medical staff is currently estimated to be in the region of £1-1.5 million.

### **Issues and Risks**

There is the obvious financial risk which needs to be explored further taking account of vacancies, competing priorities and other pressures in the system.

There are various options as to the terms and conditions on which these trained doctors might be appointed:-

- current consultant terms and conditions;
- current consultant terms and conditions with local flexibility with work patterns;
- as specialty doctors on current terms and conditions;
- as consultants on current terms and conditions with fixed term contract.

There is a further risk around the timing of any such appointment given the availability of trained doctors and the competition from other local Boards and the relative attraction of posts elsewhere.

Posts will need to be advertised to coincide with the bulge of trained doctors expected to achieve completion of training over the next few years.

There remains another risk with regards our current middle grade establishment and further reductions in trainees. It will be important to finalise our recruitment strategy for these additional posts by the beginning of October at the latest.

## **2. Developing the Role of Non medical Practitioners      lead Paul Wilson**

This group is examining the role of non-medical practitioners such as physician assistants, MINTS (minor/major, illness/injury nurse treatment service) Nurses and AHPs.

Issues being considered and emerging conclusions include:

- The physician assistant model is unlikely to make any significant contribution because of the lack of supply and limitations on their clinical practice such as the legislative restriction on being able to prescribe because they are not regulated professionals.
- There is clear support for the MINTS Nurses in emergency receiving units and the “see and treat” component of the minor injuries service which varies from 40-70% of the patients seen. Extension of the range of cases seen by MINTS Nurses from limb injuries to eye and head injuries and minor illnesses is being considered.
- Support for the MINTS Nurses role in major cases is less clear although it should be self-evident that they can help to improve the patient experience by reducing delays, improve waiting times and throughput and supporting medical colleagues in their staffing difficulties.
- A clear model of service needs to be established across all 3 Departments, albeit that there may be a need for variation provided this is rational. This can then provide a base on which to come to definitive conclusions about the contribution of non-medical staff in assisting medical staff to resolve their staffing issues. This will also make a significant contribution to MINTS Nurses having confidence that the Board consistently values their contribution.
- Tension exists in some areas over the perceived use of the medical staffing budget for the development of nursing posts and in the clinical accountability for patients treated and discharged by MINTS Nurses. There are other specialities where Nurses (and AHPs) are doing this, but the governance arrangements vary and these require harmonisation and set out as Board policy.
- There may be merit in the MINTS level of practice being the default position for all career-grade Nurses in the Accident and Emergency Department to provide greater flexibility in staffing to meet the quickly changing demands from patients and problems in medical staff supply.
- The overall nurse staffing in the Accident and Emergency Departments is at a low level when compared with many other (but not all) Boards, however there is no absolute measure which can be used with confidence to determine what the level should be.
- Indicative costings for maintaining and developing MINTS Majors service in the Emergency Receiving Units is £600,000. This is currently being incurred on a non-recurring basis.

### **3. Role of Primary Care**

**lead Alan Lawrie**

This workstream has concentrated on 3 specific areas; the development of a hybrid role for GP registrars (GPVTS) who have just completed their training programmes, the potential to direct further patients from the Emergency Department into the primary care OOH service as capacity allows and the potential to redirect patients away (during the in hours period) from the Emergency Department back to more appropriate practitioners / services within a primary care settings. The first of the strands is very much focussed on providing additional doctor input to the middle grade rotas whilst the other two are aimed much more at looking to address issues of volume of activity within the Emergency Departments.

The development of the hybrid role has moved a pace with the production of a job role which has a component within the Emergency Department, a component within the OOH service and finally an element within daytime General Practice. An invitation was issued to all doctors completing GPVTS to an engagement event and expressions of interest from several suitable doctors were elicited. This event was very successful in attracting interest from 7 GPVTS and a number of GP Practices who would be involved in the daytime component. A job description has been finalised and an advert is ready to be published. The potential requirement for sessions to be covered in the ED looks to be in the order of 16 requiring circa 4 of these hybrid doctors to be appointed. Subject to final checking on available finance interviews will progress in early September.

Work is progressing rapidly looking at the demand and capacity within the primary care OOH service, this work will conclude by the end of August and will allow there to be a debate about how patients attending the Emergency Departments could be streamed flexibly into the OOH service. Work is also ongoing to develop a pilot in the East Kilbride area where patients attending the Emergency Department would be directed, following clinical engagement, to services that were more appropriate to their needs on a daytime basis. This work would look to be concluded by the end of the calendar year.

### **4. Role of Hospital Emergency Care Teams ( HECT)**

**lead Jane Burns**

The HECT comprises between 4 and 5 medical staff and 2 nursing staff (medical & surgical). The role of the nurses within the team is a supporting role in terms of supporting nurses on the wards. They give practical guidance and advice to ward staff and carry out initial assessments of ward patients and in conjunction with the medical staff in the HECT agree and implement any care plan that may be required. HECT medical staffs should agree as a team how to prioritise their time between the needs of the ward patients and the patients presenting through the Emergency Department. This needs to apply to all medical members of the team, medical and surgical. They should also take account of clinical activity within the Emergency Department and where possible and appropriate, provide assistance when there are peaks of activity overnight. Effective team working of the HECT is entirely dependent on the evening handover from all late shift doctors to the on coming HECT, a 'mid-point' briefing and a further morning handover.

This format of the HECT team has been reviewed and is regarded as sound. It is this model that works well on the Hairmyres site where there has always been strong clinical leadership from the Emergency Department Consultants with one in particular championing the HECT with consultants in other specialties and the postgraduate tutor to ensure that attendance at the handovers is regarded as mandatory by all. This has shown that the HECT team has a valuable role of in supporting overnight activity in the Emergency Department.

At Wishaw and Monklands, general team working of the HECT and handover procedures in particular need to be refreshed, in order to replicate this good practice. The chairs of the medical staff associations on each site will be approached along with the postgraduate tutors to ask for their support in 're-launching' the role of HECT. Senior clinicians on each site will also be asked to identify a nominated champion to continue to pursue this. (September 2010)

The participants of the Hospital Emergency Care Team (HECT) have remained the same numerically, but each participating specialty has seen a drop in skill mix which can result in very junior medical cover over night. Without a 'senior decision maker,' the hospitals are vulnerable as the team may lack the necessary practical skills and experience.

The potential to combine the senior decision maker for the ED with the HECT cover is being explored in conjunction with the CCT group

## **5. Operational Issues/Patient Flow**

**lead Rosemary Lyness**

This group is subsumed into the Acute Access Action Group. The preliminary work of this group was reviewing existing contingency plans across Scotland and England. Unfortunately the group were unable to source any existing material from any Scottish or English health systems. A contingency paper has therefore been developed in draft to determine key staffing rotas required across all specialties to maintain a safe level of operation at the 3 Acute Hospital sites. In addition, the paper sets out the process to be followed to fill rota slots and/or redeploy staff and the escalation process to be followed. The paper uses "red, amber, green" categories, with a further "black" status employed to identify key shifts which if left uncovered may result in a need to divert GP emergency referrals or self presenters or downscale a service on any particular hospital site. It is anticipated that this work will be completed for formal approval in October 2010. In the interim the ability exists to manage service diversions based on activity or staffing pressures as part of the Performance Management System in place across the Acute Division.

This group has also begun work on defining "Core Emergency Department service", and an initial draft of a Standard Operating Policy for the Emergency Departments in NHSL has been submitted for comment. Currently, there is no agreed standard operating procedure in place across the 3 Emergency Departments and as a consequence, variation exists. This work will also be informed by and act on recommendations from the recent Audit Scotland Report on Emergency Department services. This paper recommends that "non-core" ED work should not take place in the Emergency Department. Examples such as specialty referrals from GPs,

specialty transfers and planned returns are deemed, within the report, to constitute “non-core” ED work.

A self-assessment audit will be completed by this group to ensure recommendations from the Audit Scotland report are addressed. It is anticipated that this work will be completed by March 2011.

### **3. CONCLUSIONS**

The complexity of the problems as well as the solutions should not be underestimated, however, each workstream is making good progress and will complement the overall solution. The proposals will be subject to a more detailed costing model and presented as part of the final paper. The Board is asked to note the progress to date and further work will be progressed through the Executive Steering Group for ratification by the Board.

### **4. FURTHER INFORMATION**

For further information on any aspect of this paper please contact Alison Graham, Board Medical Director on 01698 206318 or Rosemary Lyness, Director of Acute Services on 01698 245003.

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