Clinical Educator in Emergency Department

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Glossary

Term	Definition
ACP	Advanced Clinical Practitioner
AHP	Allied Health Professionals (such as Physiotherapists, Occupational Therapists, Speech and Language Therapists, Podiatrists).
CBD	Case Based Discussions - is a supervised learning event (SLE) tool. This is a structured discussion of a clinical case managed by a Trainee. Its strength is investigation of, and feedback on, clinical reasoning.
CE	Clinical Educator is responsible for a variety of training duties in Emergency Department. Much of their work (about 90%) focuses on shop floor teaching ensuring that learners have the skills and training as per their respective curricular requirements.
CESR route	Certificate of Eligibility for Specialist Registration - a route to entry on to the specialist register for those doctors who have not followed an approved training programme.
DOPs	Direct Observation of Procedural Skills - is a supervised learning event (SLE) tool. The primary purpose of DOPS is to provide a structured checklist for giving feedback on a Trainee's interaction with the patient when performing a practical procedure.
ED	Emergency Department.
ENP	Emergency Nurse Practitioner.
ESLE	Extended Supervised Learning Event.
HCA	Health Care Assistant.
Mini-CEX	Mini-Clinical Evaluation Exercise - 15 – 20 minutes, observed, real-life, interaction between a trainee and a patient and/or doctor. The observer provides the trainee with immediate feedback on this interaction, focussing on the clinical skills, attitudes and behaviours of expected of the trainee
RCEM	Royal College of Emergency Medicine
SAS Doctor	Specialty and Associate Specialist doctors - are non-training roles where the doctor has at least four years of postgraduate training, two of those being in a relevant specialty.
SLE	Supervised Learning Event.
tACP	Trainee Advance Care Practitioner.
WBA or WPBA	Workplace Based Assessment

Who is a Clinical Educator?

Clinical Educator (CE) provides a consistent visible clinical shop floor presence to support all the learners in ED to have the skills and training as per their respective curricular requirements. In addition to providing clinical supervision on the shop floor a CE will also complete assessments using work-place based assessments [WBPA] as required by the learner curricula (E.g., Mini-Cex, DOPs, CbD, ACAT, ELSE and management WBPA's). Although majority of teaching is shop-floor based it is also acceptable that CEs are also apt in other forms of teaching (classroom, clinical skills etc) to able to adapt their teaching to the learner and departmental needs.

The CE should not be wholly responsible for all the education and training in the department. The CE contribution is **in addition** to education delivered per agreed job plans. **This role does not alter the need for all trainers in ED to continue to participate in shop floor training and assessment.**

Learners in Emergency Department

Emergency Departments are melting pots of learners. It is very much a multi-professional workforce. CE must be a resource for all learners in Emergency Medicine. The learner group in ED are listed as below.

Group	Description
Doctors in training	• Foundation years (FY1 & 2) • EM trainees: EM streamed ACCS, DRE-EM trainees, ST3 & Higher Specialty Training (HST) • Non-EM trainees: GPVTS, AM or Anaesthetic streamed ACCS, etc
Doctors who are not in training	Locums and SAS doctors (staff grade specialists including those going the CESR route).
Allied Health Professionals (AHPs) and other Clinicians in the ED	• Health Care Assistants [HCA] • Advanced Clinical Practitioners [ACP] • Emergency Nurse Practitioners [ENP] • Clinical Pharmacists. • Paramedics • Physician Associates • Nurse Associates • Advanced Nurse Practitioners [ANP] • Surgical Care Practitioners • Advanced Critical Care Practitioners • Pharmacy Associates

What makes a good Clinical Educator?

CEs should be the exemplar for the delivery of shop floor-based training in the fundamental clinical skills of EM. The following characteristics are essential for a CE in the ED:

- A CE in EM should have patience, be respected and most importantly be credible in the field of EM
- CE must not only have a detailed knowledge of RCEM Curriculum and its application to practice but also how the curricular needs of various EM leaner groups vary.
- A CE should ideally be working at Tier 5 level as per Royal College of Emergency Medicine's recommendation.
- A CE in EM should be approachable by all EM learners so that all EM learners irrespective of their grades need to feel safe and secure.
- A CE should possess good communication skills that are essential for any good educator. These also include positive motivation skills, effective body language, listening skills, etc
- EM is a dynamic high-speed speciality. Being able to adapt the teaching/ supervision activity to shop-floor pressures so an essential requirement in any CE in EM. In addition to this important skill, a CE should also be able adapt their teaching and feedback technique to the learner/s requirements.
- CE should also have knowledge of assessment needs of the various learner group and how to complete the required assessments.
- CEs must foster a safe and nurturing learning environment.
- A CE should possess the drive and passion to meet the educational needs of the learners in the ED.

Why be a Clinical Educator in Emergency Medicine?

- Opportunity to develop a portfolio career with the CE role as the role leads to a better understanding of learners and their needs through an increase in contact time.
- This could result in renewed interest in specialty of EM
- Opportunity for uninterrupted education/training for complex patients or procedures
- Opportunity to develop other non-clinical skills such as project management, creative thinking, team development
- Better control over job plans with a higher degree of flexibility
- Choosing what to teach can lead to a renewed enthusiasm for teaching;
- Feeling of empowerment due to autonomy over decisions regarding methods of teaching and supervision.
- Reduction of direct departmental service pressure whilst conducting training, if time is adequately protected.

Why have a Clinical Educator in ED?

- Relevant workforce development of the ED can enhance job satisfaction of the individual learner
- Informed contribution by CEs to faculty statements helps focus learning needs by helping build individual learner educational profile.
- Commitment to education is demonstrated through protected teaching time during busy periods
- Pro-active CEs will actively engage learners making them feel valued.
- Individualised shop-floor supervision/ training may lead to better teamwork and improved clinical outcomes.
- Ring fenced time should increase the availability for high quality procedural training
- Opportunity to observe excellent education and training facilitation
- All of the above will help enhance the reputation of the ED and help with recruitment and retention

Who would be make a good Clinical Educator in Emergency Medicine?

- Consultant in EM:
  - Have demonstrated competence at FRCEM or Equivalent.
  - Knowledgeable in application of curriculum to practice.
  - Desirable to be Examiner.
  - Desirable to have PGCert or higher in Education

- SAS doctor in EM:
  - Many have interest in Education
  - Many have a wealth of Experience, though may not be equal in all areas of curriculum.
  - Should be supported by a Consultant CE

- Higher Speciality Trainees in EM:
  - Many have interest in Education
  - Should have passed all parts FRCEM to show knowledge
  - Should be supported by a consultant CE

- ACPs in EM:
  - Many have interest in Education
  - Many have a wealth of Experience, though may not be equal in all areas of curriculum.
  - Should be supported by a Consultant CE.
  - Should not be expected to take on a CE role while undertaking practitioner training

Clinical Educator session delivery:

A) How much?

Learners love learning sessions. So, they would like as much as possible. The delivery of educational programmes however will be dependent on the number of hours of CE time and the total number of learners. It is also possible for a predominantly shop floor-based role to be integrated into the overall strategy of educational delivery in the ED by the whole faculty. A minimum of 8 hours of shop floor clinical educator session per week in an average DGH ED is recommended. Tertiary and Trauma Centre may need more.

In addition to shop floor teaching/ supervision, the CE role is ideally placed to deliver WBPAs whose main focus is on shop floor assessment. However, it is impossible for a single CE on 1 PA to deliver all shop floor based WBPAs for all EM learners in the ED. This burden should be equally shared amongst the entire ED educational faculty.

B) When?

These sessions can't be a 9-5 thing. For these sessions to be useful to the department and the learners, they need to be matched to both learner availability and when majority of learning opportunities are available

C) CE identification

An effective CE will have a high level of both visibility and availability to learners to ensure they are accessible and well utilised. Various strategies used are:

- Different scrubs
- Badges
- Lanyards
- Clinical Educator role named on rota/ roster
- Present at handover/shift changes.

D) Organisation of CE session:

CE sessions should be learner centred session and the CE should be aware of learning/ curricular needs of the learner/s (clinical/ managerial/ leadership/ exams/ procedural/ quality improvement learning needs). These sessions could either be 1 to 1 or group sessions.

The CE role should be based on the shop floor 90% of the time; the advantage of this is the ability to teach using clinical cases specific to their ED, enabling CE to:

- Be responsive to both learner and Departmental needs; and
- Translate clinical cases into learning experiences.

This should not detract from the usefulness of also undertaking planned (scheduled) teaching sessions. Hence, we will explore organisation of both scheduled and unscheduled CE session further in the next section.

➢ Scheduled session

Staff should be able to book into these sessions either electronically or alternatively, a calendar on the wall that is accessible to all learners, which will detail the CE session (who it is, time) and indicate if there are bookable slots

There are several options:

1) Planned CBDs – the CBD Clinic
2) Rostered Focused teaching – Exam Prep
3) Clinical Skills –commonly performed ones such as suturing or uncommonly preformed ones such as cardioversion, thoracotomy, etc.
4) Responsive Teaching based on Clinical Incidents, Complaints
5) ESLE or Reverse ELSE or ACAT
6) Planned 1:1 teaching sessions that identify Learner needs beforehand
7) Case of week discussion either online or face to face in handovers
8) Ultrasound teaching
9) Scheduled simulation in simulation suite or in-situ either focussing on human factors or clinical teaching elements or both. These sessions could focus on either team based or individual learning needs.
10) Teaching by clinicians from outside ED or other healthcare professionals: for example: teaching on proning patients during coronavirus pandemic, etc.

➢ Unscheduled session (Majority of CE sessions)

These CE sessions timetables should be made available to all staff by email or posters or notice-boards. Staff could also be reminded at handovers that CE is working that shift. These sessions need to be adapted to departmental needs (busyness).

Unscheduled teaching session in a non-busy ED department

These sessions can be planned as opposed to the teaching in a busy department. Some of the suggested activities are:

1) Silent simulation

In the pandemic period, when staff are wearing PPE, there are risks of miscommunication. People cannot hear properly as it gets muffled. And noisy ambience makes it worse. Instructions can be misheard. There is high chance of non-verbal language being lost. This has been recognised as a known consequence leading to fatal errors. It has been noted the use of sign language, and use of alternate methods of communication will help to reduce these errors. Silent simulation sessions wearing full PPE in pragmatic clinical settings, either in high fidelity or low fidelity environment using these standardised sign languages, or white board communication in small group teaching sessions will certainly help.

2) Pop-up simulation

- Prep your team 30min before
- Get them to set an alarm 5min before kick off
- Any Empty cubicle will do
- Low Fidelity Patient – one of your team, Staff or student
- Low Fidelity Kit – SimMon App on 2 phones – 1 control 1 Monitor
- 5:5:5 Formula -5min Run, 5min Discussion, 5Min re-reun
- Spaced Repetition Learning
- Focus Debrief on Decision Points

3) Clinical Skills observation or teaching (opportunistic) such as fracture manipulation or sedation.

Unscheduled teaching session in a busy ED department

These are more opportunistic or “Grasp the Unexpected Teaching Moments”.

Strategies commonly used:

1) Have prepared various forms of mini teaching sessions focussing on high yield topics that can be used in between cases. PEARLS (clinical, governance, well-being), FOEM-ED prescription/ Post-it pearls, Bite-size learning, etc

This format suits both the trainers and learners where there are financial and time constraints. It is cost effective, quick, concise and can be contextualized to the department and to the need of the hour. These are best described as a string of multiple independent clinical information from experience or observation which is useful for clinical practice, gained from real life clinical experiences. This can be done in various platforms. E.g. writings on white boards in department for display, sticky posters on post up wall or using the different electronic media like email, social media platforms like WhatsApp, Twitter, Instagram or Facebook whichever is popular in the department recognising the governance issues of patient confidentiality, data protection and adhering to the local policies with safety measures in situ.

2) Use current clinical cases as a teaching resource, focusing on their care, clinical process and management. Most of these are one to one, over a short period (no more than 30 mins for each individual), tailoring the learning to the learner’s specific needs. This can help to reduce pressure on the shop floor.

Teaching strategies used for clinical cases could include:

- ✓ 1 Minute Preceptor or 5 Step Micro Skill
- ✓ SNAPPS

Teaching strategies used for clinical skills could include:

- ✓ Active Demo of Clinical Skill

E) Capturing Learner Feedback

To ensure the success of the CE role, capturing the feedback of learners is essential as it enables CE to improve their teaching and the training they provide. This can be achieved using specific forms either in the paper format e.g. Leicester CBD (appendix1) and SIM feedback (appendix 2), teaching session feedback (multidisciplinary) and can be done immediately after the teaching or online using survey monkey / Google survey / JISC;

Potential Challenges of Being a Clinical Educator with possible solutions:

1) All WPBAs left to the CE: Use quota system where the responsibility for completion of WBPAs is shared between all consultants:

$$\frac{\text{Number of assessments per trainee x number of trainees in ED}}{\text{Total number of faculty delivering education in ED}}$$

2) Being pulled into clinical management during a CE session: This can be helped by gaining support for the CE role from Operational leads/ managers/ matrons OR by modifying the CE role to reflect how busy the department is.

3) Department recognising that CE role is in addition to existing training not as a substitute for it: The training activities of all consultants and its audit is the responsibility of the clinical lead/training lead who should undertake to monitor all consultant training activity.

4) Learner buy-in for CE sessions: Popularise these sessions so that the leaners are aware

5) Assumption that patient flow affected negatively due to CE: Adjusting teaching and training to minimally disrupt flow is an important skill of the CE. As suggested in the manual maximum 30 minutes per learner.

Lone Nuts Dancing & Embedding the Change.

The key to embedding any change is building a movement to support it. At TED in 2010 Derek Sivers, used the analogy of the Lone Nut Dancing, to describe how movements are formed. This analogy deals with the concept of leaders, and the importance of recruiting followers. Once a change has a big enough following it rapidly becomes accepted practice, and even those that initially opposed join.

As you move from a pilot to business as usual for the CEED programme you will need to build our own movements. This involves:

- Identifying and engaging our key stakeholders, who will be your followers.
- Pitching the idea by telling a narrative that speaks to their priorities.
- Showing we have analysed the project and thought it through.
- Demonstrating it aligns with Trust Priorities.
- Completing a business case.

This is new to many clinicians and can be quite daunting. The aim of this section is to demystify the process and provide some tools that can be used to help.

The Audience – Key Stakeholders

The exact audience will vary from organisation to organisation, but for CEED they can be classified into 5 main groupings, these are summarised in the table below.

Table 9 Example Stakeholders

	Examples:	
Medical Leaders	Consultant Colleagues	Departmental
	Clinical Lead/Director	
	Divisional Director	Division/Care Group
	Medical Director/Chief Medical Officer	Trust Executive
Nursing Leaders	Band 7s	Departmental
	Matrons/Nurse Educators	
	Associate Directors of Nursing	Division/Care Group
	Chief Nurse/ Director of Nursing	Trust Executive
Operational Managers	Service Manager	Departmental
	Divisional Director	Division/Care Group
	Chief Operating Officer/ Managing Director	Trust Executive
	Chief Executive	
Financial Manages	Divisional Finance Manager	Division/Care Group
	Chief Financial Officer	Trust Executive
End Users	Our Learners	Departmental
External Bodies	RCEM	National
	HEE	ALB/National (England)
	School of EM	Regional

Stakeholders will have varying levels of power and interest in the CEED project, which will dictate how you will need to engage with them (Figure 1 https://tinyurl.com/ycgf5hxx https://tinyurl.com/hrqv9yx) . Mapping out this can help us prioritise who we need to get on board with to move the project forward. Table 10 is a useful tool for mapping the impact of your stakeholders. It is important to remember that while the end users (learners) will be very interested in the project, they will often have very little influence or power over it.

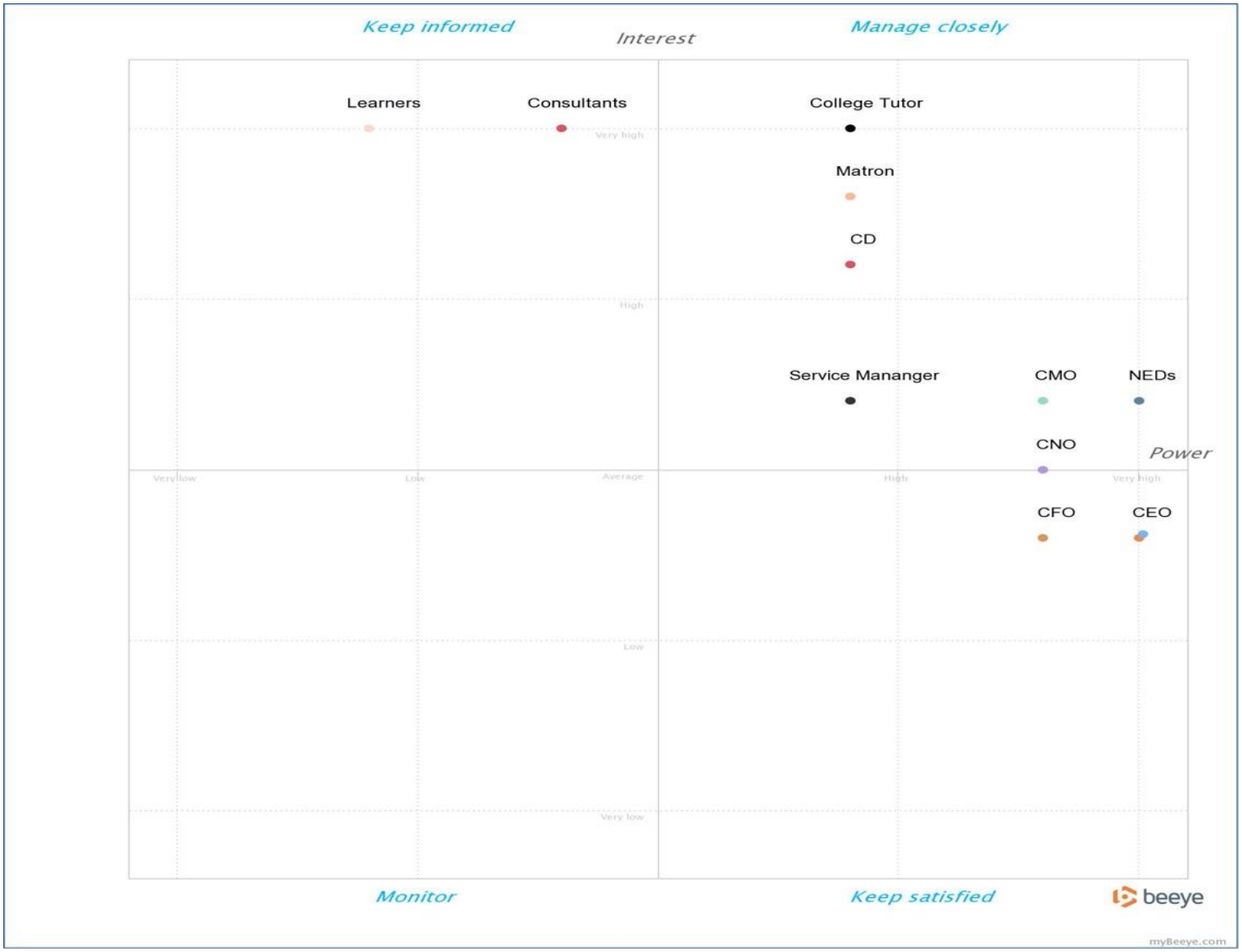


Figure 1 Power v Interest

Table 10 Stakeholder Mapping

	Stakeholder Role	Journey Impact Upon Stakeholder (Low, Medium, High)	Influence How much influence do they have over the journey? (Low, Medium, High)	What is important to the stakeholder?	How could the stakeholder contribute to the journey?	How could the stakeholder block the journey?	Strategy for engaging the stakeholder in the journey	Interventions for dealing with stakeholder knowledge gap(s)
1 Example	Clinical Director	High	High	KPIS, R&R, Staff satisfaction Safety	Support is key, Financial and job planning Open Doors to other stakeholders	If not supportive will be difficult to recruit other stakeholders	Frequent 1:1s	Link with other CEs and departments who have them
2								
3								
4								
5								
6								
7								
8								

Pitching the Idea.

Once you have identified the stakeholders and their respective influence over the project, you need to pitch it to them. This may seem alien, but it actually you pitch every day in your clinical day job.

On the shop floor, patients tell stories that are related to you. You then pitch those stories to key stakeholders. It could be the story of the patient with abdominal pain who needs a CT. Or the patient with pneumonia who needs admission. You are an expert in identifying the priorities of your stakeholders, and ensuring you speak to those.

Pitching for support for CEED as business as usual is the same. You need to speak to the key stakeholders with the most influence, ensuring the story is tailored to their priorities.

This means that when you pitch to senior clinical leaders you should emphasise the patient safety aspects of improved retention. Equally impact on GMC survey results or local surveys you have done as part of the pilot will be useful here

The pitch to Chief Finical Officer will probably focus on the impact on financing, so improved retention means less money on locums.

The Chief Operating Officer may be more focused on performance against key indicators such as the 4-hour standard, so improved retention means fewer locums, which means fewer breaches.

Non-executive directors will be more focused on patient and staff experience. Thus, improved retention means fewer temporary staff which means better patient experience.

By the nature of their jobs key stakeholders may only have a few minutes for you to win them over. The key is a practiced, short succinct pitch which speaks to them – in business this is an elevator pitch. This video gives a nice summary of the elevator pitch.

Data Drives Change

Just as in clinical medicine we use data to drive change, the same is true in a business case. If you want Trusts to invest funds, you need to show how it will positively impact on key Trust objectives. Data from the pilot will help here, but you also need to factor in local data. This could be:

- Recruitment and retention.
- Markers for staff satisfaction – GMC survey, Staff Survey, Sickness.
- Conversion of Trainees to substantive consultants.
- Spend on temporary staff.
- Patient Safety.
- Impact on Key Performance Indicators.

Remember that your story needs to speak to your most powerful stakeholders, so you need to map things as much as possible to your departmental and Trust priorities. When analysing the potential impact of the project, SWOT and PESTLE are useful analytical tools that allow us to clearly map out the costs, benefits and potential barriers to the project.

SWOT stands for:

- Strengths
- Weaknesses
- Opportunities

- Threats

It is mapped out in a 4x4 box plot. Strengths and Weaknesses are internal to the organisation while Opportunities and Threats are external.

An example SWOT for CEED is below:

Clinical Educators in the Emergency Department

Last modified: Aug 14, 2020 9:31 AM

	Helpful to achieving the objective	Harmful to achieving the objective
Internal Origin (attributes of the organization)	Improved Trainig for Staff Team building multi professional learning Improved staff satisfaction Better retention Drives innovation Improved Patient Safety Decreased Locum spend Reenforces clinicl skills in clinicians	Requires additional funding Takes staff away from other duties May reduce teaching by non CEs
External Origin (attributes of the environment)	Tool for recruitment Translation to other clinical services Build links across teaching ecosystems Address CQC domains Aligns with Trust Principals	Shifting political landscape Trust budget Reorganisation of Arms Lemght Bodies

Figure 2 SWOT Analysis Example

PESTLE (Table 11) analysis is tool for mapping external forces that will impact on the project. It is broken into:

- Political
- Economic
- Social
- Technological
- Legal
- Environmental

Many consultants will be naïve to both of these tools, however by adding them to our narrative for change we can show that we have thought through things and analysed them in a structured way. Just as we do when we clerk a patient or review with a junior. This level of analysis will instil confidence in our most powerful stakeholders that the project is well thought through and not just a flight of fancy.

Completing the Paperwork

All Trusts will have their own version of business case template. We have included a generic example, with some suggested wording. The templates can be very daunting to the uninitiated, so a key step here is to enlist the help of

your service manager or equivalent. Once you have drafted your case they will be able to help you tweak the language and importantly add the data that will reinforce your case for change.

Whenever possible make the case for a permanent change. The aim is for Clinical Educators to be part of Business as Usual rather than something that requires annual funding review.

Table 11 PESTLE Analysis Grid

Political	Economic	Social	Technological	Environmental	Legal

Appendix 1 - #EM3 Educational Fellow CBD Clinic Feedback

University Hospitals of Leicester NHS Trust

#EM3 East Midlands Emergency Medicine Educational Media

#EM3 Educational Fellow CBD Clinic Feedback

Education Fellow Clinic Type (Please Circle): Adult Paediatric

What grade are you? (Please Circle)

FY1 FY2 GPVTS ST1 GPVTS ST2

Trust Grade SHO ANP ACCS CT1 ACCS CT

Was the booking process for the CBD Easy? (Please Circle)

Very Easy Not Easy

Easy Difficult

Do you like being able to book you Educational Assessments online? (Please Circle)

Yes No

How many CBD Clinics have you done before? (Please Circle)

None 1 2

3 4+

What was the topic you brought to the CBD clinic today?

Why did you bring this topic?

What did you want to learn from your CBD Clinic visit?

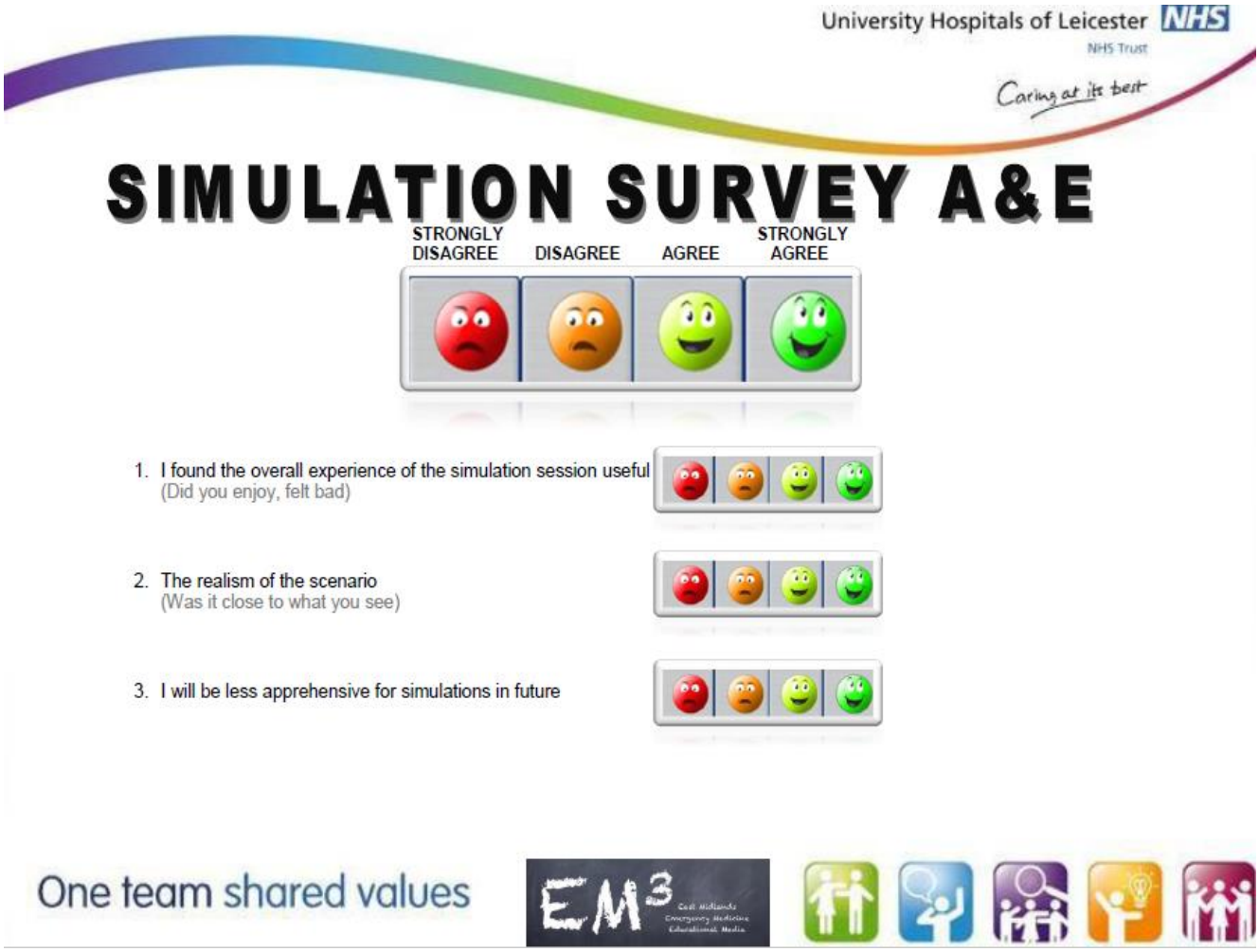
What did you learn from your CBD Clinic visit?

Are the CBD clinics a useful resource? (Please Circle)

Yes No

what could we have done better? Any other comments

Appendix 2 - Simulation Survey A&E



Appendix 3: One Minute Preceptor Model

The one-minute preceptor model was first described in Family Medicine Education literature by Neher et al 1992

Four Steps to the One Minute Preceptor Model

1) Get a commitment from the learner
2) Probe the learner for what led them to their differential diagnosis or plan
3) Teaching a general principle
4) Reinforce what was done right and correct errors

OR

This is a 5 step model of clinical teaching that utilizes Simple, discrete teaching behaviors or "microskills."

1) get a commitment,

2) probe for supporting evidence,

3) teach general rules,

4) reinforce what was done right, and

5) correct mistakes.

Reference:

Neher J, Gordon K, Meyer B, Stevens N. A five-step "microskills" model of clinical teaching. J Am Board Fam Pract. 1992;5(4):419-424

Appendix 4: SNAPPS

This is six steps teaching method

1. Summarize Briefly the History and Physical Findings.

2. Narrow the Differential to Two or Three Relevant Possibilities.

3. Analyze the Differential by Comparing and Contrasting the Possibilities.

4. Probe the Attending / Preceptor by Asking Questions about Uncertainties, Difficulties, or alternative Approaches.

5. Plan Management for the Patients Medical Issues.

6. Select a Case-related Issue for Self-directed Learning.

Reference:

Wolpaw, T., Wolpaw, D., & Papp, K. (2003). SNAPPS: A Learner-centered Model for Outpatient Education, Academic Medicine 78(9), 893-898.

Appendix 5: Clinical Educators Model Business Case to submit to Trust exec for funding

STRATEGIC BUSINESS CASE Clinical Educators in Emergency Departments

1. Executive Summary	
Service Development	
Division / Service	
Clinical or Service Lead	
Strategy & Business Development Lead	
Strategic Lead	
Executive Sponsor	

Strategic Review Y/N	***Divisional Board Y/N***	***Budget Setting Y/N***	***Capital Plan Y/N***	***TEC*** *dd/mm/yy*	***TIG*** *dd/mm/yy*	***S&FC*** *dd/mm /yy*	***Trust Board*** *dd/mm/yy*

This case is to seek approval to fund X amount of PA's for time to provide multi-professional education in the Emergency Department which is outlined within this case.

A Health Research Authority (HRA) approved research evaluation of the pilot has been completed and suggests the following core benefits to the Trust and department:

- improved or accelerated capability and clinical confidence of Emergency Department learners,
- improved safety/decreased risk,
- an improved recruitment profile,
- an improved working environment that supports the wellbeing of staff,
- enhanced support for new staff including those from overseas.

The service require the changes by the department to the Consultant rota and workforce plan to increase it's capacity in order to accommodate the request.

Financial Summary

Breakdown of request of number of PA's required (including the additional time required to accommodate any clinical work)

Service Development title	***Value***	***Pass/Fail***
Is I&E impact positive in the remainder of the current financial year? (If applicable)		
Is the I&E impact positive in the first 12 months?		
If a revenue only case is the ROI positive?		
If a revenue only case is the ROI 2:1 or greater? (year 5)		
Is the NPV positive?		
If capital, is there x3 payback within the first 10 years or asset life (whichever is sooner)?		
Are all quantified benefits cash generating?		

Approval Threshold Required:

TIG: Y / N	**TEC: Y / N**	**TB: Y / N**

TIG/TEC/Trust Board are asked to:

-

2. STRATEGIC CASE

Note: Only detail relevant to the case being made is required, however robust supporting evidence should underpin the case and be available upon request. A clear, succinct rational for why an investment decision/approval is being requested is also needed.

Current Top 3 Division Priorities:

Local input: Consider priorities such as ED dashboard, reduced wait times, staff recruitment and retention, overall cost savings, improved staff wellbeing

How does this proposal compare to the priorities above:

Outline how the strategy responds to the priorities above.

How does the case deliver the Trust's strategic priorities:

Outline Trust strategic priorities and how the strategy responds to these

2.1 Case for Change *[Why?]*

National driver, commissioner intention, market/ growth changes, capacity or operational pressures, governance/safety concerns, investment...

In 2012 RCEM highlighted a number of concerns to the General Medical Council [GMC] related to emergency medicine training, these included:

- continuing service pressures, which reduces the amount of time trainers can dedicate to delivering training;
- rota gaps, which increase the pressure on doctors in training to work more out-of-hours shifts;
- a lack of senior supervision for junior doctors in training; and
- a lack of resources, leading to ineffective simulation training.

The GMC in turn published a review of training in seven emergency medicine departments where they highlighted concerns around:

- understaffing as evidenced by increases in unfilled training posts;
- the perceived undesirability of the specialty due to the high and intense workload;
- an increase in unsatisfactory outcomes in Annual Review of Competence Progression [ARCP];
- the amount and quality of supervision received by Trainees.

These issues have been further highlighted and evidenced in the following sources:

- Previous assessments of training by EM trainees has indicated that training could be

improved in a number of ED. (GMC NTS 17&18).

- Trainees reported disillusionment with the specialty of EM with high rates of burnout reported, concerns over intensity of the workload, and the quality of training. (GMC National Training Survey [NTS] and Emergency Medicine Training Association [EMTA] surveys).
- Recruitment has previously been reported as a problem but also retention with trainees leaving EM typically after core training or remaining in EM but pursing their career in another country. (RCEM data 2017/18).
- Anecdotal suggestions that staff shortages and the pressure of clinical work may have been impacting on the ability of educators to deliver training.

This suggests that there is a link between the quality of training and:

- recruitment and retention of staff;
- the ability to successfully progress through the training programmes;
- the recipient's sense of value, morale and wellbeing; and
- creating a culture that supports learning and challenge enhances patient safety, leading to fewer clinical incidents.

In October 2017, RCEM, HEE, NHS England and NHS Improvement published 'Securing the Future Workforce for Emergency Departments in England' to ensure a sustainable workforce capable of meeting the growing demands of the future. The publication refers to the development of a clinical educator strategy to support junior clinical staff working in (ED) and reduce attrition to the workforce.

This was to be achieved by offering increased time for education with senior clinicians; the absence of which can often be exacerbated by clinical pressures in the ED, lack of teaching infrastructure, small clinician bases and workforce gaps. The Clinical Educator strategy looked to address these issues and undertake a pilot scheme that focused on providing dedicated training time within ED within up to 60 underperforming Trusts in England; Trusts which were in the lowest third of all Trusts (according to the GMC trainee surveys).

The CEED pilot ran from October 2018 to October 2020, providing dedicated or 'ring fenced' time for education on a weekly basis for a minimum of 4 hours for the multi-professional team in the ED.

An independent evaluation of the project was commissioned by HEE and delivered by Aston University (Academic Practice Unit), supported by the Royal College of Emergency Medicine.

Insert local information about EM training, multi-professional education and drivers for change.

2.2 Evidence for Change

Long-term Plan, benchmarking, utilisation rate, occupancy %, peer assessment, pathway redesign, skill mix shortage etc

An independent evaluation of the project delivered by Aston University (Academic Practice Unit), supported by the Royal College of Emergency Medicine is due to be released early 2021. Findings from the evaluation report have suggested that the strategy provides the following benefits:

- Improved or accelerated capability and clinical confidence of Emergency Department learners. 179 (83% of) learners stated that having a clinical educator in the emergency department improved their competence and confidence.
- Improved safety/decreased risk. There was support from all three stakeholder groups that patient safety has improved or significantly improved as a consequence of clinical educators – Learners (n=177, 82%), clinical educators (n=100, 91%) and managers (n=29, 88%).
- An improved recruitment profile. 90% managers surveyed expressed the opinion that the potential impact of having a CE on recruitment and retention of clinical ED staff was better or much better.
- An improved working environment that supports the wellbeing of staff. All three stakeholder groups expressed the clear opinion that wellbeing at work was improved or significantly improved by the clinical educator programme - Learners (n=152, 70%), clinical educators (n=106, 96%) and managers (n=26, 79%).
- Enhanced support for new staff including those from overseas. 90% of managers consider it very important or of some importance for CEs to support overseas trained staff with their development and training needs. Almost all clinical educators (n=95, 86%) considered it important or very important for them to support staff who are trained overseas with their development and training needs.

The evaluation demonstrated due to the clinical educator strategy, enhanced quality of education in the Emergency Department. 'The extra time afforded by the Clinical Educators to the learners enabled a greater depth of education to be provided, that was relevant and targeted to the learner, and expressed in the context of how this might be applied to patients'. Shop floor teaching is highly relevant and valued by learners. The strategy also supports progression with a variety of learner assessments, essential for demonstrating and supporting learner development and advancement through training stages. It was also noted that learners with identifiable training needs could be given extra support by the clinical educators.

Insert Local Data and Case -

2.3 Top 3 Project Objectives (look at local data to demonstrate)

1. **Improve educational environment leading to improvement in learner progression through training**
2. **Improve patient safety through improved clinical competence and confidence from staff**
3. **Improve staff recruitment and retention through improved wellness and demonstrated value for staff**

2.5 Proposal / Summary of Change *[What/How/Who/When?]* ***Please see Schedule A for supporting detail***

'Business needs' - service change, operationally, workforce, kit, support service impact ie Radiology, Pathology, Microbiology, other

Local input –

Permanent changes to current staffing levels to enact required changes if increased PA numbers within department.

2.6 Supporting Estate Plan *(if applicable)* ***Please see Schedule B for supporting detail***

N/A

2.7 IT Impact *(if applicable)*

N/A

2.8 Estate Procurement Impact *(if applicable)*

N/A

3. OPTIONS APPRAISAL

3.1 Option Appraisal Process

Describe what assessment criteria informed the exclusion or inclusion of options, led to the shortlist and recommendations:

[Text]

i) Do Nothing
ii) Fund Minimum
iii) Fund Maximum

Option 1 - Do Nothing

- This would involve providing no further funding to the role after the HEE funding envelope has closed. However, this would effectively reduce the current allotment of time attributed to education and remove the benefits gained during the pilot which cannot be sustained without continued funding.

Option 2 – Fund Minimum

- The trust would continue to provide the department with the amount of funding it was using to match fund the CEED pilot. This would reduce the current allotment of time to half of that provided during the pilot. It may maintain some benefits, but the evaluation strategy will more fully outline whether there is a requirement for a minimum amount of time for the strategy in order to provide benefits.
- Insert costing

Option 3 – Fund Maximum

- The trust would provide the department with the full amount of funding required to run the strategy as outlined in the pilot, making up the amount that would have bee provided by HEE through the pilot funding envelope.
- Insert costing – consider how many staff are in the department, how many are trainees/ students/ learners, and how much time is required to ensure all education obligations are fulfilled.

Recommended Option *(including the reason for this decision)*

Option 3 is recommended because this option ensures that the benefits from the pilot period are sustained and enhanced as the strategy is given sufficient resources

4. ECONOMIC CASE *(Financial & Non-Financial Benefits)*

Business cases should quantify the net change from existing run rate

4.1 Contracting

Commissioner/s impact, new work/service or existing? Where is the work coming from? Which commissioners? Letter of support?

4.2 Performance

*Are there any impacts on performance/ fines that the case will address? **be specific and quantify*

Look at local performance indicators

- Recruitment and retention
- Locum spendage
- NHS staff survey on wellbeing
- Local gmc survey / school survey results
- SI numbers
- Wait times
- Deanary surveys

4.3 Estates

Assumption, procurement strategy & timeline

N/A

4.4 Efficiency (CIP)

Quantify CIP benefits (< LOS, theatre time, cost saving)

See if there have been cost savings from reduced locum expenditure, increased ability to take on placements including medical trainees, ACP trainees, and PA trainees. See if there is any improvement in ED dashboard measures.

Are there any benefits of the case in your CIP Schedule: **Y / N** **£saving**

4.5 QIPP *(Quality, Innovation, Productivity & Prevention)*

Change of pathway, process, disinvestment, demand management

4.6 Risks

Financial, capital, commissioner, service & other

Patient Safety: The impact of the CEED pilot on risk and safety was explored in the evaluation. Participants confirmed that in their opinion risk is reduced and safety increased. At least one site noted that the clinical educator could focus on recommendations following serious untoward incidents, and thereby supporting the clinical staff to adopt new, often urgent, guidance. Quantifying the effect on adverse incident reporting is beyond the scope of the CEED evaluation, but this will be explored further in later phases of the study. Trusts could look at number of recurring SI's in department, learning shared from incidents etc.

Patient Flow: Many participants in the evaluation agreed that patient flow is not adversely affected by the CE programme. CEED pilot survey results show that both patient flow and wait times improved during CEED pilot.

Sustainability: This is may be an issue especially where clinical educators are employed beyond their normal working time. It is recommended that consultants be offered the opportunity to take on the role instead of time allocated to clinical care. This will have a knock on effect in possibly requiring an extra consultant post to cover this clinical time, however the benefits of retention to the consultant workforce outweigh the financial cost.

5. FINANCIAL CASE

5.1 Financial Case ***(Please see Schedule C, D & E for supporting detail and table in Exec Summary)***

*How does this proposal deliver value for money and benefits financially **

5.1.1 Core financial assumptions:

5.1.2 Impact on balance sheet:

5.1.3 Cost/benefit analysis:

5.1.4 Impact on I&E:

5.1.5 Financial Metrics:

FINANCIAL METRICS	£
Income per £ of pay bill	
Cash flow	
NPV	

5.1.6 Optimism bias/sensitivity analysis:

5.1.7 Capital Summary:

Project Costs	SQM	SQM £	Total £
Sub-total estate/capital Cost		**£**	**£**
Consultants	-	-	£
Contractors	-	-	£
Other development costs	-	-	£
Communications	-	-	£
Standard Equipment	-	-	£
Specialist Equipment	-	-	£
Software	-	-	£
Project management costs	-	-	£
Sub-total project costs			**£**
Overall total cost			**£**

Strategic Maintenance related cost: £ / X% of investment

5.2 Commercial Case (if appropriate)

N/A

5.3 Financial Summary Conclusion:

6. MANAGEMENT CASE

A project group will oversee development of the case with a nominated Chair and project manager from the Trust Strategy team. The governance, delivery, monitoring and risk escalation will be co-ordinated by this group together with project and business plans. If the project is complex or high risk a Steering Group will be established so that governance is strengthened, as well as level of expertise.

Schedule	TIG & TEC Case Supporting Information
Schedule A	**Demand v Capacity Analysis (supporting evidence)**
Schedule B	**Estate Plan & Timeline**
Schedule C	**Workforce Plan**
Schedule D	**Production Plan**
Schedule E	**Financial Plan**
Schedule F	**Impact Consultation**

Note: The schedules above are required for TIG and TEC as supporting information however, not S&FC or Trust Board other than the recommended NPV

APPROVAL PROCESS

Internal Trust sign-off

Stage I *- upon completion of the case the following* ***mandatory*** *signatories are required. Signatories must be given at least 5 days before sign-off is needed to review the case appropriately.*

Stage II *- cases are then to be sent for approval to the required deadline date of the following committees/Boards (c2 weeks before the meetings):*

COMMITTEE / BOARD	FINANCIAL THRESHOLDS
Trust Investment Group (TIG) *Cases requiring capital / capital and revenue* *TIG Lease Sub-group*	**<£250k** *(revenue)* **<£1.5m** *(capital)* *To £50k*
Trust Executive Committee (TEC):	**£250k to £1m** *(revenue)* **& £1.5m - £2.5m** *(capital)* All revenue only cases to TEC
Strategy & Finance Committee (S&FC)	*Cases going forward to Trust Board*
Trust Board (TB)	**>£1m** *(revenue)* **& >£1.5m** *(capital – new schemes)* ***>£2.5m*** *(capital – schemes in capital plan)*

- *All cases with negative I&E impact in-year or over initial 12 months will only be approved in exceptional circumstances – CEO and CFO approval required.*
- *All revenue only cases should target an in-year revenue return on investment of 2:1, although all positive in-year return on investment will be considered by exception.*
- *All cases with negative NPV will only be approved in exceptional circumstances if in line with our strategy – CEO and CFO approval required.*
- *Capital cases should aim to repay initial capital investment by 3 times over the initial 10 years or life of the asset, whichever is sooner. Cases with a longer return period will be considered by exception.*

APPROVAL **To be signed-off in the order shown*

Stage I - Divisional Sign-off	**Name and Date**
DCD / DDO	
Division Board Date Signed-off	
Stage II - Corporate Sign-off *(in order shown)*	**Name and Date**
Director of Contracting / Commercial Development *(as appropriate)*	
Director of I&MT *(when appropriate)*	
Director of Estates & Capital Development *(if Capital required)*	

Deputy Director of Strategy	
Director of Finance	
Executive Sign-off	**Name and Date**
Sponsoring Executive	
Chief Finance Officer	
Trust Investment Group	Date:
Trust Executive Committee	Date:
Trust Board	Date:

Schedule C

WORKFORCE PLAN

Summary table (current v request by band and WTE):

Consultant Job Plan if part of the case:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM						
PM						
Evening/ 3rd						
Trust Private Session						

Signed-off HR Business Partner: Name: **Date:**

Schedule E

FINANCIAL PLAN

Gavin - standardised NPV template for all DFMs

Signed-off DFM: Name: **Date:**

Schedule F

IMPACT CONSULTATION

Service	Specific Service/s Consulted	Core Feedback	Service Lead	B/Case Revenue £	B/Case Capital [Y / N]
Surgery					
Cancer					
Theatres					
Critical Care					
Specialist Medicine					
Emergency Medicine					
Medicine for Older People					
Ophthalmology					
Pathology					
Psychiatry/Psychology					
Child Health					
Women & Newborn					
Support Services: Pharmacy Physio Medical Physics RT Other?					
Cardiovascular & Thoracic					
Neurosciences					
Trauma & Orthopaedics					
Radiology					
Contracting					
Finance					
Commercial					
IM&T					
Estates					
Other					

BUSINESS CASE CONSULTATION:

DDOs are kept advised of pipeline business cases monthly via the TIG Report produced by the Strategy Team, to devolve this to their teams and ensure appropriate representation is then part of the development at the right time.

The Trust structure for consultation on cases and for communication includes:

- *Trust Strategic Development Meeting (monthly) chaired by the Deputy Director of Strategy*
- *Trust Capacity Group Meetings (weekly) chaired by the Deputy Chief Operating Officer*
- *Divisional Board Meetings chaired by DDO*
- *Divisional Director of Operations Meetings (DDOs) chaired by the Deputy Chief Operating Officer*
- *Divisional Clinical Director Meetings (DCDs) chaired by the Chief Executive Officer*
- *Care Group and Operational Meetings chaired by CGM or nominated representative*
- *Project team meetings chaired by nominated representative subject to the scale of the case*
- *Other Trust meetings and governance structures*

Equally the project team for a business case is responsible for engaging across Trust services and externally if appropriate to ensure all impacts of the case have been appraised, as well as included within the case if needed. These are recorded in the table above.