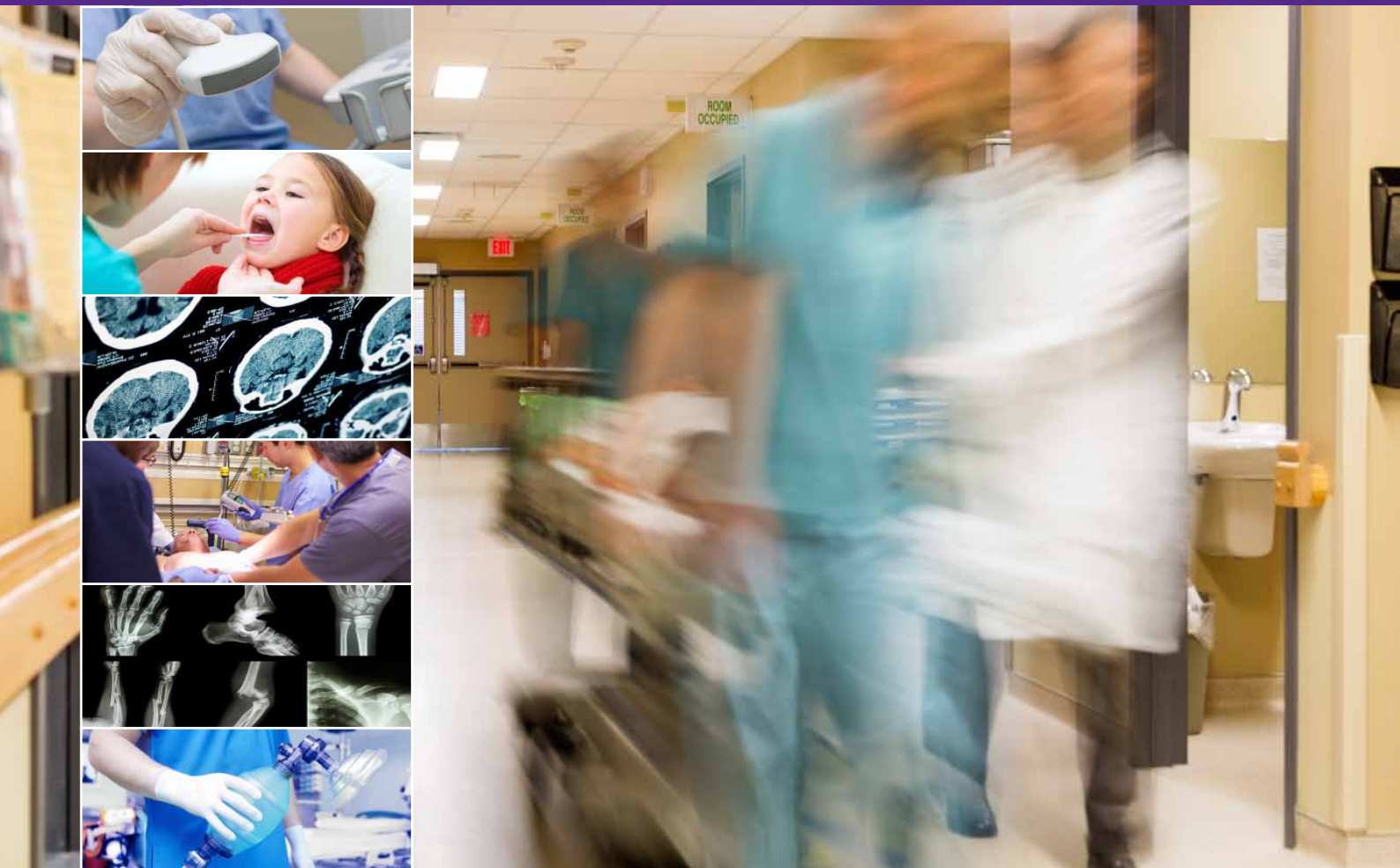


The College of Emergency Medicine

Creating successful, satisfying and sustainable careers in Emergency Medicine



Guidance from the College of
Emergency Medicine

Foreword

It is a great delight to introduce the College's work on promoting, establishing and maintaining a sustainable career in Emergency Medicine. All of us deal with the challenge of delivering safe and effective emergency care each and every week. Emergency Medicine was never the easy option but the current pressures threaten not only to diminish the care we deliver to our patients but to undermine the resilience of each and every one of us.

The College is campaigning hard to end or reverse the most egregious problems that the specialty faces. In particular tariff reform, contract reform, doctor to patient ratios and exit block are issues that we need to engage and persuade others to address. Nevertheless we are not victims, we are heroes; we are not without intellect, endeavour or even imagination and we can and must do more to protect all who join 'Team EM'

Last year's Scientific Meeting in Twickenham hosted the first presentations from the sustainability work streams and 'standing room only' was the response. The contents of these documents have built upon the original work and provide tool kits of value to us all.

I have had no part in the development of these documents but I am proud to be part of a College that champions the wellbeing of its members.

Clifford Mann
President, College of Emergency Medicine

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Scene setting – why this is important

Context

Emergency Medicine (EM) remains the most exciting, stimulating and rewarding specialty for those of us fortunate enough to have been involved in it for the last 27 years (and counting.....). However, together with the excitement and satisfaction of caring for people in those first few critical hours of their illness or injury there is a sense that we have not paid enough attention to ourselves and defining what 'good' is for us. This guidance developed by the College aims to address this for the first time in a comprehensive and structured fashion.

The College also continues to work hard to help to define solutions for the pressures being placed on senior staff in Emergency Departments (EDs) both to deliver a safe high quality service and also to train the next generation of senior medical decision makers. A great deal of work is ongoing to improve urgent and emergency care systems so that there is capacity and system resilience to meet the increasing demand. Equally important is the need to provide expert opinion for employers and commissioners of healthcare on how to care for senior medical staff in ED so that they can have long and fulfilling careers, prevent premature career 'burnout' and for the next generation to be attracted to what is still arguably the best specialty in clinical medicine.

This guidance strategy developed by the College aims to address these very important issues, applying expert opinion from a range of leaders in our specialty. Each of the contributors have either led on authoring or contributed as a team to writing the articles in this guidance. We are grateful for the time, energy and commitment they have shown. Recommendations are made throughout which we feel are achievable and merit urgent attention. Failure to address these issues will create a greater number of systems lacking adequately trained emergency physicians. There is good evidence that such fragile systems are unable to cope in delivering a safe emergency service and the quality of care that is expected. The public who seek our help in an emergency should and will rightly hold our politicians, policymakers and commissioners responsible for exposing them to such added risk.

What is needed now?

This strategy guidance has been written primarily for Executive Boards, Commissioners and Clinical Directors of Emergency Departments. If properly implemented, it will help them to ensure that senior medical staff are able to work sustainably and have successful and satisfying careers in EM. As a result, the service delivered will be of a high quality, safe and meet system performance targets. Equally important is the need to create a vision of a career in EM that is rightfully attractive to future trainees and empowering for the young consultant who should be enthused by being able to work in a way that is stimulating and fulfilling for them and good for their patients.

We believe that this strategy addresses the key areas of what is required and we hope it will be an iterative piece of work. The guidance will help three key groups in different ways.

- We wish to give clear expert opinion to Executive Boards of Trusts and hospital systems, their Commissioners and also Clinical Directors in EM that they can use and implement. Protecting the vital resource of the senior clinical decision maker in the ED should be a high priority for any Chief Executive who has emergency care as part of their responsibilities. The guidance has been written for them and their Executive Directors to work with Emergency Medicine Clinical Directors. It covers vital areas of job planning, flexible careers, support for career development and maintaining wellbeing for doctors working in ED.
- The second group are those consultants, SAS doctors and senior trainees working in the ED who require better guidance on how to achieve balanced working patterns. There are support strategies for those who wish to pursue more flexible portfolio careers and approaches on how to enhance their leadership and team working skills.
- Finally and almost as importantly, we are keen to describe for the medical student or trainee who might be considering a career in EM why that is the right choice and how they can and will be best supported to have an excellent career that is both successful and fulfilling.

Finding ways to deliver successful change

We know that none of the above can be achieved however without much hard work. Any large guidance strategy or tome can too easily gather dust on an 'electronic shelf' somewhere and be forgotten within months or even weeks. Publication of our approach will lead, we hope, firstly to better understanding of the issues. Secondly, it should engender the ability of relevant personnel to reflect and then to develop local plans that implement what we have recommended. Delivery of successful change traditionally takes a long time in the healthcare environment and yet we know that time is not on our side.

The College is therefore committed to ensuring that we work hard over the next year to help colleagues who are responsible for, or work in emergency care systems in the UK and Ireland, to find innovative ways to 'fast track' this process. We are developing a range of implementation strategies that we believe will help colleagues in individual systems.

Yet true success will only occur if we take a top down and bottom up approach at the same time. We need you all to actively help us on the road to implementation. We hope you will follow our approach on the College website, social media (#makingEMgreat) and other outlets to stay up to date. Most importantly, we need your ideas and feedback on our progress until we deliver on our objectives.

Emergency Medicine-what it was, what it is and what it may become

Summary points

- EM is a new specialty that has had a rather turbulent first 50 years.
- The pressure of working in an ED and the conditions of service for staff has caused a recruitment crisis in the specialty.
- There is an imperative on current Fellows of the College of Emergency Medicine to improve the working environment for the next generation.
- The types of EDs in the future and consequently the jobs of the Emergency Physicians who work in them are likely to be much more varied than at present.

Introduction: the new specialty of Emergency Medicine

Emergency Medicine is 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 undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development (International Federation for Emergency Medicine, 1991). The European Society for Emergency Medicine in its "Manifesto for Emergency Medicine in Europe" provided a similar definition in 1998. (1)

EM is a relatively young specialty. Its origins in the UK date back to 1952 with the appointment of Maurice Ellis as the first consultant "Casualty Surgeon" at the Leeds General Infirmary. Prior to this (and for a considerable time after it), "Casualty Departments", as they were originally called, were run by an assorted collection of doctors and nurses usually, in the case of the medical staff, from a junior surgical background. In 1962, a report by Sir Harry (later Lord) Platt, Britain's first Professor of Orthopaedics, recommended a change of name from "Casualty" to Accident and Emergency (A&E) Departments. (2) A more recent change to "Emergency Departments" (EDs) has not been mirrored in either the media or in the sign-posting of most UK towns. Thus the symbol of "A&E" in a red box remains one of the best-known urgent care brands in the world with consequent and inevitable brand loyalty.

The boundaries of Emergency Medicine begin to expand

Right from the beginning, the fledgling Casualty Departments had an attraction for the public that cramped conditions and long waiting times did nothing to dispel. The immediacy of treatment, the availability of x-rays and the mystique of the white-coated "specialists" proved irresistible. Recognising this heady combination, Platt - in a suggestion that resounds over 50 years later - maintained that the work of the Casualty Department should be confined to "serious" cases and that other patients should be encouraged to go their General Practitioners (GPs).

In 1974, the Parliamentary Expenditure Committee on A&E services suggested that "...any attempt to educate the public by methods based on explanatory leaflets and television fillers would be unsuccessful. Nor is it likely that more efficient GP appointment systems would materially alter the situation". The same paper also suggested that some hospitals might have an emergency GP service on site. A generation ago (in 1990), an editorial in the Archives of Emergency Medicine (the predecessor to the EMJ) also suggested ways of attempting to reduce attendances at A&E Departments. (3) However, ever-increasing numbers of patients have confirmed that it takes more than words and "education" to deter the public from choosing their preferred urgent care provider. In recent years, the increase in the number of people attending EDs has shown an unprecedented rise, even allowing for the population growth of 1.7% per annum over the last decade. The College of Emergency Medicine (CEM) believes that this increase in ED attendances is in the order of 3-5% per annum, notably in England and during out-of-hours period. (4) Surprisingly, even such basic figures as the rates of increase in ED arrivals are contentious and disputed at the highest levels of NHS management.

The changing job of the Emergency Department doctor

Lord Platt opined that a life spent as a senior doctor in a “Casualty Department” was unlikely to be a fulfilling career for a consultant. This would appear to be a view shared by many of the current trainees who are at the start of their careers in acute medical care. During the last three years, there has been a vacancy rate in EM specialist training posts of over 50%. To some extent this may be related to a failure to clearly define the expected role of ED consultants in the future. It may also be due to the perceived life styles of the current generation of consultants.

“I love the work but I want a different type of existence to you.” (ED trainee)

Surveys suggest that the majority of trainees enjoy their training time in the ED but that reducing numbers of them want to pursue a career in the specialty. Amongst other things, they cite poor working conditions, a harsh work-life balance, a target-driven culture and the lack of 24-hour support for the ED as barriers to a long-term career choice in EM.

The CEM website offers advice on careers in EM, illustrated by vignettes from established and practicing EM consultants. They describe the excitement of the resuscitation room, the diversity of the case mix, the challenge of the generalist role and the absence of long-term follow-up responsibilities as some of the factors in their own choice for pursuing the specialty. But tempering this enthusiasm is the reality of the modern ED as the default access to healthcare around the clock with all the problems that this entails.

The stressful Emergency Department environment

It should be the shop window of the hospital but many EDs look shabby and neglected. Increased attendances, exit block and queuing ambulance arrivals lead to a cramped, over-crowded working environment and problems with cleaning a never-empty space. Many departments have an inadequate number of resuscitation bays and inadequate accommodation for staff. Despite the current (and long overdue) attention to hygiene, staff and patient facilities are limited and toilets and sinks are too few in number. There are inadequate maintenance programmes for equipment, poor storage facilities, old neglected décor and a general sense of disorder and decay. Even basic items such as chairs and pillows are often hard to find. The constant attention to order and appearance that denotes a successful business environment or a well-maintained cruise ship is rarely found in an ED in the UK. In contrast, many hospital environments that do not function on a 24/7 basis are clean, neat, tidy and well-staffed.

Staffing numbers also reflect the lack of adequate funding and support. Most departments have unfilled middle grade posts and below-recommended numbers of nurses and consultants.

“My dentist works with a dental nurse beside her to assist her at all times. Yesterday evening, I put a chest drain in a breathless patient with the help of a nurse who was caring for (and moving between) patients on three trolleys.” (ED trainee)

Emergency Departments are overwhelmed

“ED crowding” is becoming a major problem throughout the developed world. In the UK, ED attendances have risen from just over 14 million patients in 2000/01 to over 21 million in 2010/11 and the ability of EDs to meet the NHS four-hour target is falling. (5) This situation has occurred for a variety of reasons but this is largely due to the following:

- An ageing population suffering from more chronic illnesses (especially dementia) with relative lack of social support and community care. People over the age of 60 make up nearly a quarter of Britain's population; half of them have at least one chronic illness. (6)
- A withdrawal from round-the-clock care or arduous rotas by many health care professionals both in hospital and in the community.
- Reduction of the NHS hospital bed stock with inevitable consequences in the ability of the system to respond to surges. The number of acute hospital beds has decreased by a third in the last 25 years whilst bed occupancy rates have increased from around 80% in 1997 to nearly 88% in 2012.
- Hospital exit blocks due to extensive cutbacks in community and social care budgets.
- More complex treatments with instructions to “go to A&E” in the event of problems.
- Increased numbers of patients with mental health and alcohol problems.

- Immigrant populations that have no previous experience of UK general practice and may not be registered with a local practice.
- Complex systems of access to urgent care that either do not deliver what they claim to or that defy understanding by patients.
- A 24-hour society and patient expectation. If you can shop at 2.00am, then why can't you go to A&E and have an x-ray at 3-00am?
- Political tampering with healthcare systems without any trials or an evidence base for the costly "improvements" that have been introduced.

Emergency care has changed in many ways over the last 50 years; advances in medical knowledge, treatment options and the structure of care has led to significant progress in the care of patients with acute illness and injury. The demographics and illnesses of those patients have changed a huge amount. Patients over 65 years now account for more than 40% of hospital admissions and around 25% of these people have dementia (which is likely to be the single most prevalent condition presenting to EDs in the next generation). In many ways, society is not coping with the general improvements in healthcare and the longevity of the population lifespan and this mismatch of resources and demand is seen most acutely at the interface of the community and the hospital - in the ED.

The evolution of the specialty of EM was described in a paper by Sakr and Wardrope in 2000. (7) At the start of the new millennium, they stated that "...the challenges facing A&E Departments continue to grow and so the specialty must grow to meet these demands". Thirteen years later, those challenges seem ever larger and the demands are still far from being met.

New models of urgent care

Multiple reports on the subject of urgent care have been produced over the last 30 years by a huge variety of agencies. They have all highlighted failures in staffing, training, resourcing and funding for EDs. Few of their many recommendations have been adopted. The House of Commons Health Committee acknowledged failing systems of urgent care provision throughout its report of July 2013. It only proposed a limited number of solutions, most of which were not particularly new. (8) The required improvements to unscheduled care will not be easy to make – the same issues have confronted every generation of emergency practitioners. They are not new problems but ones that have been inadequately addressed for over 50 years. However, we no longer have the luxury of "muddling through" because the system is now reaching its elastic limit.

There is a strong belief that we need to redefine EM as being the specialty that caters exclusively for the needs of patients with true life- or limb- threatening problems. This view rejects the holistic mantle of the ED being regarded as "Always & Everything". At its most extreme, it sees the only real gate-keeper as money. A second, more benign view is that all patients who think that they have urgent health care (or even social) needs should have access to round-the-clock advice. Whatever sustainable model is decided upon, it will require the understanding of the population that it serves in order to make it work.

"In most cases, the patient himself defines the problem as being urgent by his attendance at an unscheduled care facility." (PCT urgent care advisor)

Consequently, there are three main models of urgent care facility:

1. EDs and EM-trained staff treat only those patients with serious acute conditions. There are other facilities, which may or may not be co-located, available around-the-clock for less serious problems. This is the current system in the UK that, for reasons detailed above, is facing such significant challenge.
2. A combined urgent and emergency care centre caters for all attendees. Patients are streamed to different parts of the centre on arrival. No condition is deemed inappropriate for treatment, advice or re-direction. This is the model that is being widely proposed; it is dependent on adequate staffing and facilities.
3. EM staff disappear into history as a failed experiment of the English-speaking nations. Patients are triaged on arrival at the hospital into specialty groups (earache to ENT, chest pain to medicine, red eye to ophthalmology etc.). This is the current system in many European countries but a considerable number are trying to move towards the UK model. Notably, 15 years ago, there were only four countries in the European Union that recognised Emergency Medicine as a distinct specialty. Now, there are 26 countries in this position.

Whatever model is adopted, almost everyone agrees that the urgent care system needs to be standardised across the UK. The public are generally confused about who does what out-of-hours and are often forced into making the wrong choice by unnecessary complexity and disorganisation. Even the nomenclature of urgent care facilities needs to be agreed.

There is also general agreement about the need for more investment in 24/7 services. Much more of the UK's healthcare workforce needs to be readily available during so-called "unsocial" hours. This includes diagnostic staff, social care staff and managers. The NHS will have to develop contractual arrangements that ensure the availability of higher numbers of staff when needed and a more equal sharing of the burden of healthcare around the clock. It would be ideal if all commissioning decisions in the future were considered for their impact on unscheduled care in the same way as they are currently considered for other possible implications.

For the Emergency Physician of the future, there may be several types of job and several possible combinations of these work patterns:

- Standard urban practice similar to the current work of most ED doctors (likely to involve 16 hours a day consultant presence in the ED).
- Major trauma centre work (likely to involve round-the-clock shifts).
- Urgent Care Centre or rural ED work (variable patterns).
- Split work between EM and another specialty (intensive care, management, medical education, pre-hospital care or possibly general practice).

Conclusion: the need for the provision of urgent care to change

There are difficult balances to reset in the healthcare equation which will require new approaches to the delivery of urgent and emergency care by both the NHS and society as a whole. This needs to be debated at the highest level of government; we have some influence in that debate. Ultimately, the future of EM and the working lives of the next generation of ED doctors in the UK will be defined by the outcome of these critical deliberations. The model of acute care decided upon will and must be different to the present fractured model. A fair deal must be offered to the diminishing numbers of practitioners who undertake this difficult but indispensable work. They must have long-term job security, coupled with a sustainable work-life balance and appropriate rewards. The working environment must be re-designed to make it safer and more attractive and to enable the ED staff to optimise their core skills. If we can look after these staff, then they will be able to do what we rightly expect of them: to look after their patients to the best of their abilities.

Within every generation, as with Maurice Ellis and the "Casualty Surgeons" of 60 years ago, there will be a core of medical practitioners who are enthused and driven to provide care to acutely ill and vulnerable people. We have a duty to those currently doing this job and to those contemplating following in their path to negotiate terms of engagement that are fair and sustainable. This will require many others, in the fields of both medicine and politics, to play their part in enabling that to succeed. To continue our evolution we must have some degree of devolution – a separation of non-acute problems from the true work of the ED. We cannot do this alone. We are at yet another seminal moment in the course of our history as a specialty and the decisions made will define urgent and emergency care for the decade to come and possibly for very much longer.

References

1. Carew-McColl M. **"Gently adjusting open doors"** (1990) Archives of Emergency Medicine 7(2): 59-60.
2. College of Emergency Medicine (May 2013) **"The drive for quality - How to achieve safe, sustainable care in our Emergency Departments?"** www.collemergencymed.ac.uk
3. Council of the European Society for Emergency Medicine **"Manifesto for Emergency Medicine in Europe"**, Europe J Emergency Med 1998; 5(4): 1-2.
4. Department of Health (2011) **"Accident & Emergency attendances"** available at www.gov.uk/government/organisations/department-of-health
5. House of Commons (July 2013) **"Urgent and Emergency Services (HC 171)"** available at www.publications.parliament.uk
6. Platt H. (1962) **"Report of the Standing Medical Committee"**, Accident & Emergency Services, London: HMSO
7. Royal College of Physicians (2012) **"Hospitals on the edge? The time for action"** available at www.rcplondon.ac.uk
8. Sakr M and Wardrope J, (2000) **"Casualty, Accident & Emergency or Emergency Medicine, the evolution"** J Accid Emerg Med 17: 314-319. doi:10.1136/emj.17.5.314

Profiling the consultant in Emergency Medicine

Summary points

- EM is an exciting, stimulating and fulfilling specialty with patients that provide a rich variety of challenges.
- The clinical job is one of the last bastions of the generalist in acute care approach and will be a major appeal to many young doctors.
- There are significant opportunities to also develop skills in a range of allied activities that add to the stimulation and variety of the post.
- Shifts and rotas if well-structured are not onerous and indeed have much that will be appealing to those seeking flexible or portfolio careers.

Background

The purpose of this document is to highlight the positive aspects of a choosing a career in EM. It should be read in conjunction with 'Protecting a vital resource - How to create satisfying careers in Emergency Medicine.'

The clinical job

Whilst there are many issues that affect career choice, most consultants will spend the majority of their sessions in the ED directly involved in patient care. EM is one of the last (if not the last) truly general acute specialties seeing the complete spectrum of presentations. In the majority of cases these patients are presenting for the first time with little if any assessment, investigation or diagnosis.

As well as keeping boredom at bay, this variety also allows development of special interests in just about anything from major trauma and critical care through care of the elderly to minor injury and liaison psychiatry. Moreover it is perfectly possible to develop these interests after CCT and throughout a consultant career. The model of consultant delivered care means that most 'average' departments need 8-10 consultants and this further encourages the development of individual interests and strengths.

EM continues to be a 'hands on' job throughout a consultant's clinical career, and there are often no ward rounds or clinics with all their incumbent letter-writing and follow up to distract from the acute care of patients. Clinical shifts are busy and at times stressful, but they generally have a definite start and finish, and it is possible to handover to a colleague both at the end of a shift and on days off as there is no on-going ownership of individual patients. Also time for Supporting Professional Activities can be clearly ring-fenced on the rota such that there is no expectation of any clinical availability during that time.

Other allied clinical work

EM training and practice gives a unique set of skills that lend themselves to medical work outside of the NHS. These might include sports team doctors, event doctors including sporting events and music festivals, expedition doctors (including mountaineering, remote area trips, ship's doctors), pre-hospital care either paid or as a volunteer or overseas aid work with organisations such as *Medicin sans Frontieres* and the Red Cross.

Rotas and work patterns

It has to be accepted that the work of EM consultants does not stop at 5pm or 6 pm or slow down at weekends. It is imperative that a team of consultants agrees together a way of working that is sustainable and fair. A well-structured annualised rota should allow a safe work-life balance, create job satisfaction and help maintain wellbeing.

Consultant rotas are not as onerous as trainees might think they are. Work outwith normal hours is remunerated at a higher rate. This means either more time off each week, or if working annualised hours, the ability to take periods of time off whilst still being fully paid. This has the advantage of allowing adequate time for rest, and

the flexibility to fit in with interests outside of the ED whether that is other types of allied medical activity or quality family time. When things happen at short notice, it should be possible to swap shifts or find alternative cover as there are no ward rounds or clinics to cancel or re-arrange.

The career 'portfolio' and progression

For some of the reasons already discussed it can be possible to develop non-clinical aspects of the career alongside clinical shifts more easily than a '9-5' pattern of work may allow. Interests in management, education, clinical governance and roles such as Clinical Director/ Medical Director or work with Boards and Colleges can be developed, and the unpredictable nature of some of this work can be flexed around clinical rotas. The nature of this portfolio and the balance of clinical: non-clinical work does not need to remain fixed, indeed it is anticipated that for many it will change as a career progresses. The different ages or 'seasons' of an EM consultant's career must be allowed for and a consultant approaching the third or even fourth decade of their clinical career should be able to tailor their job plan to play to the strengths of their expertise for their department. Work is ongoing with NHS Employers through the NHS Working Longer strategy to understand these issues better and allow such flexibility.

The great strengths of the specialty are its variety, stimulation and working in a team. This paper has described these issues but it is also aimed at creating further debate and discussion at others ways we can profile our great specialty.

Annualised rotas for Emergency Medicine consultants and SAS doctors

Guidance and recommendations

Summary points

- As a speciality, we are at the forefront of delivering care during unsocial hours and contracts and rostering systems must be adapted for this way of working. As we have no fixed commitments, if rostering is done correctly, it can make EM a very attractive speciality.
- Self-rostering annualised contracts are one way of improving the working lives of EM doctors. This can lead to increased sustainability, better recruitment and retention (especially people on less than full-time contracts), reduced burnout and better work-life balance.
- The system can also be used to help fit in non-clinical commitments, whether they be NHS work or non-work related. It can also be used to increase the amount of antisocial hours delivered by senior doctors including 24/7 shop floor cover in a sustainable way.
- Contracts for staff working annualised rotas with a high degree of antisocial work need to be reviewed, both in terms of sustainability, time off and remuneration.
- Where an annulisation self-rostering system has been used, there has been an improvement in doctors' reports of wellbeing, as well as shop floor coverage and job satisfaction.
- The CEM has provided a guide on how to implement an annualised system, and pre made excel spreadsheets, which can be adapted for departmental needs.

Introduction

The working lives and job plans of EM physicians in the UK and Ireland have become increasingly complex and stressful over the past decade. The pressures have become ever greater in ensuring that the service EM consultants work in and/or lead is delivering safe, high quality clinical care on 24/7 basis. In addition, poor performance of other parts of the urgent and emergency care system coupled with the workforce issues in the ED have exacerbated the pressures and environment. Many systems have increased shopfloor presence by EM consultants significantly, especially during out-of-hours and at weekends in keeping with College recommendations, but also to meet short falls in middle grade rotas and the introduction of Major Trauma Centres. (1) (2)

An important aspect of ensuring consultants are able to work in a safe and sustainable fashion is to adhere to good job planning procedures. (3) Indeed good job planning was identified as being the major contributory factor in a safe and sustainable work pattern in a recent College survey. (2) The main issues to consider are appropriate recognition of Direct Clinical Care (DCC) activity both in and out-of-hours, recognition of Support Professional Activities (SPAs) and how best to apply the principles into an annualised rota. The ability to structure these principles into an annualised rota helps optimise flexibility, transparency, consistency and fairness for both managers and clinicians alike.

This guidance document and its appendices are intended to share the principles and practices in how to devise and run an annualised rota for EM consultants. The same principles apply for specialty and associate specialist (SAS) doctors. We have highlighted these principles to ensure they adhere to the Consultant Contract (2003).

We hope that Clinical Directors will share their experiences either online or by feeding back directly to the College (makingEMgreat@collemergencymed.ac.uk).

Principles

The following four principles are essential to the development of an effective annualised rota for your ED.

Appreciating the advantages: Good annualised job planning for senior EM staff (consultants & SAS doctors) that has been agreed between the clinicians and managers will help lead to a high performing team.

This process allows transparency, flexibility and intelligent application of human resources to be used most effectively.

Starting with the basics: The first step is to appreciate the exact amount of resource (Direct Clinical Care and Supporting Professional Activities) that is available to the team. Secondly, address the clinical and non-clinical priorities that need to be completed in order to manage the department effectively. Then assess how the available programmed activities (PA's) can be best allocated against the needs of your ED. The Clinical Director and manager can then design the service they will be able to deliver in terms of 'breadth' of senior clinical cover. They must also now consider the 'depth' of cover (how many senior decision makers on at times of surge) and ensure that their clinicians will have enough time to rest and recuperate to be able to perform their duties consistently and effectively.

Embedding safe, sustainable working practices: The importance of ensuring that a 'shopfloor' EM shift in the ED is appropriately recognised depending upon the time of day or night is also vitally important. There is clear evidence that the work of a senior decision maker in the ED is amongst the most challenging in medicine. The number of decisions made per hour by a consultant working in the ED is bigger than any other speciality and these stresses are exacerbated in evenings and during night time working. Good job planning should allow these factors to be taken into account to ensure adequate periods of time off for rest and recuperation. A failure to recognise this leads to dissatisfaction, poor team performance and eventually burnout. Senior managers and Clinical Directors must be fully aware of these issues and negotiate appropriately, especially for out-of-hours working.

Measuring success: High performance EDs requires a workforce that is able to work sustainably and retain its permanent workforce for the long-term. In addition, they must ensure that they have the time and energy to focus on designing and calibrating systems that have a constant focus on quality improvement in care delivery. Creating safe, sustainable working patterns for consultants lies at the heart of this process and leads to satisfying careers. Clinical Directors and managers should be able to create their own metrics of success in this regard. This will give them a clearer view of how well their strategy is working.

Specific considerations

In this section, specific considerations are described that help to provide an understanding of the advantages of an annualised EM rota and how it can best work.

What is an annualised rota?

An annualised rota allows the totality of DCC/SPAs allocation to be recognised for a consultant body. It ensures flexibility, transparency and fairness for individuals. It also allows robust business planning for service expansion and helps in 'value for money' discussions with Commissioners.

Who should it be for?

Annualised rotas in this document are focused on the activities of consultants and SAS doctors in EM, but can be applied to other grades too.

Where to start?

A number of key principles are worth considering when discussing annualisation of rotas as a consultant body.

- Ensure that all colleagues appreciate the advantages to them personally and to the team. These advantages are maximised if all involved (including managers) appreciate the importance of transparency and flexibility.
- Make sure to include all the different types of departmental activity both direct clinical, clinical related activities and supporting activities as well as additional and external duties.

What to include?

Ensure that you include all possible departmental activities. These will include:

- Direct clinical care
- Allied direct clinical care (e.g. complaints)
- SPA for appraisal and clinical governance to ensure revalidation needs are met
- SPA activities for training and supervision

- Study and professional leave
- Annual leave
- Defined project work and other Trust activities (additional)
- College work for examinations and other duties (external)

Involving your managers

Engagement and active involvement of managers is vital in order to ensure transparency. It will also help them to appreciate:

- The importance of safe sustainable working practices
- Transparency
- Accountability
- The importance of weighted shift tariffs for out-of-hours premium time working

Creating flexibility

The consultant body and managers must understand the requirements of the service for the full 12 month period. These include:

- The existing availability of the consultant workforce in terms of PAs in their job plan
- This will then optimise matching of resource, flexibility of service delivery and value for money care in the ED

Adhering to principles of good job planning

The principles of good job planning are well described by the BMA & NHS Employers. (3)
The key aspects to consider are that objective setting in a job plan must be SMART:

- Specific
- Measurable
- Achievable
- Realistic
- Time specific

Transparency and precision will also ensure work life balance issues are appropriately addressed.

Embedding sustainability and safe working

Strategic vision

It is vital that the Executive Directors and Human Resources Department in the Trust appreciate the significant stresses on EM consultants at present. (1)(2) These are likely to be exacerbated in some emergency care systems that are more fragile than others. Executive teams must ideally agree a clear vision of the senior ED decision making workforce as well as the supporting medical and nursing workforce that is required and ways in which to manage the transition to annualised job planning. For example - trainees in EM, SAS doctors, non-training grade, Clinical Fellows, Advanced Care Practitioners, Physician Assistants and Emergency Nurse Practitioners may all be required in different proportions to ensure resilience. (4)

A clear vision will both attract, help develop and retain the EM consultant workforce for the long-term. This will minimise the need for more expensive interim locum staffing, market facing remuneration packages and 'golden hellos' (though in the present environment these seem to be occurring with increasing frequency in some systems).

Recognising out-of-hours working practices

This will be a contentious area of discussion between clinicians, Trust Managers and Human Resource (HR)

Departments. The National Consultant Contract 2003 is clear that working practices for consultants outside 7am to 7pm weekdays are for local negotiation. The current intense pressures in some EM systems have allowed this aspect of the consultant contract to be applied in different ways.

The College is aware of Fellows who have negotiated rates with their Trusts between 7pm till 10 pm that vary from the standard accepted premium time (IPA = 3 hours) to a range of 1PA = 2 hours or even down to 1PA = 1hr in very hard pressed departments.

Rates after 10pm, including night time working by consultants (mainly in order to fill the middle grade workforce deficiencies) also vary around the country. It is difficult to gain a uniform 'currency' view that easily describes how Trusts are recognising this activity. In some, the tariff is increased within an annualised job plan to allow subsequent time off for recovery. In others, additional remuneration on top of normal clinical duties is provided in order to retain a safe service. The latter is not sustainable for the long-term.

It is clearly recognised that night time working as a single senior decision maker in the ED is amongst the most stressful and intense of all jobs in healthcare, especially in major centres. Anecdotal evidence from around the country suggests that rates of remuneration vary from 1 PA equal 2 hours to 1 PA equals 0.7 hours for locum work (approx.).

A number of systems seem to be reaching agreement with their Trusts at rates of 1 PA equivalent to between 1 hour to 1.5 hours within their job plans depending upon the intensity of the service. The College believes that this is a reasonable and well-judged approach.

For example: working actively all night on the 'shopfloor' as a single decision maker will be likely to attract a higher premium. Recognition for weekend late working and bank holidays is also specifically recognised in some centres with resilient workforces.

The rate of remuneration is often related to the demand, intensity of the workload, complexity and the fragility of the emergency care system that consultants and SAS doctors are working in. Trust Medical Directors and HR Departments with stable and resilient senior EM workforces have in general been pro-active in addressing these issues and agreeing reasonable tariffs as described above in order to attract and retain individuals in the present job market.

The College is conducting further work in this area and is currently in discussions with the BMA to ensure a more consistent approach. These issues will be vital in any future negotiations between the BMA and NHS Employers regarding a new consultant contract based on 7 day working. It should be recognised that consultants in EM are already at the leading edge of specialties that commonly have significant out-of-hours clinical activities as a proportion of their overall duties.

Decades of life as a consultant

In order to attract the young trainees of the future into the specialty and also to retain and provide fulfilling careers for consultants and SAS doctors, better career planning is required as EM doctors near retirement age. Until now, older individual consultants who feel unable to fulfil exhausting out-of-hours shifts have negotiated more tailored job plans with their Clinical Directors, with the involvement Occupational Health or made a team decision as a consultant body. Colleagues who have reached the age of 50 to 55 have reasonably agreed job plans that for example might remove them from on call commitments. The College strongly supports this approach taken by good employers. The importance of recognising older workers in a more structured approach is the subject of ongoing work by NHS Employers and a number of strategies have been identified. (5)

The College has also now produced guidance which provides support on how clinical careers can progress through decades of a consultant's life. (6)

Measuring success

There are many markers of success that a Clinical Director and management can employ to measure the success of a good annualised rota scheme. These include:

- A healthy and happy consultant workforce with high levels of retention
- Better support for business planning strategies which allow clarity on the value for money of investing in a consultants led emergency care system
- Better support for the rest of the EM workforce in terms of education and training

Conclusion

This document should be read in conjunction with a set of appendices that provide examples and resources to support Fellows optimise job planning for the senior EM workforce. Clinical Directors and Managers will get the best out of their team by applying the principles set out in this document and understanding the exemplars described to get the best for their local circumstances.

References

1. BMA & NHS Employers (July 2011) "**A guide to consultant job planning**" available at www.bma.org.uk/
2. College of Emergency Medicine (September 2013) "**Achieving Career Satisfaction - A practical guide to planning your career in Emergency Medicine**" www.collemergencymed.ac.uk/
3. College of Emergency Medicine (September 2013) "**Protecting a vital resource - How do we create sustainable and fulfilling careers in Emergency Medicine**" www.collemergencymed.ac.uk/
4. College of Emergency Medicine (May 2013) "**The drive for quality - How to achieve safe, sustainable care in our Emergency Departments?**" www.collemergencymed.ac.uk/
5. Medical Education England (December 2012) **Emergency Medicine Task Force - Interim Report** www.collemergencymed.ac.uk/
6. NHS Working Long Review (May 2013) "**Extending working life- Audit of research relating to impacts on NHS Employees**" available at www.nhsemployers.org

Being a good leader in Emergency Medicine

Summary points

- Developing and honing leadership skills are vital at every stage of a career in Emergency Medicine from the junior trainee through to those working at a national level in the specialty.
- Leadership as a set of skills require commitment, focus and constant attention especially in the seemingly hectic environment of the ED.
- Trainees, SAS doctors and consultant emergency physicians should actively pursue leadership roles and learn from their experiences in order to constantly improve themselves and most importantly lead to better care for their patients and the health service.
- Leadership at every level drives a higher quality of care delivery for our patients.

Context

EDs need and deserve good leadership. The challenges have never been greater: delivering consistent safe clinical care and ensuring patient satisfaction on a background of increasing activity and complexity, with the expectations of quality and performance.

One of the key ingredients to meeting and exceeding this "quality bar" is the ability to keep the ED team motivated, focused and practising to the best of their ability. Good leadership recognises the importance of personal satisfaction in the work environment, maintaining wellbeing and the link between these and delivering quality safe clinical care.

This short review aims to describe some of the models and concepts of leadership and to provide a framework to aid clinicians in navigating their way through the good times and more difficult days. It is intended to be an iterative document and further ideas and suggestions are welcomed.

Why we need leaders?

The requirement for leaders to step forward and take responsibility is now greater than ever. Following on from the Francis Enquiry, Professor Berwick, in his landmark report, set out a series of principles that led to recommendations at a macro level for safe effective care to be at the very heart of what we do. Yet a decade earlier in 2004, the National Patient Safety Authority described seven ways in which to make the NHS a safer place in which to work in. Each of these steps required leadership and a clear will to enact them at every level. Sadly these recommendations were not addressed or implemented as expected for reasons which are not clear. However, the manifestations of continued failure were dramatically realised at Mid Staffordshire.

All systems and environments have leaders. Some individuals may not recognise their role as leaders and those who do too often have not received enough training and support to be effective. The increasing focus on patient safety and need to deliver a consistent quality of care in an ever pressurised system can expose gaps in our skillsets or potentially undesirable behaviours and actions as leaders.

Many of us learn about leadership through a process of experience, modelling behaviours of others and all too often our own mistakes, though these can be some of the most valuable and important lessons. Yet the intensity of what we do as EM physicians exposes us to heightened risks of stress, impaired performance and poor job satisfaction if we do not produce a more structured strategy and approach to leadership.

Being a good leader in the ED spans many levels of a career. Skills are acquired and honed over time. Leadership principles are universally applicable from a junior trainee through to an experienced consultant but the challenges are of course different. For example:

- Coming onto a busy late shift as a single senior decision maker in the ED. How to bring order to a difficult environment?
- Managing and resolving conflict with other specialities

- Understanding and optimising the skills and performance of your team in a busy ED
- Negotiating with managers and specialty clinical colleagues to improve system flow
- Negotiating with EM colleagues to agree on a common vision of working practices
- Tackling bad habits e.g. 'office working' when on a clinical shift
- Managing error, harm and their consequences for patients and staff
- Finding ways to help solve poor morale in the team
- Having a vision for the future
- Coping personally with a tough day at the office
- Balancing work and life

Learning about leadership

The old saying "leaders are born not made" is a myth. Accepting that leadership is rarely a natural gift and requires specific training will encourage pursuit of the skills and competences that requires both enthusiasts and those who need to be enthused. The environment and resources need to be made available so that people are able to more easily believe in themselves, their need for self-development and their potential to make a difference to their patients and the healthcare system in which they work.

So what should you do? Learn about the fundamentals of leadership theory and learn about yourself. There are many resources available to meet your needs through reading, courses or leadership networks. Most organisations are able to assist with psychometric questionnaires to understand your cognitive style. Do you see the big picture or is attention to detail important to you? Are you an ideas person or someone who sticks with a task until it is done? Do you prefer numbers or a narrative approach? It is useful to understand your style and that of others.

As an example of leadership theory, one of the doyens of leadership training, John Adair describes his 3 circles model representing the three responsibilities that leaders have. These are for the

- Task
- Team
- Individuals in the team

The three of these overlap because, firstly, the Task can only be performed by the Team and not by one person; secondly, the Team can only achieve excellent Task performance if they are all fully developed; and thirdly, the individuals in the Team need to be challenged and motivated.

Adair developed 8 key functions that team leaders are responsible for.

1. Defining the task - setting clear objectives
2. Planning - looking at alternative ways to achieve the task and having contingency plans
3. Briefing the team - creating the right team climate, fostering synergy, and making the most of each individual through knowing them well
4. Controlling what happens - being efficient in terms of getting maximum results from minimum resources
5. Evaluating results - assessing consequences and identifying how to improve performance
6. Motivating individuals - using both external motivators such as rewards and incentives as well as eliciting internal motivators on the part of each team player (Adair thought the ratio of internal-external motivators should be 50-50)

7. Organising people - organising yourself and others through good time management, personal development, and delegation
8. Setting an example - the recognition that people observe their leaders and copy what they do

There are many models of leadership and more are listed below. The Faculty of Medical Leadership and Management provide an excellent set of resources and training opportunities. Gaining some knowledge of these and others will give you the tools to draw on in a particular circumstance, whether that be system based or with a team member.

The key levers for success include the need to ensure time to focus, access to good mentorship and ensuring they fit within an organisation of a shared vision. The metrics should ideally be tailored to the appraisal process. At the very heart of course is the ability to ensure team satisfaction and personal happiness in the clinical environment. These two are immeasurable but probably the most important parameters to consider.

Top tips - what should I think about as an EM Leader?

Set out below are some concepts and tips that provide a guide to the qualities that one should consider when thinking about developing leadership skills. They are written as a springboard for reflective practice whether you are a trainee or an experienced emergency physician.

The aim is for each of them to be a challenge to your vision of who you are and what you do. If you have other top tips please send them to makingEMgreat@collemergencymed.ac.uk

1. What is my style?

As a leader in Emergency Medicine understanding different styles is important and knowing how best to apply them is vital. Democratic and transformational leaders seem to produce the best results that lead to long-term successful change. Understand and develop your skills to be able to adapt your style to need.

2. Caring for my team

The ability of the leader to mentor and support team members and celebrate individual success lies at the very heart of a high performing unit. There are many ways to do this and it is outside the scope of this paper to explore in any detail. Showing genuine regard for the needs of the individuals within the team and managing potential conflict early is vital.

3. What is my vision?

Having clarity of thought and vision is vital not only for any individual task but the wider view of what you want to achieve. Having a shared vision with the rest of the ED team and also senior management is key. The title above is intended to be wrong! You will probably have the most success when you get to "What is our vision?"

4. Being a role model

This is hard and yet some people make it look so easy. You will be representing your department in many arenas and to some extent you will be on show. A role model is more than being looked up to or admired. Think about how you can inspire your team to give their very best. Lead by example.

5. Communication

Good leaders must be able to use different communication strategies to ensure people feel involved and there is a consistent purpose. Using traditional methods or even social media technologies may not be as good as being on the shop floor, being in the coffee room. Constant feedback from and to the team is vital.

6. Identify and harness talent

Every team has members with differing skills and talents. Sometimes the leader gets to choose the team. Often in the ED that is not the case (especially with junior staff) and it is a case of finding the right niche and skills of existing team members and allowing them to flourish.

7. Manage group dynamics

Ensuring the team works well together and recognising potential conflicts early as a leader is a much sought after skill. Finding the areas of discontent so that they can be diffused early will pay dividends and it is time well spent. Do not shy away from potentially difficult conversations hoping everything will go away.

8. Focus on the big things

In the midst of everything, the leader in ED needs to be able to stand back and focus on the most important things. In many ways we are trained to do this when resuscitating patients or managing on the "shopfloor" but it can become more difficult when running a project or interacting with colleagues in other specialities. Sometimes allowing oneself to lose the battle in order to win the 'war' is a better strategy - better to "keep your powder dry" and choose your moment.

9. Horizon scanning

Depending upon the environment in which you are functioning as a leader it is vital to be able to look around and see where future challenges and opportunities may arise. Is your ED exposed to future reconfiguration? What bridges need to be built? Where do you want the unit to be in 5 or even 10 years from now?

10. Look after yourself

Developing as a leader comes partially through experience but also through design. Think about where you personally want to be in 3 or 5 years. Identify your learning needs. Find a mentor or a trusted colleague so you have a safe place to talk about the challenges you face. Make sure above all else that you give yourself and your family enough time to stay energised. They will be the most important component in aspiring to be a good leader.

Bibliography

1. Avolio, B.J, Bass, B.M and Jung, D.I (2010) **"Re-examining the components of transformational and transactional leadership using the Multifactor Leadership"** available at Wiley Online Library.
2. College of Emergency Medicine (2013) **"Safety Toolkit"** available at www.collemergencymed.ac.uk
3. Covey, S 15th Edition (2005) **"The 7 habits of highly effective people."** The Bath Press
4. Department of Health (2013) **"Berwick review into patient safety"** available at www.gov.uk
5. Manage Train Learn **"Models of Management: Adair's Three Circles"** available at www.managetrainlearn.com
6. NHS Leadership Academy **"The leadership framework for doctors"** available at www.leadershipacademy.nhs.uk
7. NHS Leadership Academy Self-assessment tools **"Leadership framework- self assessment tool"** available at www.leadershipacademy.nhs.uk/
8. The Faculty of Medical Leadership & Management available at www.fmlm.ac.uk
9. The National Patient Safety Agency (NPSA)(2004) **"Seven steps to patient safety: full reference guide"** available at www.nrls.npsa.nhs.uk/
10. Snowden, D.J and Boone, M.E (2007) **"A Leader's Framework for Decision Making"** Harvard Business Review.

What makes a great Emergency Department team?

Summary points

- Good teams are the essence of being able to deliver a great service in your ED.
- The ED team is required to function at a consistently high level with both clinical and non-clinical colleagues in different settings across a range of different agendas.
- There are many key ingredients to having a great team. Shared values that will result in the right culture lies at the heart of this.
- A set of top tips are provided to create a spring board for discussion with your team to create a coherent plan for strengthening your approach.

Context

Excellence in team working is at the very heart of a high performing ED. Teamwork is central to the safety culture necessary in the clinical area to deliver efficient and effective care for our patients and for the ED to be progressive and forward thinking. A great team also inspires passion and drives the engine that creates job satisfaction and fulfilment for all the staff in the team.

Purpose

This paper provides an insight into the principles and practices of teamwork, the role of the EM physician within various teams and some tips of how to optimise teamwork.

Background

There are many different teams that operate within a healthcare organisation. The ED team is required to function at a consistently high level with both clinical and non-clinical colleagues in different settings across a range of different agendas; from the resuscitation room and other clinical areas through to risk management, clinical governance groups and enhancing patient experience to name a few. Optimising the way that the team works is an intrinsic component of ensuring the care delivered in the ED is safe, effective, efficient and compassionate. We know that great teams have a common purpose and have complementary skills to create the right culture and generate synergy in everything they do. They also help each other get through the good times and the bad. Vitally important is that they help and support the person chosen to lead them.

The qualities of a good ED leader are described in an associated paper and should be read in conjunction with this document. Good leadership and good teamwork go hand in hand and the team has a responsibility to support their leader to achieve success and deliver the task or strategy they have agreed. Remember the leader may be the enthusiast, have been elected to that position or it may just be their turn to do the tough job. Finding ways to understand the expectations of the team and the leader are key from the beginning.

The ED team and their interactions?

The ED has clinical and managerial teams but these are not mutually exclusive. In the clinical area any given shift may bring together a team with a different combination of staff and skill sets. Some teams have responsibility for specific areas such as risk management, others have external interactions. ED teams interface with many others and the list below is not exhaustive.

- Patients, relatives, carers and the public
- The consultant body
- EM trainees and middle grades
- Junior doctors
- Core ED nursing teams
- Emergency Nurse Practitioners, Advanced Nurse Practitioners, Physician Assistants
- Porters, receptionists, administration staff, cleaners
- Specialty colleagues
- Middle managers
- Executive teams
- Training and education teams

- Commissioning teams
- Lay groups
- The press
- The police
- Social care professionals
- HM coroner

Principles

Each member of the team will have talents and attitudes that if properly harnessed can bring remarkable success. At the same time, poor team working linked to conflicts of various types (e.g. professional jealousy, miscommunication, personality clashes, poor leadership and attitude) can eventually lead to dysfunctional thinking, implosion of the team and ultimately the service.

Systems need to have leaders at every level who are able to take responsibility for their role in the design and delivery of safer health care. At the same time, leaders can only often function well when they have team that has the right competencies. In addition it is important to understand that some of the problems in healthcare, especially in urgent and emergency care, require different modelling and thinking in order to design the right solutions.

Building a set of resources that can support an EM trainee or consultant to develop and enhance their skills to work in teams and as leaders will lead to satisfaction in the task at hand as well as wider achievement for the team.

Change is not always easy. An essential start is to know what resources and tools are available to help quantify where you or your organisation is in your journey to be a great team and how to maintain momentum.

Fundamental to the process of gelling teams together is also to allow individuals to recognise and enhance their own and other's "emotional and social intelligence" (ESI). ESI is a set of non-technical skills that govern our interactions with ourselves and others. It is argued that high ESI is likely to be the most important indicator of how effective a person is in their job and in supporting a team to function well. For teams to work well they, and their leader, need to be able to focus on ESI and link it to a common set of key principles.

Measurement lies at the heart of good science. It is important to have the right systems and culture in place so that you and your team can measure progress and then be able to celebrate success as well as being able to maintain momentum.

Key ingredients of a top ED team

Set out below are some concepts and tips that provide a guide to the qualities that the team should consider when thinking about how they work together. They are written as a springboard for reflective practice and discussion.

The aim is for each of them is to be a challenge to your vision within your team and what you do. If you have other top tips please send them to makingEMgreat@collemergencymed.ac.uk

1. BUILD

Build the team around its values and identify these early to maximise interdependence so that the team can rely upon each other to perform at their very best. Find ways to allow individual talents to flourish no matter the team you are given or chosen by you.

Top tips to help it work:

Find champions within your core strategic team and give them the time and tools to connect people together and make sure they focus on having common purpose of the task or tasks at hand. Teams that change every 4 or 6 months (medical) or where cross communication is poor, results in greater challenges.

2. COMMUNICATE

Encourage the team to build a communication strategy that is multi-faceted and constantly fresh in its approach.

Top tips to help it work:

Emails, letters, communication boards, blogs and fliers are all good. Real impact comes with your core team constantly striving to communicate messages regularly and making sure there is enough of a two way process, with a genuine sense that suggested improvements from the wider team are listened to and valued.

3. **MOTIVATE**

Encourage a strategy that will maximise motivation for individuals and the team to perform and excel on the task but also link to the bigger picture.

Top tips to help it work:

All members of the team will have intrinsic (internal need, pride and desire) and extrinsic (rules, regulations or exams) motivators to make them contribute to the task at hand. The more openly the team and the leader can understand and share their motivation, the greater the likelihood of success.

4. **INNOVATE**

Find ways to encourage innovation. Link the blue sky thinkers to the pragmatists in your team.

Top tips to help it work:

Understand your team, decide who will be good at what and try to ensure it links to the major activities that will help deliver on the strategy. The more time that is invested in finding innovative ways to achieve and choosing the people who will lead on those streams, the greater the stimulation, engagement and involvement to make change happen.

5. **CALIBRATE EMOTION**

Teams and their members need to understand each other's ESI and work at ways to support each other through the good days and the bad. Linking back to the values that the team set out with can be a powerful way to help people push through some of these issues.

Top tips to help it work:

As a team be aware of the members who are having a tough time or struggling for whatever reason. Make sure they have access to resources for support and information about making contact with external agencies easily if required. Have a session with your team to help understand their ESI. It may sound a bit 'touchy feely' but in the heat of the ED it can help people to re-calibrate their behaviours where necessary.

6. **RESOLVE**

Finding strategies that will help neutralise and resolve conflict is important for a team and especially the leader who may be called upon to adjudicate or help certain team members address the issue at hand. The concept of "empathic assertiveness" is important so that situations are tackled with patience, willingness, fairness and positive intention.

Top tips to help it work:

You will know the people in your team who have great antennae for recognising impending conflict. Get them to do what they are good at. Conflict recognition and resolution is best managed within the team linking to the values that everyone has agreed to.

7. **MANAGING STRESS**

Despite all of the above, all team members will experience stress from time to time and exhibit it in many different ways. The leader and team need to ensure that there are strategies in place to support each other and mitigate the impact that too much stress can create.

Top tips to help it work:

Fixing the EM system, maintaining flow to prevent crowding and learning positively from incidents are the best ways to minimise stress but these are a major challenge for many systems at the moment. Keep a regular review of what will work best for the team to manage stress in EDs is important. Note symptoms and signs in the early stages will be subtle.

8. **ENVIRONMENT AND MOOD**

Ensuring that the team is able to function in the best possible environment with a positive mood is vital. "Positive emotional contagions" leads to improved outcomes through a variety of ripple effects. However being happy at all times is unlikely. The leader and the team need to find ways to recognise the early signs of low mood/morale and find strategies to manage these situations. The central importance of the leader instilling a positive approach is vital, especially at times where the mood or morale is low.

Top tips to help it work:

Find ways that are meaningful to your wider team and that they can relate with to feel good about their ED and their team. More importantly find ways to recognise the team when they have done well.

9. **SUPPORTING LEADERS**

The best teams have leaders who are there to facilitate and allow team members to flourish. At times a leader may need to adapt their style to the situation and this can prove unpopular or uncomfortable. The likelihood of this happening is reduced when there are shared values and objectives. There will also be times where the leader needs feedback and more importantly support. Teams need to recognise that their leader is human and fallible. Only by supporting each other will create a happy working environment.

Top tips to help it work:

This is really important if the team is to work well and thrive. It all comes down to trust in the leader and each other. The leader and the team need to be able to appreciate and reward each other even if it is with just a few words showing a sense of appreciation.

10. **RECOGNISING SUCCESS**

Decide as a team exactly what you want to achieve each year and ensure the objectives are three dimensional encompassing the needs of patients, staff and the wider organisation. At the heart will be ensuring good, safe clinical care and system performance to ensure compassionate care and a good patient experience. Equally important is that teams and leaders find ways to care for each other, ensure they produce job satisfaction for themselves and are able to work sustainably in their organisation in order to achieve success.

Top tips to help it work:

Ensure that the outputs and successes from your efforts are communicated well in many different ways. It is important to ensure that everyone understands that success is much more than the 4 hour standard. Most importantly, once the matrix of what you want to achieve as a team has been created, link this to the recognition of the efforts of individuals and the team. Make sure to provide regular fuel for the team (fuel equals calories, caffeine and compliments!)

10 Top tips for Trainees

Summary points

- Be organised
- Be exam-focused
- Be proactive – manage your training
- Consider sub-specialising
- Expect tough and stressful times
- Keep interested!
- Develop management skills
- Enjoy your downtime
- Push for educational opportunities
- Fight for your patients!

Introduction

We hope that these tips will be useful pointers that may help trainees maximise their learning and enjoyment from their training experience. Training in EM brings with it huge reward from the delivery of care to patients when they need it most. There is also great satisfaction from the continuous acquisition of new skills and experience.

However, training is also tough, and the nature of working in EM can often mean antisocial hours and intense shifts. We hope that these tips may assist trainees in being resilient to the demands of their training programme, and to derive from it the most satisfaction and enjoyment along the way!

1. Be organised

Establish important contacts at the Deanery, the College and within your regional training programme.

Identify mandatory training days and inform your rota organiser well in advance.

Book courses and conferences early and secure study leave in good time.

2. Be exam focused

The MCEM and FCEM exams are challenging - they help to drive up the quality of doctors working in EM, but preparing for them is tough alongside clinical work.

Sit the critical appraisal paper early – it will help in writing your Clinical Topic Review, and it is a relief to get it out of the way.

Start planning your CTR early – find a topic that you are interested in and become an authority.

Try to attend a mock exam at least once per year in higher training.

3. Be proactive – manage your training

Arrange regular meetings with your Educational Supervisor, and outline clear objectives for your training with them.

Get to grips with the e-Portfolio, and maintain up-to-date curriculum-linked evidence of activity so that preparation for ARCPs is not frantic.

Carry a list of assessments (WPBAs) that you require – aim for one per week, and focus on the rare presentations early each year.

Participate in your regional training days, and develop a tight, sociable group of trainees with meaningful teaching sessions.

Keep a logbook of procedures / ultrasound scans / interesting patients.

4. Consider sub-specialising

Emergency Medicine is a fantastic career and can be made even more interesting by adding subspecialty interests and skills. Few trainees regret taking time Out of Programme.

- Pre-Hospital Emergency Medicine
- Paediatric Emergency Medicine
- Intensive Care Medicine
- Toxicology
- Ultrasound
- Academic Emergency Medicine
- Clinical leadership etc...

5. Expect tough and stressful times

ED rotas can be challenging, and every shift can feel like an 'on-call'.

Plan holidays and time-off well ahead.

Arrange study leave that will break up your working routine and keep you interested when you are feeling tired and risk feeling burnt out.

6. Keep interested

Stay up to date with brilliant online resources, blog sites, podcasts and the wealth of Free Open Access Medical Education (#FOAMed via Twitter)

- Life in the Fast Lane
- ENLIGHTENme
- EMCrit podcast
- St. Emlyns

7. Develop management skills

This may not be the sexy part of a career in EM, but it is an essential and often sizeable part of an EM consultant's role.

Take an interest in service development – it is everyone's duty to improve standards and trainees often bring a fresh perspective from other sites that they have worked at.

Practice with your consultants how to respond to complaints / incidents / staff issues etc.

Attend and contribute to local clinical governance activity.

8. Enjoy your downtime

To be effective as an ED clinician you need to keep a lid on exhaustion and stress.

Be sure to develop a healthy work/life balance.

Socialise with colleagues and the wider hospital community.

Don't take it all too seriously!

9. Push for educational opportunities.

Shop floor/real time teaching can be difficult - especially with the balance between service provision and training. Be motivated and determined to push for innovation in training, and continuous learning opportunities.

Look for the learning points with every patient encounter.

Engage with other specialties and recognise shared learning opportunities.

Find a mentor whom you respect and trust and meet with them regularly. There are plenty of inspirational people out there in the world of EM.

Remember why you chose a career in EM.

Compared to other specialties, EM is still relatively young: think of the specialty that you want to be working in for the next thirty years, and make sure that is where you are going.

Get involved in delivering teaching – there is no better way to consolidate your own knowledge.

And above all...

10. Fight for your patients

Take ownership of their care. EDs will always be tough, busy and demanding environments, and it is futile to dream of an empty department. Patients are vulnerable to these pressures, and it is easy for care to be compromised by external stresses.

Timeliness is an important skill, but above all, patient's care comes first.

Be the best you can be at all times to inspire and motivate those whom you work with from junior colleagues to nursing staff. It is infectious.

Enjoy being a team player – there is no other specialty like EM for the reward of working so closely with so many different members of a team.

10 Top Tips for Training Programme Directors

Summary points

- Show your enthusiasm for EM
- Highly specific 1:1 mentoring
- Listen to trainees
- Train your trainees
- ED Time Out
- Support your trainees
- A simple 'thank you' or 'well done'
- Be present
- Avoid negativity
- Be an inspiring role model

1. Show your enthusiasm for EM

Remember why you chose this specialty as a career and retain your enthusiasm when speaking to trainees. If we want more trainees to start and then continue in EM we need to sell the job on a daily basis. If you don't feel enthusiastic about a career in EM you need to seriously reflect on this – maybe consider a career break, or possibly a secondment?

2. Highly specific 1:1 mentoring

Schedule regular formal meetings (beginning / middle / end of post at least) with clear goal-setting and regular informal meetings in between.

Know your trainees –

- what makes them tick?
- what is important to them?
- what is their news?
- ask how can we help you?
- ask what do you want and need to get from this post?

Find the ACCS trainees in your Trust that are planning a career in EM and ensure they are adequately supported and mentored, e.g. by a senior EM trainee. Give assistance and guidance especially when applying to higher training posts and around exam times. Also, encourage mentorship of higher trainees to give support above and beyond normal clinical supervisor input. Mentors may be within your ED or regional training boards may have a specific mentoring scheme.

3. Listen to trainees

Offer opportunities for your trainees to vent their feelings- 10 minutes at the start of any departmental teaching with constructive support.

It may have all been said before but listen when trainees complain about the rota and their work-life balance. The rota is usually the toughest and most antisocial in the whole hospital and experienced ED clinicians all understand why this is necessary and unavoidable. Explain this to trainees and ask for trainees' ideas on how to make the rota better– be open to change, feedback and suggestions. This applies to any other change or improvement they may suggest for the department. Try to keep hours below EWTD. Be flexible about time off, special events or courses whenever possible as this investment will pay off in the form of better morale, harder working and less sick leave.

4. Train your trainees

A common complaint from trainees around the country is that they do not receive much on-the-job training. This is clearly highly variable between departments and is often related to consultant presence on the shop-floor, which in turn depends on consultant numbers. Many trainees make direct comparisons with anaesthetics and its high level of consultant supervision and contact. Try to incorporate brief episodes of teaching during every DCC- this could be just a few minutes per trainee per day. Evidence suggests this helps trainees feel valued and may encourage any interest they may have in a career in EM.

Build in supernumerary assessment days and never cancel teaching. Make the effort to facilitate attendance at training days for specific groups - F2s, GP trainees and ACCS trainees. These doctors may not be going into EM but their teaching will make them better ED doctors and it is important to them.

5. ED Time Out

Promote wellness – encourage outside activities and support departmental initiatives - social functions, running clubs, talent shows, dancing competitions can all form part of crucial team-building and coping strategies for you and your team.

6. Support your trainees

We should expect our junior doctors (and indeed consultant colleagues) to be spoken to in a polite and respectful manner, e.g. when requesting a CT or referring to an in-patient team. This does not always happen and it should be made clear that this is not tolerated. We should be actively encouraging a team approach to patient care. This could be covered in the Trust induction and any problems should be investigated and dealt with promptly.

7. A simple 'thank you' or 'well done'

Say thank you (and mean it!) at the end of every shift. Give regular, positive reinforcement of a job well done but also constructive criticism. On the whole, junior staffs want to learn and improve and most are happy to hear how they can achieve this. A genuine thank you doesn't take anything out of the departmental budget. Think about written acknowledgement of "extra-mile" behaviour – good for the portfolio and attractive to a naturally competitive set of humans.

8. Be present

The "not now" face is unhelpful – be aware of the barriers you impose. Keep your eyes open – can you spot a colleague on the edge? Do trainees feel they can disturb you? Make it clear that they can and keep an open door.

9. Avoid negativity

EM is a challenging specialty but trainees don't want to hear this on a daily basis. Be aware of your behaviour and its impact on everyone. You are a role model ALL OF THE TIME. It's fine to be realistic and open but try not to let your own frustrations and disappointment get in the way. Disillusion is contagious. Banish negativity about colleagues, other specialties and EM.

10. Be an inspiring role model

Go on - you know you want to!!

Top Tips for Training Programme Director

- 1. Know your trainees as individuals:**
 - Names
 - Training requirements
 - Contact details
- 2. Know your trainees as people:**
 - Strengths
 - Likes/dislikes
 - Background
- 3. Know your trainers as people:**
 - Strengths
 - Likes/dislikes
 - Background
- 4. Know your EM Rules and Regulations like you wrote them:**
 - Curriculum
 - ARCPs/OOPs
 - Exams
- 5. Know your Team:**
 - College Tutors
 - College/Deanery admin staff
 - Trainee Reps
- 6. Know your Responsibilities (1):**
 - Construct balanced rotations that ensure coverage of the curriculum
 - Deliver a training programme that prepares trainees to be consultants
 - Monitor quality of training and consultant supervision at LEPs
- 7. Know your Responsibilities (2):**
 - 24 hour availability
 - Listen.....Hear
 - Respond
- 8. Know your Challenges before they become a reality**
 - Targets
 - Workforce
 - Burden of assessment
- 9. Know how to mitigate against them**
 - Engage with the 'authorities' (LETB, CEM, DH roles)
 - Network of friends with influence
 - Forward planning and being ahead of the game
- 10. Know how IMPORTANT this is**
 - Believe in it
 - Be in it for the 'long haul'
 - Realise that: understanding all these things is more important than knowing them

Know who to turn to when the rain sets in

Flexible careers for consultants

Summary points

- A flexible working contract is anything less than 10 sessions. It allows individuals (both female and male) to work in a hard and demanding specialty such as EM and pursue other personal or professional activities sustainably.
- It is important for the Clinical Director and consultant body to appreciate the advantages and also some of the limitations of colleagues working flexibly and be able to best integrate their skills and working patterns to enhance team practices.
- Potential solutions that will address concerns include the ability to have an annualised rota scheme, allotting adequate time for supporting professional activities and a positive attitude to addressing concerns.
- Be open to different ways of working. Expect high standards of all, irrespective of their work patterns.
- Encourage a healthy work/life balance by promoting flexible working. To survive in EM everyone needs to be valued –offering real and realistic flexibility helps.

Introduction

EM and flexible working are natural partners. The relatively small need for patient continuity means that most clinicians do not need to work adjacent shifts. The ability to split the day into manageable shifts and the natural role split within a department (in charge, majors, minors, paediatrics and resus) help with task and role clarity, which is what a good ED needs.

What is flexible working?

If a full-time contract is 10 sessions anything less than 10 in the ED is considered to be flexible. Flexible work does not only mean part-time work or a phrase that should surely be banished “less than full-time work” to allow for example for childcare, being a main carer or when illness mitigates against working full-time.

Flexible working also allows for the development of a portfolio of career options. The EM doctor often has an interest in other disciplines. These fall into four main areas:

- **Dual-accredited posts** – critical care and pre-hospital care being the most common.
- **Work for other related bodies** – The College, the Ambulance service, Schools of EM, research and government bodies.
- **Medico legal** – such as police work, medico legal and expert witness work.
- **Unrelated other interests** – writing, medical politics or semi-professional performing.

Why is it important?

ED work is hard, physically demanding and has high decision-density and retrospective criticism from others. Consultant rotas have a significant out-of-hours component. At present remuneration is the same for all specialties. What makes the specialty attractive is the nature of the work, the support we receive, the training we gain and the flexibility that is shown to us. Work-life balance is hard in many careers and our needs vary with the stages of our lives. Rather than seeing flexible working as something for women with young children, we should see EM as a trailblazer of flexible working opportunities, not only within medicine but also in the working world.

Flexible careers in Emergency Medicine for Trainees

Summary

- Less than full-time (LTFT) training is available for doctors who, for well-founded personal reasons, are unable to train full-time. It should provide exactly the same opportunities as a full-time training programme. LTFT is not an “easy” option. Training on a LTFT basis requires dedication and organisation.
- Extended training means greater maturity and more experiences so it is important for LTFT trainees to turn this into a positive aspect on their CV.
- There are obvious advantages to LTFT training as it allows one to carry on training alongside some other commitment that is very important. The major disadvantage, which most trainees talk about, is the length of training. Most trainees may opt to train at a greater percentage or intersperse periods of LTFT training with full-time training.
- It is important to understand how best to integrate LTFT into the rest of life. Building some leeway into clinical shift finishing times is important. Knowing that you do not have to rush off at the end of a clinic/session to collect from school, nursery etc. can make the clinic/session much more enjoyable. Supervisors and the trainee must discuss closely all the various options and tactics to employ to prepare well for such situations.
- Some doctors choose to train more flexibly, or indeed may need to for well-founded personal reasons. Remember to seek out help early as there are many options to explore. Always speak to your Educational Supervisor and Deanery (HEE) for advice and support.

What is it all about?

Less than full-time (LTFT) training is available for doctors who, for well-founded personal reasons, are unable to train full-time. A LTFT training programme should provide exactly the same opportunities as a full-time training programme including study leave and professional development. However, the programme will take longer to complete depending on the percentage the doctor chooses to train at.

LTFT training programmes are available across all specialties in the United Kingdom. However, some specialties are more suited to it than others (see later).

Please note that this document refers to Emergency Medicine (EM) training in England in the first instance. The College will be developing a further iteration of guidance which addresses flexible training in the Devolved Nations.

How do I know if it's right for me?

Unfortunately, LTFT training opportunities are not available for everyone. This is because they require additional resources provided either by Health Education England (HEE – formerly ‘The Deanery’) or the Trust.

To access LTFT training a doctor must demonstrate a well-founded personal need to train LTFT. This falls into one of three categories.

1. The doctor has a health need: which means they cannot train full-time but are able to train LTFT. All doctors who train LTFT for health reasons must have the support of the Occupational Health Department from the Trust in which they are based.
2. The doctor needs to care for a close family relative: the majority of the doctors in this category are caring for children. However, some doctors are caring for a partner or a parent with health needs.
3. The doctor wishes to pursue a unique opportunity for personal development: in the past this has included training for a national sporting event, undertaking religious duties or working with a charity.

LTFT training is not generally available for doctors who wish to combine their training with other paid employment. Sadly, if you want to open a shop or go and run a riding school then you need to look for other

ways of completing your training. Similarly, doctors who are training LTFT should not undertake any form of paid employment whilst they are not at work. The exception may be helping out on a hard pressed rota alongside your colleagues if you are able to do so.

If you do want to combine your training with some other form of employment there may be other ways of doing this, although always remember it is worth talking to your educational supervisor, Head of School or your HEE department.

This sounds great but who pays for it?

LTFT training is funded mainly by the HEE Department in the area in which you are training.

Doctors who are training for health needs are generally placed in supernumerary funded placements as this enables them to be much more flexible about their working hours. The daytime work is funded entirely by HEE who have a separate budget for this. Any out-of-hours work is always funded by the Trust.

Doctors with carer responsibilities, particularly for small children (because these are in greater numbers), are often placed into job shares alongside another LTFT trainees. This can work extremely well as the two doctors' share the responsibility of the post including the out-of-hour work. This type of arrangement is funded from the salary attached to the post.

A minority of LTFT training doctors remain within their full-time post but work at reduced hours. This has advantages in terms of funding (the money attached to the post pays for the doctor) but has disadvantages in that the doctor may feel under pressure to work longer hours if there is work still to be done.

It sounds great – how do I go about seeing if I am eligible?

There are a number of ways you can find out more about LTFT training. Most HEEs have a web site which you can access where you will find the contact number for either an Associate Postgraduate Dean or an administrator who you can go and meet at your local office. If you are hoping to train LTFT for health reasons it is really important that you contact your local HEE so they can advise you. You will need to be seen by an Occupational Health Department so they can support your application.

Doctors who are planning to train LTFT to enable them to look after children will always be welcomed at HEE, though you will have to produce a birth certificate to show that you do have a child.

If you want to train LTFT because you are going to be a carer for a relative, HEE will always try to support you. You will need to provide a letter from your relative's GP explaining that a carer is needed to support the individual.

Most HEEs do not have a waiting list for LTFT training but, understandably, it takes a bit of time to set these posts up. In real terms, you should be thinking about contacting HEE approximately 6 months before you are hoping to go LTFT. This will give everyone plenty of time to make the arrangements, particularly in ensuring that you are eligible.

Obviously doctors who have health needs or those who are caring for sick relatives may not have the luxury of this sort of forward planning. The fastest turn-around time on record is two weeks, but that is very quick. Remember though that everybody will want you to stay in training and will do their best to help you as soon as possible.

Finally, some doctors do not want to talk to their own specialty trainers about undertaking LTFT. There will always be somebody available at HEE who will discuss LTFT training with you and try and help you decide if it is right for you should you wish to do so.

It does sound right for me but I wonder what the drawbacks are?

There are obvious advantages to LTFT training. It allows you to carry on your training alongside some other commitment that is very important to you. Later on in this article you will find some advice about making LTFT training work really well for you.

The major disadvantage, which most trainees talk about, is the length of training. Obviously, if you are training at 50% your training time will be doubled. However most trainees may opt to train at a greater percentage (remember this will depend on the resources of HEE) or intersperse periods of LTFT training with full-time training. There are some examples of this at the end of this article.

The other disadvantage can be that doctors feel they are sometimes “not part of the team”. Now that many doctors work shift patterns this is less noticeable. However, it is all down to you to make sure that when you are at work you are an effective clinician and trainee.

Finally, remember that you will be paid less whilst you are training LTFT. Some doctors feel that the drop in salary is not worth the benefits of training LTFT, but this is very much a personal thing which you have to decide for yourself. The LTFT adviser at HEE can always advise you on this decision.

What happens if I want to go back to full-time?

Your training number remains with you so at any time you can go back to full-time training providing it is right for you. Doctors training LTFT for health reasons would need the agreement of their Occupational Health Department and any doctors who are involved in their care.

The speed in which you can go back to full-time depends entirely on how you have been managed in a LTFT placement.

If you have been supported with supernumerary funding, then you will generally need to wait for a funded full-time post to become vacant. In practice this is not long and is usually just a few months at the most. Similarly, if you are in a job share you will need to wait for a funded full-time post to move into.

If you have been training LTFT within your full-time post then you can simply increase your hours back to full-time.

What do I do next?

If this article has awakened your interest in LTFT training the first thing to do is look at the HEE (Deanery) website. It might be helpful to talk to other trainees in your area who are working LTFT and also to your educational supervisor. Ultimately you will need to contact your own Deanery (HEE) to find out how they will assess your needs and establish whether you can be placed in a LTFT full-time training post.

Other opportunities to train flexibly

If you do not fit into the above categories which will enable you to train flexibly the following opportunities might be of interest to you.

A career break

During your training you may find yourself in a situation where you cannot work. This might be because you need to care for a family member perhaps or because your partner or family are going to move abroad and you cannot carry on your training because you need to go with them. These are just some of the difficult situations that doctors find themselves in.

This does not mean you have to give up your training number. You are entitled to apply for a career break through your local HEE which will enable you to take a pre-agreed period of time out of your training programme.

Obviously during this time you need to keep in touch as much as you can by ensuring that your medical knowledge doesn't go rusty and if possible keeping in contact with your Educational Supervisor and your Department.

Some Trusts allow doctors to come back for a week or so at a time every few months during their career break so they can keep their clinical skills fresh.

During a career break though you should generally not take any form of paid employment as the purpose of the career break is for you to attend to some important personal commitment. Local arrangements regarding this may vary. Many doctors in training have had a career break at some point during their training years and have returned to their training programme and successfully completed their training in EM.

Working overseas

A lot of doctors want to work overseas at some point before they become consultants. Some choose to do this immediately after Foundation but others decide they want to get onto a training programme and only then start to think about working abroad.

Certainly working abroad provides you with a unique opportunity to see medicine in a different environment and may also allow you to develop skills which perhaps you wouldn't be able to get in this country.

Some training programmes have innovative schemes and links with departments overseas so that you can do a job swap for a year or so and your opposite number can work in your department.

Some training programmes will also have links to Trusts abroad where you can go for shorter periods of time on a secondment.

If neither of these is available on your training programme then you can investigate the possibility of something called an OOPE (Out of Hospital Programme Experience). You do need to be able to demonstrate though that the experience you will get abroad is different to what you could have at home. Generally HEE departments are reluctant to let you go abroad so that you can do the same sort of job you were doing at home. However, if you don't enquire about this it certainly won't happen so it is always worth talking first to your Educational Supervisor and then to the Associate Postgraduate Dean who is responsible for arranging OOPEs at your HEE Department.

Advantages of working overseas include:

- New system of health care
- New skills and challenges
- Learning in a different environment
- Opportunities to pursue life style choices
- A fresh outlook

Disadvantages to consider

- How could this affect my future career plans
- Will I get 'forgotten'/out of synch with my training
- Can I still progress my career e.g. exams, research CPD
- Home life (mortgages, friends, family, pets) who will take care of things in my absence?

Portfolio Training

We have mentioned this in the section on LTFT Training however, it is worth discussing what you can do if you want to train LTFT and also undertake other paid employment.

In general this is difficult to do. Many people think it would be great to train LTFT in EM and then perhaps work alongside this in another job.

Unfortunately LTFT training is only available for those with specific needs that mean they cannot train full-time. However, if you do have another form of employment that you want to undertake then it may be worth speaking to your local HEE department to see if they can help you. Occasionally if there is an empty half of a slot share which has a LTFT doctor in one half of it they may allow you to take up that slot share for a period of time. The general rule usually though is no paid employment alongside LTFT training.

Most people are therefore faced with the prospect of completing training full-time and then doing something else for a while. This can often work quite well particularly if you have your CCT as you can undertake some other employment whilst keeping up your clinical skills in EM by doing Locum work.

Remember though that once you are not in a training programme you will not have access to things like Study Leave, Professional Leave or Professional Development Programmes. You will need to make sure that you keep on top of everything that is happening in your specialty and that you keep your own clinical skills well up to speed. You will also have to find a process for undertaking Appraisal and Revalidation. The GMC will help you with getting in touch with the Revalidation Officer in your area.

There are many examples of doctors who have trained in EM and then have undertaken other forms of employment before or during taking up a consultant post. Our section on 'Flexible working as a consultant' will help you with this.

Conclusion

Some doctors choose to train more flexibly, or indeed may need to for well-founded personal reasons. Remember there are many options you can explore and always speak to your Educational Supervisor and Deanery (HEE) for advice and support.

Appendix 1 - Golden Rules for LTFT Trainees

- LTFT Training is not an “easy” option. Training on a LTFT basis requires dedication and organisation.
- Extended training means greater maturity and more experiences so turn this into a positive aspect on your CV.
- The extended period of training allows for longer term relationships with staff, use this to your advantage.
- Try, where possible, to timetable your clinical work alongside your Educational Supervisor so that they can give you feedback on your clinical skills.
- Make sure that you have sessions when you are the most senior Doctor around and that people know that!
- Try to mirror your full-time colleagues' out-of-hours/emergency rota, so that you get the same exposure to acute care. If anything, try to do a little more out-of-hour work than a little less. It will be rewarding in the longer term.
- Buy yourself a diary with big pages and keep it with you at all times. Make a note of things you might want to check on next time you are back at work, patients outcomes etc.
- Build some flexibility into your finishing times if possible. Knowing that you do not have to rush off at the end of a clinic/session to collect children from school, nursery etc. can make the clinic/session much more enjoyable.
- If you do have time constraints be upfront with colleagues and explain at the start of the clinic/session what your deadlines are. If you need to leave before the end of a clinic/session make sure that you hand over any tasks that haven't been completed.
- Support your colleagues whenever you can. If you do someone a favour then they will be more disposed to return the favour in the future.
- Most of all enjoy your training.

Appendix 2 - Case Studies of Emergency Medicine Trainees who train LTFT.

Please note that these examples are fictional.

Barry

Approximately 2 years into his training into EM Barry developed a serious form of blood cancer. He received chemotherapy and ultimately had a bone marrow transplant. When he had recovered enough to go back to work he was advised that he should think about LTFT training.

To begin with, Barry felt worried that he would not be taken seriously as a LTFT trainee and also he was concerned about how long his training would be extended for. He went to speak to Occupational Health who were very supportive and told him about other doctors who had done the same thing.

Barry visited his local HEE Department and spoke with the Associate Postgraduate Dean who was responsible for LTFT training. They discussed how he could look after his health better if he was training LTFT, and how all the opportunities available to full-time trainees would be there for him.

With the support of his Deanery, his Programme Director and Occupational Health, Barry was able to return to training at 60% and complete 2 years of his training programme whilst ensuring he made a full recovery to good health. At the end of this time he felt well enough to go back to full-time training and is now a consultant.

Jessica

Jessica trained full-time during Foundation as she had a baby girl. She had a lot of help from her parents and her partner took some time off from his job as a landscape gardener to support her.

Jessica was accepted on to a training programme in EM but then the trouble started. Her parents decided they wanted to move to another part of the country to be with one of her sisters and her partner found his business was taking off and he needed to be at work full-time. Jessica no longer had anyone to support her in looking after her little girl and became extremely worried about training full-time.

She struggled for several months trying to get home from work to collect her daughter from nursery and balance the activities of running a home and being a parent alongside training.

Eventually, she got so tired and worn out she needed some time off and she felt her training was beginning to suffer. She went to see her educational supervisor, (who had trained LTFT time himself to look after his children). He advised her to contact HEE (the deanery). It was possible to identify a slot share for Jessica with another trainee who was training LTFT because she also had children.

After a few months whilst the paperwork was set up, Jessica was able to go into the slot share with her partner and has trained LTFT since.

She has found that her training has been challenging but it has meant that it has enabled her to complete her training in EM whilst raising a family. She now has a little boy and is able to manage both her children and her home without it impacting on her working life.

As Jessica has had longer placements in certain hospitals she feels she has got to know the departments really well, and a couple of the hospitals have been encouraging her to think about applying for consultant posts working LTFT in the future.

Sebastian

Sebastian was an extremely good rower at school and had rowed for his school's first boat and then went to Oxford where he rowed in the Oxford blue boat. In his final term at Oxford he was spotted by a coach for the Great Britain squad and asked to do a trial for the Great Britain rowing squad. Sebastian was very excited by this but also wanted to go and start his Foundation post in August as he was hoping to be a General Surgeon. Sebastian could not see how being a General Surgeon would be possible if he was training LTFT as he thought that was only for people who had children.

Fortunately, the coach with the British squad had had doctors on the team before and advised him to go and speak to his local deanery to see what could be done.

Sebastian decided to wait until after his trials for the British squad but he was successful in gaining a place and was told that he would certainly row in the Olympics the following year providing he could commit himself to training.

An excited Sebastian went to speak to his local deanery who contacted the Foundation Programme Head for the school where Sebastian was due to start work in August.

There were only a few months to go so timelines were tight. It was vitally important that Sebastian joined the training camps in August and was able to dovetail his training in Foundation alongside his sporting vocation. Fortunately, this was possible and Sebastian was able to complete both of his Foundation years training at 50%. He also rowed in the Olympics and got a gold medal.

At the end of Foundation Sebastian decided that surgery was not for him but that he would like to do EM. At this stage, he was a key member of the British rowing squad and was captain of the boat. He was torn as to what to do as he felt that he ought to really train full-time but the opportunities for rowing in a second Olympics were there for him. He spoke with his Head of School and again with the Deanery and arrangements were made for him to go into a slot share in his CT1 year in EM. This enabled him to train at 50% in EM but also to train with his team and the British squad.

Sebastian's educational supervisor realised what a great opportunity this was for him and allowed him to work flexibly so that he could attend some of the training camps which required his presence for a week or two at a time.

Sebastian rowed in his second Olympics for Britain and gained another gold medal. At the end of this time he gave up his rowing career and completed the rest of his training in EM full-time.

Making a success of your first year as a consultant

Summary points

- A number of top tips are provided to help as you embark on your career as a consultant in Emergency Medicine, how to understand the new environment and to get the most out of your job.
- Broad guidelines for the established consultant body are also included and intend to stimulate discussion so that support structures can be enhanced to optimise the experience for a new colleague.

Context

Trainees and specialty doctors tell us that the transition to being a consultant can be exciting and, at times, challenging. The excitement of having reached your goal can be combined with feeling a bit overwhelmed knowing you have so much more to learn. Common concerns include, feeling the weight of responsibility on one's shoulders and 'I am on my own now'. The following tips and advice are designed to help dispel the myth of splendid isolation as a new consultant and help make the first few months a little easier.

Top tips for a new consultant

Understand and accept your limitations

Don't panic! Some of your colleagues may have 20 or 30 years more experience than you, and you are the same person as you were last week when you were not a consultant. You can't know everything you think you are supposed to, and no-one is immune to mistakes at any time in their career. It takes years to understand all the workings and nuances of a department and hospital. You have worked hard to develop your clinical skills and these will continue to evolve and improve. Feel at ease and comfortable to seek advice from consultant colleagues about a patient or protocol, or to admit that you have had too many goes to get a line in a patient and ask for a fresh pair of hands. No-one will think less of you if you have some humility.

Start slowly

Try not to take on too much in the first few months. Take time to settle into your day to day role before you start to volunteer for committees, extra roles and responsibilities. Do not be upset that you are not getting as many emails as your established colleagues (that time will come and you will look back enviously on when you have time to think!).

Use that thinking time creatively, looking at systems and processes with a fresh set of eyes. If you see things that you think could be done better or need changing, take a gentle approach and explore the issues with the key players. Maybe your suggestions have been tried before and have not been successful. Don't be put off if this is something you want to pursue to make things better and continue to tactfully explore as the timing and environment might now be right for change. Remember, you are now an integral part of this team and change must be managed carefully.

If you have been appointed because of a special interest, show by your actions that you are expert in ultrasound/sedation/bereavement or whatever it is – your team will then respect your views on what can be done better when you start making suggestions. Avoid overt declarations and direct comparisons with other departments you have worked in.

Support and mentoring

It is a good idea to identify a mentor. This may be someone within the ED, or from outside. Remember a mentor is not an appraiser, but an individual who is able to offer support and advice about any issues you have and help to guide you through. There may be some advantages if this person is involved in EM, equally you may prefer someone from outside the department or specialty. The choice is entirely up to you. The key is to identify someone that you feel you can trust. It may be wise to spend a little time settling in before you decide who you would like to have as your mentor.

Induction and networking

Make sure you attend your organisation's induction programme for new consultants. Even if you think you are familiar with your organisation this will give valuable insight into management structures and organisational philosophies. It will also give you an opportunity to meet with consultants from a variety of other specialties who have been appointed around the same time as you.

Be an active “networker” and introduce yourself to as many key people as you can. This might include informal chats with important specialties (radiology, acute medicine, trauma and orthopaedics for example) as well as operational managers, clinical and medical directors etc. Sometimes the best way of establishing who you are, as well as meeting others, is to attend hospital meetings such as grand rounds, Medical Board meetings, trauma meetings and any departmental or hospital wide social events.

Your first on call

Unless you are on a full shift, there will come a time when you are leaving the department but will be on call probably from home. Make sure you make yourself available - let the junior doctors and nurse in charge know that you are going and check your contact details are readily available in the department. There may be established criteria within your department for consultant call back, but it is a good idea to make it clear that you are available for anything else that your team thinks they need to call you about.

For your first few on calls, it is good idea to accept any offer you have from more senior colleagues to contact them if needed. Or ask for it. You probably won't need them, but it gives reassurance to know that there is someone to ask if you get stuck (usually with politics and procedure). Check also that you know who to contact if you need managerial or legal support out-of-hours, though it is very unlikely you will need it.

You are a role model now

You might have the title but it is your behaviour that counts. Think about consultants you admire and what behaviours you would like to emulate and those you found unhelpful and avoid these. In particular avoid “acting out” as a consultant especially if you receive a critical comment, letter or email. Think about what has happened, discuss with a colleague if needed and plan a considered response.

Email etiquette is an art in itself. Always reflect before you send an initial response which may be misconstrued as being angry. Be especially careful of wide circulation emails unless they are simple communication exercises. By all means write a response (a great way to get things off your chest) but put this in a drawer or in a draft folder and read it again in 24 hours. You would be surprised how many responses you don't send or change substantially to be more constructive. A chat over a coffee might be a better approach.

Don't forget you were a junior once and continue to respect and support your junior colleagues. It may be not so long since you appeared for FCEM. Use your experience to support others who are preparing for exams.

Well being

Start as you mean to go on and look after yourself. The other sections of this document are designed to help you, and in particular the section on maintaining wellbeing. Start as you mean to go on taking care of yourself physically and emotionally.

Top tips for the established team in welcoming a new colleague

- Remember how long it took you to settle into the role and establish yourself. Consider the points above and the world that the new consultant is entering. Ensure a comprehensive induction programme both from an ED perspective as well as the Trust.
- Plan as a consultant team how you can best support the new starter both in the clinical environment as well as socially.
- Offer support explicitly both in working hours and out-of-hours especially for those first few on calls.
- Try not to ‘dump’ unpopular jobs on your new colleagues. Give them time to settle and choose what they want to do and achieve in their first year.
- Don't introduce new colleagues as ‘junior’ consultants.
- Allow some settling in time before asking a new colleague to take up extra roles or make significant changes in your department.
- Don't be resentful if a new colleague is successful in achieving something you have been trying to do for years. It often just comes down to timing.

Achieving career satisfaction - a practical guide to planning your career in Emergency Medicine

Summary points

- To achieve a successful and satisfying career you must take a more considered approach to planning all the phases of your working life.
- This guide is intended to encourage emergency physicians to reflect upon the planning and execution of their goals for their clinical career and how best to prepare themselves.
- The phases of a career are split into three decades of clinical life for the purposes of discussion though individuals may choose to have shorter periods that they wish to consider.
- A recurring theme is the ability to be innovative in how you develop your portfolio of activities as you progress through your clinical career to maintain satisfaction and meet personal goals of defining success.

Introduction

Traditionally, once you achieve your specialist registration in EM there has been a perception that for most people this is the pinnacle of their professional life and once appointed to a consultant or SAS post they remain in the same post for the remainder of their career. The reality can be very different - life in general and especially in medicine is filled with many winding roads, opportunities and occasional potholes. To achieve a successful and satisfying career you must take a more considered approach to planning all the phases of your working life.

In this guide we hope to:

- Encourage you to think about your goals over the next five to ten years and think about the steps you may want to take now, to prepare the ground for achieving these.
- Give an insight into the range of options which could be open to you. We want you to start thinking broadly and creatively about what the future may hold for you.
- Provide sources of inspiration, advice and support on the career choices which you may wish to pursue.

This document has been written primarily for consultants in EM but the principles are equally applicable to SAS doctors.

This guide is an advisory document and is not meant to reflect policy or definitive guidance for the purposes of job planning. It is however intended to stimulate further debate and discussion so that the College can refine its thinking in creating a common shared vision for excellent careers in EM.

This guide is intended for personal use to aid reflection for personal and professional development. It can also be used as a basis for discussion as part of an appraisal process.

Models of careers in Emergency Medicine

Once you are a consultant working in EM, there is no set plan for what your career should look like over the lifespan of your career. The 'traditional model' of a consultant career continues to change and some doctors are being much more innovative in how they develop their careers. This is important in being able to have a fulfilling and satisfying career.

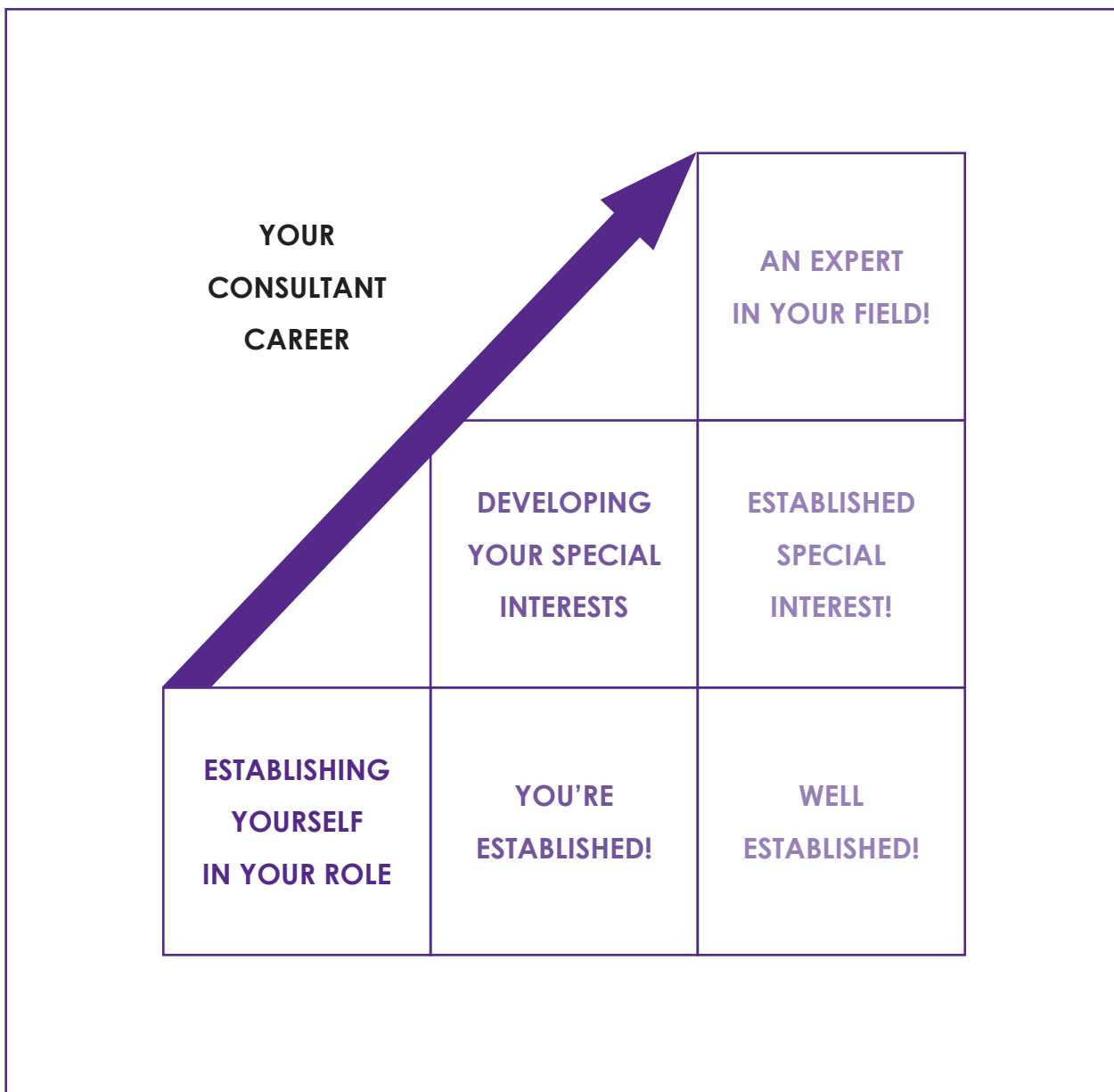
It is useful to split your career into at least three phases:

- The first 10 years – establishing yourself in your role
- The second 10 years – you and your special interest
- The third 10 years and beyond– you as an expert in your field

The key reason for splitting your career in this way is that this will allow you to set clear milestones to achieve. This can also be tailored around revalidation cycles so that having your revalidation appraisal at the 5, 10, 15, 20, 25 and 30 year marks will also give you the opportunity to plan within these blocks of 10 years. Crucially this will allow you to pace yourself over the course of your career – a vital element to ensuring that you have a fulfilling, rewarding and stimulating career ahead of you.

In this guide we are not going to be prescriptive about what you should do within these blocks of time however we want you to think about planning for the future from an early stage so that you have a clear sense of direction regarding your goals.

This guide focuses on your plans for the future from a work and professional perspective. We all have personal lives and our personal circumstances are all different. These may also change and hence part of the process of looking into the future should involve a degree of flexibility and also building in some 'what if' scenarios. These will help you stay on track should any unexpected events threaten to throw you off course.



The first 10 years – Establishing yourself in your role

Your first years as a consultant in EM can be daunting but there are a few things you can do to help establish yourself in your role. A key tip is to pace yourself. You have 10 years for this phase and hence:

- Keep your goals simple, clear and realistic
- Don't over commit yourself
- Take your time to make sure that things that you do are done well, so that you are proud of what you have achieved

A key resource which surrounds you in those early years is your colleagues – they have a wealth of experience so take time to make sure you work as a team. Try and be flexible with your colleagues, hopefully they will pay you back in kind. Also this is your time to continue learning and so take time to learn from your colleagues and their experiences. A good way of doing this is with a weekly senior staff meeting. If you don't have this in your department, perhaps you should suggest this?

KEY THOUGHTS

This is a learning phase. Learn from others around you

- Acclimatising to life as a consultant can be difficult. Spend time establishing your clinical credibility so that you earn the trust and confidence of others.
- A new department, new colleagues & new staff – take your time, there's no rush, be inquisitive, be wise to the risks associated with anyone starting a new job in a new place.
- Get to know the system at your Trust and build relationships.
- Remember to remain flexible with your colleagues. Try to have weekly group meetings with your colleagues – this is a great forum to learn and share ideas.

A key element to getting the most out of your first 10 years is looking at how you use your time. Once you have spent time settling in, try to establish a sensible routine to your work. This will not only benefit you, but this degree of consistency will help others to plan around you. The key is getting the right balance – between administration time (SPAs) and clinical time and between when you stay late and when you leave early or take time back.

The formal element of this aspect of time management is getting your job plan right. Get help and advice from your colleagues on this and if needs be get advice from outside agencies. Ultimately, you will get a feel for what is feasible and what is not. Trust your instincts and manage your time so that you are efficient and productive as you can be whilst still keeping that balance!

Another element of time management is making time for you and your own professional development. It is easy for this to fall by the wayside as clinical commitments and department based administration can dominate your working day. Make sure you plan your appraisals, study leave and study leave budget well. Also make sure you plan your annual leave so that you don't lose out when it comes to the end of the leave year!

KEY THOUGHTS

Be patient and pace yourself. You have 10 years for this bit!

- Don't over commit yourself, don't volunteer for everything but if you do agree to do something, do it well. Make sure to define clear goals.
- Once you have spent time getting settled, try and establish a sensible routine – i.e. not staying late every night, manage your SPA time, try and get the balance right.
- Be careful about your job plan - there will be times when you will have to work in excess of time allocated – do not let this become the norm and ensure it is understood how you will take time back owed to you. Don't be afraid to negotiate appropriate time for your activities.
- Make sure you make enough time for departmental based administration – it takes longer than you think.
- Ensure you make enough time for your own professional development, CPD and appraisal – it is very easy to let this fall by the wayside.
- When thinking about CPD, think about the time and budget you have available and what you actually want to do to develop. Maximise the use of this time and budget.
- Make sure you are rigorous in planning all your leave (study, annual and days off in lieu /public holidays).

Over the course of your first 10 years, try to find out where your strengths lie. These may be in teaching, management, research, project management, educational supervision and pastoral care, liaison roles with other services /specialties, exam teaching /preparation or specific clinical domains. The key thing is to try as much as you can, find out what works for you and what doesn't. Once you know what you are good at, that's the time to think about your special interests.

KEY THOUGHTS

Discover where your strengths lie

- Try out all different aspects of your role to find what suits you and what you are good at and have a natural aptitude for and also what you don't – this could be teaching, management, research, project management, educational supervision and pastoral care, liaison roles with other services /specialties, exam teaching /preparation, clinical domains (however in the first instance try and cover all clinical areas to establish your credibility in all before focussing down too much).
- Find out what works for you and what doesn't.
- Once you know what you are good at, start to think about special interests–

The second 10 years – You and your special interest

In this phase, you will be clinically well established and will have settled in well with your department and your colleagues. However it is important that you now focus on maintaining your skills and to look for new opportunities to develop within the specialty. One way of doing this is to develop a special interest. Once you know where your interests lie, this is your time to really make your mark. Many of the same rules apply such as making sure you pace yourself. Remember, you have 10 years for this bit!

KEY THOUGHTS

The same rules apply. Be patient and pace yourself.

- Be patient and pace yourself. You have 10 years for this bit!
- You now know the system. Be clear on your times, your job plan and when you are supposed to be at work and when you are not. Good time management is key however it is also important to be flexible with your colleagues and support them as much as you can.
- Make sure you get all of your allocated study leave, annual leave and public holidays /days off in lieu.
- You are now well established clinically and have found that you have a special area of aptitude and interest – this is the time to develop and enjoy making a success out of it.

When developing your special interest chose something you are passionate about rather than something that you think you 'should' do. Many options exist including developing a clinical special interest i.e. a skill or domain with research, teaching or service development associated with this, management, teaching, research, work for external bodies, voluntary /charity sector or Consultancy work for other services.

If at all possible, try and develop allocated time within your timetable where you can focus on your special interest. If it is of importance to the Trust, you may even be able to negotiate time within your existing job plan for this work. Either way, it is important to have a degree of separation between your special interest and your remaining job plan so that you remain fresh and invigorated when working on each area.

Remember, if your job plan or your Trust does not allow for you to do this, then this may be a sign that looking for pastures new and working for another trust may be the best option for you and your career. Most people will consider this as a 'last resort' and more often are able to find ways in which to combine their personal passion with the needs of their service and colleagues.

KEY THOUGHTS

Developing your special interest

- Choose a special interest that you are passionate about, that excites you and is something that you really want to do rather than something you should do or have to do.
- Options include, clinical special interest (i.e. skill or domain with research, teaching or service development associated with this), management, teaching, research, work for external bodies, voluntary /charity sector, Consultancy work for other services.
- If at all possible, try and establish as a separate role with allocated time or PAs. It is important to have a degree of separation between your roles or your core job and any special interest which you have.
- Think about your clinical commitments and whether you need to change i.e. are you still able to work nights? – remember, if the Trust that you work for cannot provide you with that flexibility then you may have to leave and work in different Trust.

The third 10 years – You as an expert in your field

During this phase, you will have established yourself in your role and even developed your special interest. At this stage it is important to acknowledge the wealth of experience that you have. One way of doing this is focussing on your expertise and using this knowledge to further promote your work and the work of your department. This may be through representation on national committees, writing book chapters, publishing research, speaking at conferences or teaching on courses. Whatever you decide to focus on, make sure it plays to your strengths and that you enjoy doing it.

KEY THOUGHTS

Making your experience count

- Be patient and pace yourself. You have 10 years for this bit!
- Make sure you continue to engage in CPD – there is always something new to learn, refresh, renew.
- You have years of experience and are a huge asset to any department you work in. Don't underestimate the impact this has on your staff and hospital. Channel this wisdom and experience to make things even better for the patients and the staff coming up behind you.
- With your experience, you may want to think about doing some work in a wider arena such as regional or national committee work, editing book chapters, publishing research, writing opinion pieces. This may also involve teaching or speaking on the wider circuit or being involved in college activities i.e. examining.
- With your wisdom and experience, there may be other activities which you could become involved in i.e. strategic work, work with standard setting bodies, regulatory bodies, advisory committees, college committees.

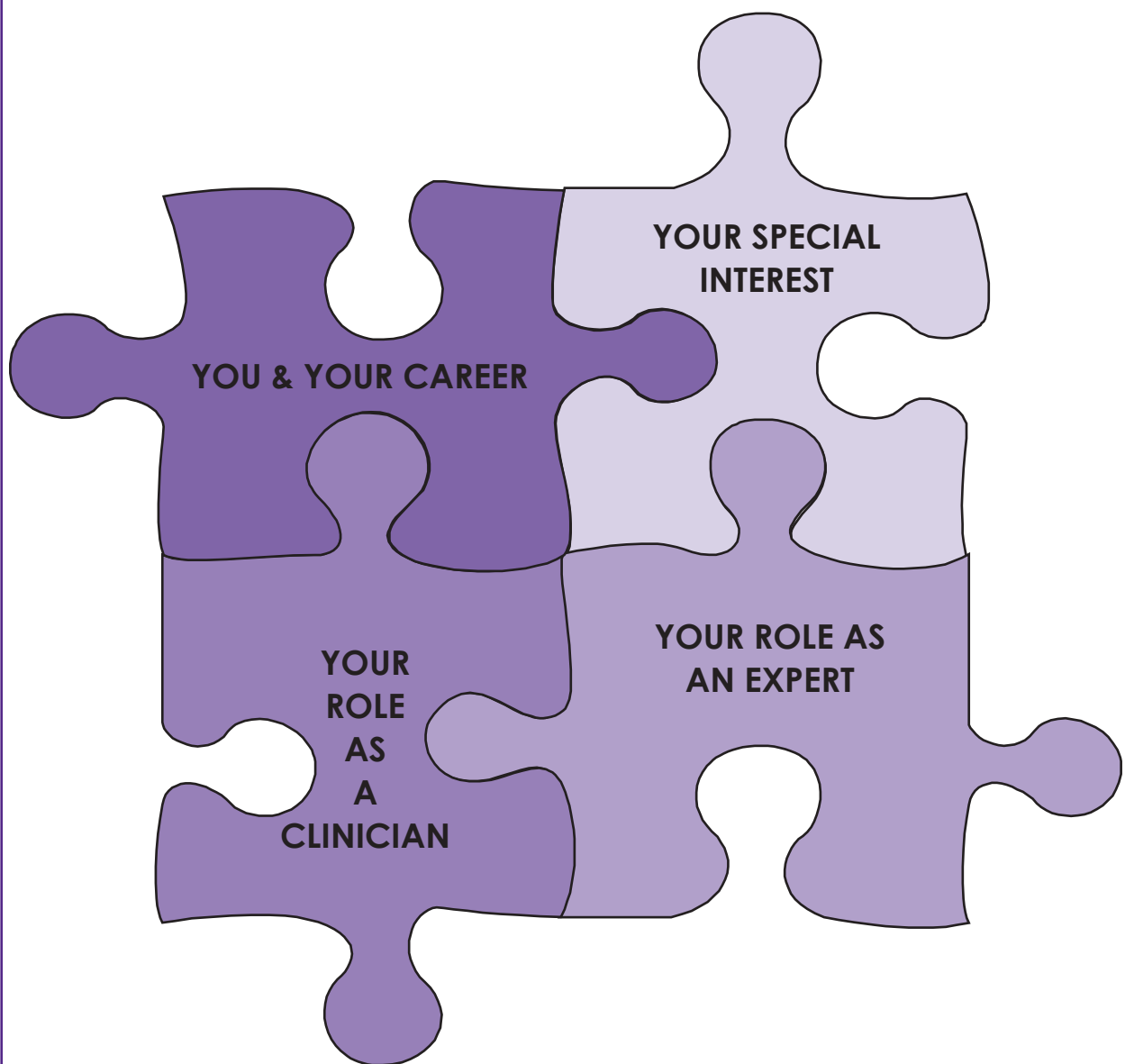
Now may be the time to also think about how you work clinically. Many of us get used to working in a particular way. It is good for staff to know and be comfortable with how you are and how you work. However it may be worth looking at new ways of working clinically within your department. For example you could mix things up a bit by working more time in resus, doing a few shifts in your rapid assessment area or in your Paediatric ED. Changing your work area regularly will make sure that you are always learning and keep your broad range of expertise.

Remember, having a degree of flexibility is important and you may have to demonstrate this in how you work if you are keen to continue working in your current Trust. However, if this is not possible, there are other options which can help renew your relationship with your Trust. Some Trusts have written guidance on applying for sabbaticals. This may be a good opportunity for you to do something new for several months. Working overseas may also be something to consider. However, if your Trust cannot provide you with the flexibility you require, you may have to consider changing Trusts.

KEY THOUGHTS

Making your experience count

- Think about your clinical commitments and whether you need to change i.e. are you still able to work nights /late shifts? – Remember, if the Trust that you work for cannot provide you with that flexibility then you may have to change Trusts
- Explore your Trust's policy on taking a sabbatical. This may provide you with an opportunity to spread your wings and learn new skills or enhance existing ones
- How about taking your experience abroad perhaps on a sabbatical? Your wealth of experience may provide much needed support to a department overseas and perhaps foster links that will enhance your own department, theirs and your personal sense of satisfaction. Taking this step may be easier than it initially looks



If you need help and support

Despite planning and organising your career, you may find that you start to enjoy work less which may lead to frustration with both staff and patients. At times like this, it is important to share your feelings so that you are able to air your thoughts and develop ways to cope better with the stresses and strains which can be associated with a career in any medical specialty, not only EM.

There are many ways to access help and support.

- Your colleagues should be a support, working together will be more likely to be successful than working in isolation
- Mentorship: many Trusts provide a mentorship scheme where a consultant from another specialty acts as a mentor for newly appointed senior doctors. If this is not already in your Trust why not consider setting one up?
- Your Regional adviser may well be able to advise on how others have handled a particular situation
- Your Trust will probably have an Employee Assistance Programme which provides an impartial and confidential view
- The BMA can offer advice on terms and conditions of employment
- For further information and support, the following organisations may be able to help or provide information on other services in your area:

Doctors Support Network. www.dsn.org.uk provides support to doctors with mental health problems. Helpline 0844 395 3010 (from 8pm most evenings)

British Doctors and Dentists Group. www.bddg.org provides mutual support and discussion on drug and alcohol related problems. For information on local meetings call John on 0779 2819 966

Doctors for Doctors. A service provided by the BMA. 24/7 support line: 08459 200 169

Final thoughts

EM is a fantastic career that has the potential to bring you much satisfaction and enjoyment as you progress through your clinical life. Events in recent times have led to a perception that perhaps this is not the case but the authors believe this is untrue in the long-term - much of how you progress and build your career is very much within your control.

This guide is aimed at providing a framework to encourage reflection, stimulate thought and create wider discussion. The authors encourage feedback in order to help share ideas that will appeal to all.

To share your ideas please send your feedback to makingEMgreat@collemergencymed.ac.uk

The Fourth Decade

Summary points:

- A career in EM should be regarded as organic with the planned evolution of a diverse portfolio.
- Such a portfolio will allow a sustaining balance between clinical work, non-clinical activities and life outside EM allowing the ED and the EM doctor to benefit from the expertise and experience gained through their career.
- Increased consultant numbers allow flexibility in working patterns to move away from unsocial hours and overnight shifts as an option at different age way points. Such changes must be free of stigma.
- Opportunities for a dynamic and seniority enhancing latter phase will provide added incentive to trainees interested in a career in EM
- A structured career template should act as an incentive for young doctors considering a career in EM who can anticipate a prolonged, fulfilling, sustainable and enjoyable career in EM

One of the many great aspects of a career in EM is the almost infinite range of opportunities to pursue a rich, varied, stimulating and rewarding career throughout – and this includes the latter stages of the career arc. However, it is entirely reasonable and indeed crucial to recognise that the full-on intensity of the earlier career phases may not be sustainable ad infinitum. Strategies for moderation and managing the later phases of the career agenda are essential. Senior EM Physicians will have spent their career being constantly busy, in demand and over achieving – this trait is predetermined and in their DNA. As such, a lifelong pattern of being highly active and involved is unlikely to diminish until an impressive Anno Domini total has been passed. However, the later stages must be actively managed to ensure continuing job satisfaction and fulfilment for the individual EM doctor and benefits for their ED.

EM provides a raft of opportunities to develop a diverse portfolio including education, research, management roles, medico legal work etc. Developing an interest in these areas at a relatively early stage in one's career can provide the platform for greater involvement at later stages. Achieving a balance between EM clinical work and these other portfolio activities should be expected to allow clinical work to continue to a later stage than might perhaps otherwise be possible. This allows the experience and expertise of the senior EM doctor to continue to benefit the ED and patients. Similarly, the EM doctor will continue to enjoy clinical work to a much later stage than would be possible if there were no alternative.

This career evolution will allow you to spend more time on those areas of special interest which you have developed during the past decades but have never quite had the time to develop fully. You will also, perhaps at last, allow realisation of the proper work- life balance you always promised yourself but which may have been elusive during the years when your work commitment was greatest. This concept of a career in EM being organic is important and sustaining, in the knowledge that opportunities to reconfigure the weekly programme will arise in the future. In turn, this should be an attraction to young clinicians interested in a career in EM.

One of the principal issues which have been identified in optimising job and work satisfaction is the concept of task and role clarity. When planning the evolving portfolio, the first exercise should be to define your sustainable core EM work. You can then select from the menu of other opportunities as you wish. Remember, perhaps uniquely in your career, selecting these options is your choice – a hard earned position in which to find oneself and you're worth it. The opportunity to develop a work plan with less onerous clinical activity, avoiding the most demanding shifts late in the evenings and overnight, is an entirely reasonable strategy to adopt at a certain stage. There is no fixed age at which consultants in EM should be expected to move away from such unsocial working hours, but it is important that over the age of perhaps 50, consultants have the option to reconfigure their job plan in such a way. It is crucial that such changes are not stigmatised nor attract any negative perception, but acknowledge that the particular demands of EM inevitably have an age related component.

Awareness of this truism will ensure that more senior EM clinicians can continue to contribute to their department, both clinically and in other areas, thus providing the ED, the team and patients with a body of invaluable experience and expertise accumulated over a career. The absence of such options to reconfigure the job plan during the latter stages of the career may lead to early retirement and loss of these benefits, both to the senior clinician and the ED. This will clearly be universally disadvantageous. The concept of remodelling the job plan should therefore be regarded as normal and healthy. The individual will reach a stage regarding

the most demanding clinical shifts when it is not a question of whether one could continue in that mode but whether one should. The hurdle preventing this type of evolution already being widespread has been the limited number of consultants in most EDs which simply has not allowed for this degree of flexibility given the unceasing demands of the ED. However, as consultant numbers increase these opportunities will become commonplace and the normal practice.

In fact, increased consultant numbers with less frequent clinical work requirements, and the advent of the shift system with a fixed input, should prolong the period in which late night or unsocial hours work is considered to be acceptable and sustainable.

However, there are some key points to note:

- This is not a passive exercise on your part
- Remodelling demands careful advanced planning and execution. The appraisal is the ideal opportunity to sow the seeds of job plan remodelling and discuss the shape of your future work/ life portfolio.

Horizon broadening opportunities

- Education
- Research
- Leadership
- Management
- College work
- Examining
- Medico-legal
- Sub-specialisation
- Commissioning
- Event Medicine
- Sabbatical
- Expedition work
- Charity/humanitarian work

Maintaining wellbeing in Emergency Medicine

Summary points

- Wellbeing at work is determined by the interaction between the individual, the nature of the work and the environment
- Working in EM places unique demands on us and there is a danger of stress, fatigue and burnout
- Individual clinicians, and management teams, have a responsibility to promote wellbeing and manage risk
- This chapter will explore the risks and offer some guidance on maintaining your wellbeing at work and how to spot the signs when things are going wrong for colleagues

Introduction

Wellness or wellbeing is often interpreted as the absence of illness but this is rather a simplistic approach. In fact, wellness is a dynamic interplay of physical, psychological and social factors. Wellbeing at work is determined by the interaction between the working environment, the nature of the work and the individual.

Work has an important role in promoting wellbeing and it is a significant determinant of self-esteem, identity and fulfilment, with opportunities for social interaction. Work can also have negative effects on wellbeing particularly in the form of stress. Work related stress is defined as 'the adverse reaction people have to excessive pressure or other types of demand placed upon them'. Although pressure can motivate and encourage enhanced performance, when pressure exceeds the ability to cope, it becomes a negative force in the form of stress.

Working environments that pose risks for wellbeing put high demands on a person without giving them sufficient control and support to manage those demands. A perceived imbalance between the effort required and the rewards of the job can lead to stress. A sense of injustice and unfairness arising from management processes or personal relationships can also increase stress and risks to mental health. Other stressful conditions include environmental factors such as noise.

Stress is not a medical condition, but research shows that prolonged stress is linked to psychological conditions such as anxiety and depression as well as physical conditions such as heart disease, back pain and headache.

Productivity at work can be reduced through lower levels of performance of those who are at work but experiencing stress or mental health problems. This is known as 'presenteeism.' Promoting wellbeing can yield economic benefits for the organisation, in terms of increased commitment and job satisfaction, staff retention, improved productivity and performance, and reduced staff absenteeism.

For EM to attract the brightest and the best to the specialty and be able to retain and motivate for the future, wellness at work needs to be an expectation of "business as usual". It is not unreasonable to suggest that wellbeing in EM translates in to better quality of care for patients.

This document aims to provide Emergency Physicians with the knowledge, skills and attitudes that are required to have a mindset of wellbeing at work throughout their career and which goes beyond avoidance and reduction of illness. The contents are relevant to Clinical Directors, Managers, Trust Executives and Commissioners.

What is it about Emergency Medicine?

EM is at the front line of care access. Clinicians work in a decision dense environment, with frequent interruptions and have to multitask on a background of moment to moment change, unpredictable workload and time pressure. Accepting a degree of risk and uncertainty in clinical decision making is the norm in a fishbowl atmosphere with decisions later dissected downstream by colleagues in other disciplines. Clinicians interact with a large number of people with varying degrees of collaboration and conflict. Managing flow on a micro and macro scale is integral to the job and yet many factors are beyond control such as 'Exit block'. Yet with good system design some of these factors can be mitigated and lead to helping the EM physician to be able to perform and enjoy their job more consistently.

Most EM clinicians thrive in this environment and it is part of their motivation. EM clinicians tend to have a resilient disposition but are not completely immune to, for example, the impact of violence and aggression, frequent attenders, trauma, death and child abuse. As a result of all these challenges, working in EM can bring out both positive and negative behaviours.

For some individuals and in some circumstances the physical and emotional rigors of EM result in stress, burnout and fatigue. Burnout can be defined as depersonalisation, emotional exhaustion and dissociation. This might manifest in a number of ways: frustration, lack of motivation, cynicism, feelings of inadequacy and failure. Fatigue is not the same as tiredness, the latter is resolved with a refreshing sleep and the former is not.

There is a potential for error and an adverse effect on patient safety and quality of care. For the clinician, stress, burnout and fatigue can lead to depression, defensive behaviours and unhealthy coping habits such as drug and alcohol dependence.

Throughout their career, an EM clinician may themselves face illness or injury, suffer a long-term condition (LTC) or disability which might affect their ability to perform their normal duties for the short or long-term.

Doctors in general could be seen as a disadvantaged group when it comes to their own health as they have a tendency to self-diagnose and self-medicate and may have concerns about confidentiality.

How to achieve and maintain wellbeing in EM?

This document aims to be pragmatic and useful. It has been influenced by feedback from College Members and Fellows on helpful strategies. It also reinforces the duties expected of any doctor and the requirements of Good Medical Practice. A perspective has been drawn from other occupations such as aviation and from companies that are considered the best to work for in the UK.

Things to avoid

- Poor job planning that you know will lead to stress and exhaustion.
- Taking on excessive non clinical activities that will not fit into your allocated SPA activities even with some latitude leading to significant stress from the beginning.
- EM physicians have ready access to a wide range of prescription only medicines but are strongly advised to avoid self-medication.
- As a general principle, colleagues should not consume drugs that may adversely affect their performance; however these may be prescribed as part of a treatment plan. Colleagues must consult with their GP or treating specialist and occupational health to monitor drugs that have this potential. **The College does not support the use of recreational drugs.**
- Whilst there is no limit legally of blood alcohol content, and no random drug and alcohol testing within the NHS, colleagues are discouraged from consuming alcohol within 8 hours of planned shift and to avoid alcohol while on call.
- Whilst it is recognised that caffeine and “energy” drinks containing caffeine can enhance acute performance, an overreliance on caffeine is likely to adversely affect quality of subsequent sleep.

Things to engage in

- The GMC requires that all doctors register with a GP.
- EM consultants should actively seek out, and line managers/employers should offer, mentorship for those new in substantive posts.
- Colleagues are encouraged to embrace a duty of candour and be open with their close working colleagues if they have an illness, disability or require treatment that may affect their performance. Colleagues are encouraged to feedback promptly if they feel the work or wellbeing of that physician is a concern.
- Wellbeing at work starts before arriving and colleagues are encouraged to avoid long commutes to work. Some industries prescribe an upper limit of commuting time. Physicians should liaise with colleagues to adjust shift times to enable better commuting and explore shift adjustments to synchronize with public transport.

- Plan shift patterns to acknowledge circadian rhythms (i.e. progressively later starts over a series of shifts) and avoiding short inter shift breaks (late followed by early).
- The quality, duration and quantity of break periods deserve particular attention. Rather than the traditional 30 minute break, colleagues should explore the approach of more frequent breaks 5 to 15 minutes break after 1 to 2 hours of work. Some occupations, such as Air Traffic Control, robustly enforce these breaks to ensure staff are not tired at work. Colleagues are discouraged from only taking a break that foreshortens their shift length.
- Exercise is recommended during the break period and colleagues are encouraged to lobby employer for time and space and equipment to facilitate this.
- In addition to breaks, colleagues should actively consider different working environments and move between the resuscitation room, majors or minors for part of the shift. Even within a certain functional area, colleagues should avoid prolonged periods which may become stagnant. For example one working area may have no natural light or fresh air, whereas another may do.
- There is a considerable body of evidence around napping. Taking a nap after a long commute to work or before the commute home after a shift should be considered. However, napping should be limited to anywhere from 10 - 40 minutes to avoid deeper sleep and avoid subsequent post sleep inertia.
- The benefits of a balanced diet and exercise are assumed to be well understood by physicians to contribute to long-term wellbeing but this knowledge has not been tested. There is potential learning from the balanced daily rations that military colleagues consume when in "operational theatre" and also the energy supplements used by triathletes and iron man participants.
- Colleagues must be transparent in their appraisals if they have health conditions which affect them (or have the potential to affect them). For example, a colleague with a LTC in remission has the potential for relapse, so while they are currently well, they need to be honest with themselves and others about potential for deterioration.
- As part of their personal development, colleagues are encouraged to be open to learning about stress protective strategies such as mindfulness, Balint groups (exploring the emotional impact and personal understanding of a doctors' work), relaxation techniques or yoga.

What makes a good employer?

It is instructive to read the views of employees in the top 100 companies to work for in the UK. While incentives of monetary value are mentioned, there are other factors in the work environment. A genuine concern about work life balance is frequently mentioned as well as working in an open, fair and honest culture. Motivation is a theme with employees encouraged to give their best every day. A social conscience and involvement in charitable work bring a sense of cohesion. Success is recognised in ways that are perceived as meaningful. Consider what could be done at no or minimal cost in your department and be creative in your thinking about simple interventions.

Acute illness and injury, long-term conditions and disability

Emergency physicians are human and get old, ill or injured and may acquire disabilities at any stage in their career. Long-term conditions may flare up and be unpredictable. All of these can have an impact on the ability of a doctor to perform their normal duties. A constructive approach is required to reconcile these facts of life with a career in EM.

Disability is clearly defined in law. The Equality Act describes disability as a physical or mental impairment that has substantial and long-term negative effects on the ability to perform normal activities. Long-term is defined as more than 12 months. Special rules exist regarding recurring or fluctuating conditions such as arthritis. Some of the challenges may appear relatively straight forward i.e. a doctor with sciatica or arthritis which impacts the more physical aspects of the job i.e. log rolling, but consider the complexities for emergency physicians who have a progressive visual impairment, need interval treatment for cancer, have acquired a communicable disease, are brain injured or have an amputated limb.

GP, Occupational Health and specialist input will be required. There may be a requirement to consider local policy (e.g. exposure prone procedures). On occasion, work with the team as a whole will be needed to

challenge negative preconceptions. There is careful balance of openness and confidentiality. However letters from Occupational Health making recommendations for adjustments to enable a doctor to return to work, or to continue working tend to be very carefully written to maintain confidentiality. These recommendations might be shared with colleagues and managers, with the permission of the doctor, to help facilitate change. There may be occasions when retirement due to ill health is considered the right way forward or this could be the source of conflict. This is a complex area and colleagues may wish to take advantage of advice from their own representative and the NHS Pensions Agency.

Return to work

After a period of illness or injury, even when it is anticipated that the doctor will return to normal duties, a phased return to work might be appropriate or a period of restricted duties. Therapeutic work can be considered as a strategy where attending the work place and contributing as the doctor feels able, while still on sick leave, is considered to have a positive influence on their recovery in a protected way.

What should the doctor do?

The GMC requires that all doctors are registered with a GP. When faced with a health problem many doctors value the important role of their GP not only in their medical management but for ongoing support and empathy. If there is a concern that the doctor might not be able perform their normal duties then the doctor should also engage with an Occupational Physician early. The doctor should consider instigating this rather than waiting for colleagues to flag a concern or for a line manager to direct the individual to Occupational Health. Talking to colleagues, obtaining their views and coming up with a team approach is helpful.

What should the employer do?

When a doctor is considered to be unable to perform their normal duties, the employer must consider "reasonable adjustments" although the interpretation of reasonable may vary. These might include shift start and finish times, reviewing on call expectations or physical adjustments to the work environment.

Recommendations

1. Promoting and enhancing EM physicians' wellbeing requires a strategic and coordinated approach. Trusts have clear employer responsibilities but Clinical Directors and managers are required to make these transparent and easy to access.
2. Wellness education must be considered as part of the curriculum for EM focusing on resilience rather than dealing with the unintended end point of physician burnout.
3. Wellness needs to be "business as usual" for sustainable careers.
4. Employing Trusts and hospitals should explore opportunities for promoting EM physicians mental wellbeing and manage risks.
5. Support and advice must be accessible and affordable.
6. Sharing knowledge and insights of best practice wellness is encouraged.
7. EM doctors must understand their own responsibility for personal wellness and be able to look at ways to design their working lives to help maintain balance.

An everyday guide to wellbeing in EM

1. **Don't sweat the small stuff:** some of the day-to-day niggles, you just have to let go. There are some things you can change, and there are some things you can't. Focus on what you know you can change – fight battles to win the 'war'.
2. **Taking pleasure from the little things:** if a patient contact or a bit of shop floor teaching has gone well, then give yourself a metaphorical pat on the back. No one else probably will but at least you will know it was a good job well done. Accept compliments that you do receive and log them for your personal satisfaction.
3. **Staying positive:** your patients need this as much as the staff around you. Much as you may feel that people won't hear if you grumble or moan, they always do. So try and stay positive, particularly when on the shop floor or in communal staff areas. Remember being in the ED is like being on stage and everyone is watching. Being a leader can be hard but that involves giving everyone around you a real sense of positive direction (and finding ways to manage their frustrations and expectations).
4. **Making the most of job planning:** this is absolutely vital. As much as possible be clear on your job plan and try to stick to it. Be rigorous in your time management and efficiency during your SPA time so that you maximise this time. You can then justifiably say 'no' if asked to take on other SPA activities as you are being as efficient as you can be and all your time is filled. For shop floor time, try as much as possible to finish patient cases before your shift ends. Minimise handovers but where this is unavoidable be clear and safe.
5. **Learning to say 'no' politely:** another key life skill that keeps you happy and engaged. Remember you can always revisit it if you just haven't got the time to take more on right now.
6. **Working as a team player:** a good team is key – support your colleagues and they will support you. Support your staff and they will support you. Even small gestures enhance and build a great culture. Encourage timely focussed "hot debriefs" after difficult experiences on the shop floor.
7. **Gaining 'cerebral bandwidth':** do other things to give your mind a rest from EM – this may be exercise or a hobby or another activity. Having this regular time away from work to do something you enjoy will make you fresher each time you go back.
8. **Special interests:** Consider a special interest which you can focus on for one day a week either as part of your job plan (most preferable) or in your own time but paid (next preferable) or unpaid (least preferable but feasible if it is something you are passionate about). Finding innovative ways to bring variety to your core job with things that you are passionate about will help in your sustainable working and general wellbeing.
9. **Annual and other leave:** make sure you take all of your leave (annual, study and days off in lieu/ public holidays) and use this time to do things other than work related. This is your time to recharge, relax and enjoy. This is your time, so make good use of it and make sure you take time regularly so that you can pace yourself in between.
10. **Family and friends:** this is a given and of course should be number one! Find ways to protect your time to get the right work-life balance.

What to do if things are going wrong for you or one of your colleagues

Be mindful of the signs

- Irritability with patients, colleagues, peers, people outside work
- Lack of enjoyment from work
- Sleep disturbance
- Over-eating /not eating
- Increased alcohol consumption
- Drug use
- Low mood
- Worsening physical health

What to do

- Take stock
- Speak to someone: family, friends, a trusted colleague, mentor or college advisor
- Get help locally i.e. occupational health, staff support helplines or counselling services at Trust
- Involve your line manager early if you feel able to do this
- If it is a colleague – speak to them if you have a good relationship or tactfully ask someone who is close to them for their views

Plan for prevention

- Be self-aware and develop “mindfulness”
- Make sure you know the early warning signs
- Act early
- Take care of yourself and look out for your team too

You may have more ideas and top tips as to how to maintain wellbeing in EM. Let us know!!

References

1. Berger, E. (2013) **"Physician burnout"** Available on Annals of Emergency Medicine Volume 61, No 3: available at www.annemergmed.com
2. British Medical Association (BMA) (2007) **"Disability equality in the medical profession and education"** available at www.bma.org.uk
3. British Medical Association (BMA) **"Doctors' well-being"** available at www.bma.org.uk
4. Civil Aviation Authority (2002) **"Publication 716 Aviation Maintenance Human Factors"** available at www.caa.co.uk
5. Civil Aviation Authority (2006) **"Publication 737 Crew Resource Management (CRM) Training"** available at www.caa.co.uk
6. General Medical Council (GMC) **"Gateways guidance: 15.4 Induction of disabled doctors in postgraduate training"** available at www.gmc-uk.org/education
7. General Medical Council (GMC) (2013) **"Good medical practice"** available at www.gmc-uk.org/guidance
8. Government website **"The Equality Act 2013"** available at www.gov.uk
9. Health and Safety Executive (2006) **"Managing shift work: Health and Safety guidance"** available at www.hse.gov.uk
10. Medibank Health Solutions (2010) **"Workplace wellness in Australia"** available at www.pwc.com.au
11. NICE (2009) **"Promoting Mental Health Wellbeing at Work - NICE Public Health Guideline 29"** available at www.nice.org.uk/guidance
12. Schmitz, G.R, Clark, M, Heron, S, Sanson, T, Kuhn, G, Bourne, C, Guth, T, Cordover, M and Coomes, J (2012) **"Strategies for coping with stress in emergency medicine: Early education is vital."** 5(1): 64–69 available at www.ncbi.nlm.nih.gov
13. The Balint Society www.balint.co.uk
14. The Sunday Times (2013) **"The Sunday Times 100 Best Companies"** available at www.sundaytime.co.uk

Further reading and resources

1. American College of Emergency Physicians (2004) **"Wellness Book for Emergency Physicians"** available at www.acep.org/
2. British Medical Association (BMA) **"Ill health retirement FAQs"** available at www.bma.org.uk
3. General Medical Council (GMC) **"Income discount guidance"** available at www.gmc-uk.org/
4. London Postgraduate Medical and Dental Practice **"London Deanery Professional Support Unit"** available at www.lpmde.ac.uk/
5. NHS Business Services Authority "Ill health retirement FAQs" available at www.nhsbsa.nhs.uk

Appendix 1

Applying annualised rotas to working lives Career Vignettes

Context

The following 7 example timetables give a flavour of how an annualised rota can be modified to suit an individual's personal preference for a work-life balance with EM at the core of their clinical activities.

We have developed some typical examples of people who work in EM and how they might tailor their working lives to get an appropriate work-life balance. Please note that all examples are fictional.

We would like to gather some real examples too. If you have a job plan that works well for you or have developed a portfolio career that you think would inspire the younger generation, please do send your submission to us at the College in a similar format as described below to satisfactioninEM@collemergencymed.ac.uk

Assumptions

The rotas shown assume a Programmed Activity (PA) allocation based on the current consultant contract unless working after 10pm when 1 PA has been assumed to be 1.5 hours.

Clearly this is one example. Around the country there is variation in PA allocation for 'premium' working. The tariff for after 7pm varies from 2-3 hours / PA while after 10pm, 1-2 hours / PA is more typical. The higher tariffs tend to represent high levels of work intensity and/or lack of other senior decision makers.

All midnight finishes in these examples come with a 0.714 PA on call supplement.

They also assume 32 days of annual leave and 2 weeks professional or study leave per year. Pro-rata amounts of annual leave and study/professional days are shown.

A 1 in 6 weekend working pattern is used.

Detailed College guidance on this topic can be found in:

[Developing annualised rotas for Emergency Medicine consultants and SAS doctors - Guidance and recommendations](#)

Example Consultant 1 - John

John is 32 and is a new consultant working 10 PAS with a 2.5 Supporting Professional Activities (SPA) and 7.5 clinical split. He leads on issues related to the Resuscitation Room and organises the SHO teaching program. He is single and has no children.

He is happy to do nights as the time off allows him to pursue his other interests inside and outside of medicine - medical cover for motor racing and following his beloved Leyton Orient to as many matches as possible. He has no specific days he needs off. He occasionally helps the ED with extra shifts in the evenings which helps top up the 'holiday fund'.

In the 6 weeks he needs to do 36.65 clinical PAs and 12 non clinical PAS. On this rota he will have done 36.82 PAs and 12.12 non clinical PAs.

John's Rota

DAY	CLINICAL	NON-CLINICAL	OFF	ANNUAL LEAVE
M	0800-1700			
T	1600-0000			
W			OFF	
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
BH MON	0800-1700			
T	1600-0000			
W			OFF	
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M	0800-1700			
T	1600-0000			
W	2200-0830			
T	2200-0830			
F			OFF	
S			OFF	
S			OFF	
M			OFF	
T			OFF	
W			OFF	
T			OFF	
F			OFF	
S			OFF	
S			OFF	
M				ANNUAL LEAVE
T				ANNUAL LEAVE
W				ANNUAL LEAVE
T				ANNUAL LEAVE
F				ANNUAL LEAVE
S			OFF	
S			OFF	
M		CEM CPD DAY		
T			OFF	
W			OFF	
T		0900-1700		
F		0900-1700		
S	0800-1700			
S	0800-1700			

Example Consultant 2 - Rob

Rob is 37. He has been a consultant for 5 years and is married with 2 young children. He is Lead Clinician and works 12 PAs; 7.5 clinical and 5.5 non clinical. His SPA activities include developing the ED service, managing the team and liaising with hospital management and the local CCG. He's keen to develop a career incorporating medical management.

He prefers not to do any clinical work on a Monday or Tuesday to make timetabling his non-clinical commitments easier.

He has Wednesdays off to look after his children.

In the 6 weeks he has to do 36.65 clinical PAs and 26.65 SPAs. On this rota, he has done 36.45 clinical PAs and 24 non clinical PAs.

Rob's Rota

DAY	CLINICAL	NON-CLINICAL	OFF	ANNUAL LEAVE
M		0900-1700		
T		0900-1700		
W			OFF	
T	1400-2230			
F		0900-1700		
S			OFF	
S			OFF	
BH MON	1600-0000			
T		0900-1700		
W			OFF	
T		1400-2230		
F			OFF	
S	1600-0000			
S	1600-0000			
M		0900-1700		
T		0900-1700		
W			OFF	
T	1600-0000			
F		0900-1700		
S			OFF	
S			OFF	
M		0900-1700		
T		0900-1700		
W			OFF	
T	2200-0830			
F	2200-0830			
S				
S				
M		0900-1700		
T		0900-1700		
W				
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M				ANNUAL LEAVE
T				ANNUAL LEAVE
W				ANNUAL LEAVE
T				ANNUAL LEAVE
F				ANNUAL LEAVE
S			OFF	
S			OFF	

Example Consultant 3 – Yasmin

Yasmin is 38 and works 'less than full-time' although given that she has 3 children so she would disagree with that description. She is on a 6 PA contract – 1.5 SPA and 4.5 Direct Clinical Care (DCC). Her SPA time is used for CPD and for organisation of the departmental rotas.

Her partner looks after the children on Monday and Tuesday so she prefers to work day shifts then. She is off most Wednesdays so in term time usually goes riding her horse. She also helps as a Race Doctor at the local race course and attends the Burghley Horse Trials as site doctor where her EM skills are put to good use.

In the 6 weeks she needs to do 21.18 clinical PAs and 7.25 non clinical PAs. On this rota she will have done 21.79 PAs and 8 non clinical PAs.

Yasmin's Rota

DAY	CLINICAL	NON-CLINICAL	OFF	ANNUAL LEAVE
M		0900-1700		
T	0800-1700			
W			OFF	
T			OFF	
F			OFF	
S			OFF	
S			OFF	
BH MON	0800-1430			
T		0900-1700		
W			OFF	
T			OFF	
F			OFF	
S			OFF	
S			OFF	
M		0900-1700		
T	0800-1700			
W			OFF	
T			OFF	
F			OFF	
S			OFF	
S			OFF	
M		0900-1700		
T	0800-1700			
W			OFF	
T			OFF	
F	2200-0830			
S			OFF	
S			OFF	
M				ANNUAL LEAVE
T				ANNUAL LEAVE
W				ANNUAL LEAVE
T				ANNUAL LEAVE
F				ANNUAL LEAVE
S	1600-0000			
S	1600-0000			
M			OFF	
T		CEM CPD		
W			OFF	
T			OFF	
F			OFF	
S			OFF	
S			OFF	

Example Consultant 4 – Omar

Omar is 45. He has been a consultant for 13 years and is the Regional Training Programme Director and local Patient Safety Lead in which he has developed academic interests. He has been working voluntarily with the University on safe system design and mobile application development for urgent and emergency care environments. They want to offer him 2 PAs a week next year to take this work further and is working with the University to patent some of his proposed applications.

He has a fixed non-clinical day on Fridays. He chooses not to do nights (partly for health reasons - he finds night shifts mess with his diabetic control) but does do on call. He likes to have Mondays off so he can go sailing. He is on 10 PAs – 7.5 clinical and 2.5 SPA.

In the 6 weeks he needs to do 36.65 clinical PAs and 12.12 non clinical PAS. On this rota he will have done 36.65 PAs and 12 non clinical PAs.

Omar's Rota

DAY	CLINICAL	NON-CLINICAL	OFF	ANNUAL LEAVE
M	1400-2230			
T	1600-0000			
W			OFF	
T			OFF	
F		0900-1700		
S	0800-1700			
S	0800-1700			
BH MON			OFF	
T	1400-2230			
W	1400-2230			
T			OFF	
F		0900-1700		
S			OFF	
S			OFF	
M				ANNUAL LEAVE
T				ANNUAL LEAVE
W				ANNUAL LEAVE
T				ANNUAL LEAVE
F				ANNUAL LEAVE
S			OFF	
S			OFF	
M			OFF	
T	0800-1700			
W	1400-2230			
T	1600-0000			
F		CEM CONFERENCE		
S			OFF	
S			OFF	
M			OFF	
T	0800-1700			
W	1600-0000			
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M			OFF	
T	1400-2230			
W	1400-2230			
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M			OFF	
T	1400-2230			
W	1400-2230			
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	

Example Consultant 5 – Zara

Zara is 58 and has been a Paediatric EM consultant for 25 years. She still works 10 PAs but doesn't work after 10pm as she found it exhausting as she got older. She is on 6 clinical PAs and 4 non clinical PAs running weekly simulation training within the Trust.

Her CPD and simulation work takes place on Thursday and Friday. She does regular medico-legal work on a Wednesday. She also works voluntarily for St John Ambulance half a day a week and some weekends which she finds very satisfying and invigorating to teach in a different environment.

In the 6 weeks she needs to do 29.96 clinical PAs and 19.38 non clinical PAS. On this rota she has done 29.46 clinical PAs and 20 non clinical PAs.

Zara's Rota

DAY	CLINICAL	NON-CLINICAL	OFF	ANNUAL LEAVE
M				ANNUAL LEAVE
T				ANNUAL LEAVE
W				ANNUAL LEAVE
T				ANNUAL LEAVE
F				ANNUAL LEAVE
S			OFF	
S			OFF	
BH MON	0800-1700			
T	1400-2230			
W			OFF	
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M	0800-1700			
T	1400-2230			
W			OFF	
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M	0800-1700			
T	1400-2230			
W			OFF	
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M	0800-1700			
T	1400-2230			
W			OFF	
T		0900-1700		
F		0900-1700		
S			OFF	
S			OFF	
M	0800-1430			
T	1400-2230			
W			OFF	
T		0900-1700		
F		0900-1700		
S	0800-1700			
S	0800-1700			

Example Consultant 6 – Andy

Andy, 42, has been a consultant for 7 years with an active interest in pre-hospital care. Building on a long-term commitment to overseas aid work he has just been offered an unpaid development role with Voluntary Services Overseas working three weeks on and three weeks off. He finds this work incredibly fulfilling.

The annualised rota allows him to do this without dropping any pay. He is happy to work nights, as he wants to eat into his PAs to 'earn' the time off. He also knows that this is just a 6 month project and so is happy with high night intensity for a short period of time.

He is on 7.5 clinical PAs (2 PAs in pre-hospital care with the local ambulance service) and 2.5 SPAs. His additional non-clinical work is with the medical school examinations team and can be fitted in within his 3 weeks 'on'.

In the 6 weeks he needs to do 36.35 clinical PAs and 12.12 SPAs. On this rota he works 36.80 clinical PAs and 12 SPAs.

Andy's Rota

DAY	CLINICAL	NON-CLINICAL	OFF	ANNUAL LEAVE
M				ANNUAL LEAVE
T				ANNUAL LEAVE
W				ANNUAL LEAVE
T				ANNUAL LEAVE
F				ANNUAL LEAVE
S			OFF	
S			OFF	
BH MON			OFF	
T			OFF	
W			OFF	
T			OFF	
F			OFF	
S			OFF	
S			OFF	
M			OFF	
T			OFF	
W			OFF	
T			OFF	
F			OFF	
S			OFF	
S			OFF	
M		0900-1700		
T		0900-1700		
W	2200-0830			
T	2200-0830			
F	2200-0830			
S			OFF	
S			OFF	
M		0900-1700		
T		0900-1700		
W	1600-0000			
T	1600-0000			
F			OFF	
S			OFF	
S			OFF	
M		0900-1700		
T		0900-1700		
W			OFF	
T			OFF	
F			OFF	
S	1600-0000			
S	1600-0000			

Example Consultant 7 – Sarah

Sarah is 43. She has been a consultant for 5 years following a training period prolonged by a Masters and then a PhD. Last year she was appointed Professor of Emergency Medicine. She is extremely active in research in trauma and now supervises 2 PhD students and 3 research nurses as well as having undergraduate students completing student selected components under her guidance.

She works 6 PAs for the hospital (4.5 DCC and 1.5 SPA) and 4 PAs for the University.

In the 6 weeks she needs to do 21.18 clinical PAs and 26.65 non clinical PAs. On this rota she will have done 21.79 clinical PAs and 26 non clinical PAs.

Sarah's Rota

DAY	CLINICAL	NON-CLINICAL	OFF	ANNUAL LEAVE
M				
T	0800-1700			
W				
T		0900-1700		
F		UNIVERSITY		
S				
S				
BH MON	0800-1430			
T		UNIVERSITY		
W		UNIVERSITY		
T		0900-1700		
F	0800-1700			
S				
S				
M				ANNUAL LEAVE
T				ANNUAL LEAVE
W				ANNUAL LEAVE
T				ANNUAL LEAVE
F				ANNUAL LEAVE
S				
S				
M		UNIVERSITY		
T	0800-1700			
W		0900-1700		
T				
F	2200-0830			
S				
S				
M		CONFERENCE		
T		CONFERENCE		
W		CONFERENCE		
T		CONFERENCE		
F				
S	1600-0000			
S	1600-0000			
M				
T				
W		0900-1700		
T		UNIVERSITY		
F		UNIVERSITY		
S				
S				

Appendix 2

Supporting Professional Activities within a job planning process

Emergency Medicine is a unique specialty in its intensity and variety of work both clinically and non-clinically. The College of Emergency Medicine (CEM) believes that the correct balance of DCC:SPA activity is essential for maintenance and development of service, patient safety, professional development and sustainability. The recommendations are 7.5 DCC:2.5 SPA in England, Scotland & Northern Ireland, 7:3 in Wales.

The view of College Council, is precisely that expressed by the British Medical Association and NHS Employers.

British Medical Association and NHS Employers- A Guide to Consultant Job Planning (2011)

The BMA similarly supports the 7.5:2.5 split in England, Scotland & Northern Ireland as well as 7:3 split in Wales. The CEM view is that a standard 10 session consultant contract should have a 7.5:2.5 split. For specialty doctors and other "middle grade" posts there should be a minimum of 1 session of SPA in a 10 session contract.

It is College policy that should a job description with less than 2.5 SPAs be submitted to a College Regional Advisor(CRA) for approval, this split will be discussed by the CRA with the Trust for clarification purposes. Part of this should involve direct discussion between the Regional Advisor and the Clinical Lead in the ED, as the Clinical Director may not be an Emergency Medicine consultant. It is felt that obtaining the view of the EM consultants, as a body, is vital.

Advertising an Emergency Medicine consultant post at less than 2.5 SPAs (for a 10 PA contract), could adversely affect recruitment to those posts. Even if existing consultants have agreed to a post being advertised as having less than 2.5 SPAs, the College will advise against proceeding unless there is clear guidance that an opportunity for appropriate SPA recognition will be provided. For consultants on a part-time contract, SPAs should consist of a minimum of 25% of contracted sessions.

The CEM view is that there is a requirement of a minimum of 1.5 SPAs to ensure sufficient personal CPD is undertaken as a weekly average to allow for successful appraisal and revalidation for each individual consultant.

This would leave 1 further SPA for the many other activities that need to take place outside of direct clinical care time. The following are some examples of other accepted SPA activities that should be considered within SPA activity:

This list is by no means exhaustive

- Teaching organisation
- Training (e.g. of trainees, medical students)
- Formal teaching and preparation (e.g. giving lectures, seminars)
- Audit and local clinical governance activity
- Clinical management
- Service development and quality improvement work
- Major incident planning
- Rota organisation
- Job planning
- Research
- Work for the coroner, legal issues, complaints
- Safeguarding children and vulnerable adults
- Acting as liaison with police and ambulance services

In addition CEM recommends the following allocation of SPA time for specific roles:

Clinical Director 3PAs /week

Teaching organisation 2PAs /week (up to 4 in large teaching departments)

Educational support 1PA per four trainees/week

Clinical Governance lead 1PA/week

Contingency Planning lead 1PA/week

Urgent & Emergency Care network duties 1PA/week

Again, this list is not exhaustive and there are other roles that require SPA allocation that should be negotiated locally.

The College of Emergency Medicine believes that a job plan with less than the recommended SPA allocation has significant potential to compromise departmental function. This can impact in a number of ways. The most important amongst these will include patient safety, quality improvement and the wellbeing of the staff.

Appendix 3

Members of the Working Group

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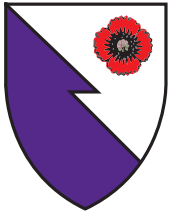
Acknowledgements

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We would also like to acknowledge all those who shared their experiences with us and gave us feedback on earlier drafts. This has been vital in the quality of the final product. Finally we appreciate that there is much still to do and will continue this important work further on behalf of members and fellows of the College with future iterations.

Please provide us with feedback and further suggestions by writing to makingEMgreat@collemergencymed.ac.uk

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