



## Pres blog

The pace of College activity continues to accelerate—hence a brief resume of the current state of play.

The spring CEM Conference in Brighton was a great success with outstanding plenaries, educational sessions, free papers and posters. Many thanks to all those who contributed and attended. This year's excellent Maurice Ellis lecture was presented by Rod McKenzie, Senior Lecturer in Emergency Medicine at the University of Leicester on Pre-Hospital Emergency Medicine. Particular thanks to Rowley Cottingham and his team of organisers in Brighton for putting together a superb programme both academic and social with unique opportunities for College karaoke, neo-burlesque CPD and a sea front fun run. You had to be there...

The September College Conference will be held at Imperial in London. Ruth Brown and Ed Glucksman are currently finalising a terrific programme. Details are on the CEM website.

The College Conference programme will be changing in forthcoming years. There is general agreement that running two full conferences each year is difficult given the current allocation of study leave time and budget. From 2010, there will be a College spring event building on the current excellent CPD programme overseen by Katherine Henderson. The plan is to have a two day CPD fest which, in addition to invaluable educational opportunities, will

include the absolutely essential College social and networking opportunity on the evening of day one. This two-day event will of course be in addition to the programme of CPD days being held in London and elsewhere. We hope that this CPD programme is mapped to the curriculum and will provide a cycle of CPD opportunity for Fellows and Members of all seniorities over a 3–5 year period. Comments and feedback on this plan and the programme would of course be very welcome. The Autumn 2010 CEM Conference is being hosted by the Military Emergency in Birmingham.

College activity at the centre continues apace.

The DH has recently merged the Emergency and Urgent Care Groups to form the unsurprisingly titled Urgent and Emergency Care Board, of which the College is a member. There have been concerns that this configuration might result in the Emergency Medicine agenda being subsumed within the overall programme, but preliminary discussions reassuringly indicate that the fundamental position of Emergency Medicine and Emergency Department care is appreciated and I intend to build upon this awareness. The key agenda item remains ensuring that our EDs are adequately staffed at a senior level to provide consistently high quality and safe care. Consultant expansion generally is inextricably linked to funding, in

turn determined by the PBR tariff which is, in turn, informed by ED data returns reflecting activity. The objective is to ensure accurate and reliable data which will then inform the PPR structure providing an incentive to invest in the Emergency Department, rather than alternatives, and secure funding for the much needed Consultant expansion. It is important to note, however, that there is still much work to do in this area.

George Alberti, the National Director for Emergency Care, has recently “retired”—at least from his role as Emergency Tsar but inevitably not from medicine entirely. I have written to Sir George on behalf of the College thanking him for his immense and invaluable support. The days of Reforming Emergency Care seem distant (they are) but, even in these continuing difficult times, it is important to note the transformation which has occurred compared to the pre-George era. The College and the specialty owe him a great debt of gratitude.

There have been a number of other notable retirements from the specialty in the past few months including some astonishingly youthful retirees—Martin Shalley, Nigel Brayley and Apollo Mullira. Martin was of course a superb President of BAEM, Nigel has been the specialty Lead for Casemix, HRGs and IT for many years and Apollo has played a leading role in representing Emergency Medicine at the RSM. Outstanding contributions all round—thank you.

**John Heyworth**

# Workforce planning: an interview with Howard Simpson

## HOW DID YOU GET INVOLVED WITH WORKFORCE PLANNING?

Having been an Emergency Medicine consultant at Basingstoke for 8 years, I was looking to “broaden my portfolio”. At the same time the Workforce Review Team (WRT) was looking to take on a new medical advisor. Being an opportunist, it seemed a good idea at the right time, with a chance to settle my curiosity and frustration over the way the NHS is organised.

## WHO OR WHAT IS THE WRT?

The Workforce Review Team (WRT) provides an impartial workforce planning service to inform the various organisations that run the NHS. We are a team of 40 people comprising data modellers, data analysts, professional advisors and operational staff under the direction of a Public Health Consultant. The WRT provides expert information and advice about the 1.3 million people that constitute the NHS.

## WHAT ACTUALLY IS YOUR JOB AS A MEDICAL ADVISOR?

I am one of several professional advisors to the WRT. Other professional advisors are from nursing, pharmacy, health scientists, allied health professionals and the academic world. The data modellers and analysts are chosen from outside the NHS for their expertise and lack of bias, and need people from inside the NHS to provide an intermediary role. I help the analysts understand the work of the NHS. I have to understand the impact of the team’s findings and explain this to people who need know. When we identify problems, for example the possible shortage of GPs, I assist people to identify ways to mitigate potential problems, for example by developing the skill mix of other professional groups who may not be in such shortage, such as nurses or allied health professionals.

## SO ARE YOU MAKING DECISIONS ABOUT THE FUTURE OF THE NHS?

No, we only have an advisory role. Our job is to understand and monitor the impact of decisions made by other people who are developing the various sectors of the NHS workforce. Hopefully we assist

them to make better, more informed decisions as a result. Although we aim to influence decision-making based upon our broad perspective, nobody is obliged to act on our recommendations.

## WHAT SORT OF RECOMMENDATIONS DOES THE WRT MAKE?

A major part of our work is to produce annual summaries about the workforce in the various clinical specialties. On the basis of the assumptions we put into our workforce models, we are able to say whether there is a general balance in supply and demand or whether there is need to expand or contract any particular group of specialists. We get this information by talking to the various stakeholders such as Royal Colleges and Trusts. For instance our models suggest that the current numbers of trainees in general surgery could be reduced by up to 50%. If the current number of trainees is maintained, it is likely that there will be greater numbers of CCT holders emerging than there are consultant posts. Cutting back on trainees is clearly going to impact on the way surgical teams and wards are organised, but equally it would be indefensible to train surgeons who had little prospect of securing a post in the UK. By contrast, it is likely that the current number of General Practice trainees will be unable to meet the increasing demand for primary care services. This sort of information would also be useful to doctors in foundation programs and even medical students to help them make sensible career choices.

## WHAT HAVE YOU LEARNED SO FAR WITH THE WRT?

I have a much better understanding of the commissioning process. All the money comes down through the 10 SHAs. They decide how they are going to spend the money in their region to deliver the services that they believe patients need. So that it’s not a complete bun-fight, the SHAs have to take into account what directives are coming down nationally, such as PCI heart attack centres, as well as requests to support new services, such as community-focussed respiratory care, or the expansion of existing services, such as intensive care. They clearly have a lot of

people knocking on their doors, and the commissioners look to the WRT workforce summaries to inform their decision-making process.

## WHAT ARE THE BIG CHANGES GOING ON AT THE MOMENT?

The Darzi Report that came out last year is undoubtedly here to stay. I think the polyclinic issue is a bit of a red herring, it’s actually the eight so-called Darzi groups that are going to have the biggest impact. They seem intuitive, particularly to patients, which I think is the real strength of the model. However, the groups cut across the way many of our specialist services run at present; for example, orthopaedics contributes to both acute care and planned care. To help people understand this change, WRT is producing workforce summaries based on the Darzi Groups, as well as individual profession summaries. There is however another big change in the pipeline. Independent providers are able to undertake NHS work at standard tariffs and patients can choose to take that route. It seems to me that opening up the market for healthcare provision, while maintaining control on workforce supply, could prove to be incompatible strategies.

## HOW DO YOU SEE THE FUTURE OF ACUTE CARE?

Acute care is probably the Darzi area which will need the greatest work. Not only do we have to work out how best for people to access acute care, but we also need to identify where they go after the initial presentation. Clearly the starting point has to be ensuring that Emergency Departments, Walk-in Centres, Ambulance services, Emergency GP services and NHS Direct provide a consistent patient experience. But as with most of our EDs at the moment, it is what happens downstream that can make or break the flow of patients. We need to ensure that the right diagnostics, out-patient services, community support, and admission to acute and community beds are available to support the primary presentations. This will be a significant challenge.

## WHAT DO YOU THINK WE NEED TO KNOW IN EMERGENCY MEDICINE?

I think we need to understand how the NHS is currently being mapped out under the eight Darzi groups and start engaging in designing how acute care will function. We will have to work alongside other

specialties to ensure that we cover all eventualities to meet the acute care needs of our patients. Much of this will need to be done at a national level via the College, but we will also need to make it work at local level. Given that we are the only professional group that sits almost entirely in the acute care Darzi Group, we really should be taking the lead on this. I think most people outside Emergency Medicine expect this.

#### WHAT IS A WORKFORCE PLAN?

The simplest workforce plan does three things; it looks at what staff are currently in place to deliver a particular service, evaluates factors that govern supply and demand for that workforce, and suggests a strategy to ensure a stable service. Traditionally, workforce plans have been for specialty-based services and the strategies have been in terms of increasing or decreasing the number of trainees entering the particular specialty. However, the time between making changes and seeing the result takes years, so unless there is some moderation this strategy risks either being too slow or causing a boom and bust effect, similar to what was experienced in recent years with Obstetrics and Gynaecology.

#### WHO DOES WORKFORCE PLANNING?

The short answer is most people should but few people do. Currently, most professional groups have national workforce plans. However there are regional variations that probably warrant smaller scale plans. For instance the North West often finds it difficult to recruit to surgical posts possibly due to its rural infrastructure and distance from London. It is likely that the 10 SHAs will undertake their own workforce plans, probably under the eight Darzi Groups. There is no reason why hospitals or departments should not have similar plans, which could be useful given the current shortfall in candidates for trust grade and clinical fellow posts.

#### WHAT GOES INTO A WORKFORCE PLAN?

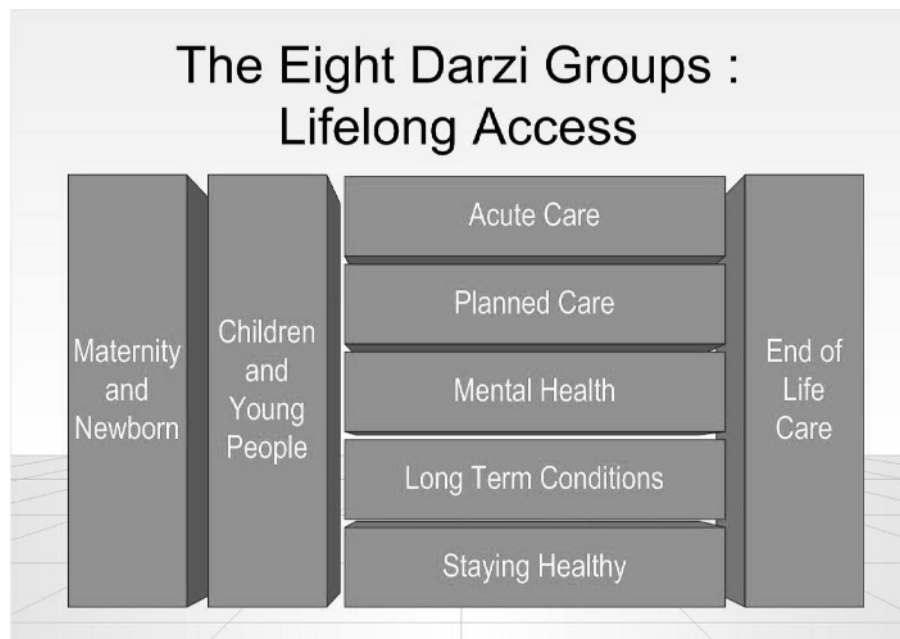
The first step is to understand the current workforce. National plans capture the number of staff from sources like the Electronic Staff Register and specialty or college censuses. The participation rate also needs to be known; the relationship between whole time equivalents and total head count due to part-time working. The age profile and the typical age of retirement are predictors for people leaving a specialty, but emigration, sickness and death also factor.

Workforce demand is the anticipated replacement rate for staff leaving, although any expansion or contraction of the service also needs to be considered. Workforce supply is the number of suitably trained staff likely to become available. In emergency medicine, this is relatively easy to predict as only FCEM CCT holders are able to take up new consultant posts and most trainees complete their training within a year of their predicted dates.

The plan then outlines how supply of staff is likely to balance demand, and to what extent any imbalance can be mitigated. For instance, Emergency Medicine currently has a relatively large training capacity which has made it possible to double the number of consultants over the last 10 years. However, unless there is a commitment to continue expanding the number of consultants, there is a real risk that training numbers will need to be cut to bring the supply of CCT holders in balance with projected demand.

#### HOW ACCURATE IS A WORKFORCE PLAN?

It's an old adage that nobody plans to fail but too many people fail to plan. The best workforce plans should serve to highlight problems in sufficient time to take effective corrective action. Typically, WRT estimates supply and demand over the next five years; this is sufficiently short-term to remain accurate but with enough time to address any predicted imbalance. The WRT models incorporate factors such as attrition rate of trainees, changes in male:female ratios, retirement rates, and the number of unfilled consultant posts, to make a sensible estimate of future supply and demand. The key is to keep reviewing the plan, typically every year, to see whether supply and demand seems to be converging or diverging. In workforce planning we make extrapolations based on historical data, develop an understanding of cause and effect, and suggest explicit and logical conclusions. But, just like any audit, there's no point in doing it unless someone is going to act on the results. Acute Care has a significant problem as so many people play a part in its delivery.



## “Who do you think you are...?”

So, colleague, what do you call yourself at work? I have to admit to suffering an identity crisis of late, not the “buy a leather jacket and motorbike” kind of mid-life identity crisis, but a crisis all the same. I don’t know how to introduce myself to patients any more; just what am I?

Older orthopods (and younger ones who should know better but enjoy the sport) are prone to using “Casualty Officer” as their moniker of choice, I’ve seen team-mates bite at this but I know better than to take the bait. That said, my elderly relatives only understand what I do if I tell them that I work in casualty,

Holby City being their point of reference. I know that I’m a member of the College of Emergency Medicine, but the sign over the department says Accident & Emergency and my badge says SPR A&E ... confused? How do you think the patients feel? Now that we have SPRs, STs, CTs and an assortment of Fs among our ranks I’ve given up trying to convey some degree of seniority in my introduction—perhaps we should all wear stripes on our scrubs?

To make things worse I’ve been working a fair bit with European and transatlantic colleagues—people with a bewildering

range of abbreviations to describe themselves. The concept of the ER is well established in North America, but still I’ve met Emergency Physicians (EPs), Emergency Medicine Specialists (EMS), and Emergency Room Doctors (ERDs) ... the prospect of some human resources comedian adding a “Trainee” prefix to that last one is all too real. Besides, in the UK EP has been nabbed by the electro-physiologists and ED is something that Pele talks about in TV adverts ...

Answers on a postcard then, what are we to call ourselves? For now I’ve given up—“I’m Doctor Gurney and I’m here to help” seems to be the safest option at the moment!

Ian Gurney

## Consultant appointments April 2009

The information for the consultant appointments is provided by the College and any errors should be notified to them and not the journal

Name	Hospital	Previous post
Dr Walid Alsalm	East Surrey Hospital	
Dr Elizabeth Turner	Lister Hospital	Locum Consultant
Dr Lesley Watson	Wythenshawe Hospital	Locum Consultant
Dr Ewan McMorris	Royal Hampshire County Hospital	SpR

In the May issue of the Supplement, we listed a Mr David Martin. This was incorrect and should have appeared as Dr David Hartin (appointed Consultant at Ipswich Hospital). We apologise to Dr Hartin for this error.



The elite athletes from the College of Emergency Medicine prove once again that Brighton (and the College) rocks.