



## 21st Century Emergency Medicine Consultant: professional issues in emergency medicine

Having just been appointed as a new consultant, I attended the College's 21st Century Emergency Medicine Consultant Workshop. The programme promised presentations on topics I'd mostly ignored until now but was certain were important. I had anticipated a day of confused and worried junior consultants asking naïve questions about contracts, plans and revalidation. However, judging by the attendance and seniority among the audience, the issues discussed were useful to all. I wanted to plot the highlights for those not able to attend and suggest places for seeking help and information where needed.

### **JOB PLANNING AND THE CONSULTANT CONTRACT (ANDREW HOBART + DON MACKECHNIE)**

The consultant contract 2003 is time based and raises some particular points for emergency physicians. 'What do I sign at the start of my post?' is a difficult question and lessons learnt from paediatricians committed to night-time provision of care in the North West should be noted. The bottom line is that you should not sign a contract without an agreed job plan.

It is vital to have an annual job plan but you can request one at any time. Many

consultants are experiencing changes to rotas and working hours. Some of this is regional (reconfiguration in the London and the South East creating major trauma centres, etc) and some of it is universal (increase in demand for shop floor presence in evenings and weekends). Scheduled work in premium time (different definitions in England, Scotland and Wales) is not usually compulsory and the compensation is negotiable. Programmed activities (PAs) over 10 are neither obligatory nor permanent. This generates questions regarding compensation for antisocial working and care provision—should the number of PAs be increased or should each of those premium time PAs be for shorter periods of work (2 hours rather than 3 hours)? A robust diary card exercise is very useful and it is best done over at least one cycle of the full rota by all involved.

There is pressure to reduce our SPA time. Where the necessity of 2.5 SPAs is being questioned, we should be clear what is expected of that time—a minimum of one PA for CPD and revalidation (CEM advice), appraisal, teaching organisation, teaching preparation, formal teaching provision (lectures, etc), training of students and trainees (each of whom should have 0.25 SPA dedicated to

them per week), audit and clinical governance, clinical management, service development and quality improvement work, major incident planning, rota organisation, job planning and research. This is not an exhaustive list and suggests that any question of reducing SPAs may be unreasonable.

Teaching on courses (eg, ATLS) should be in SPA time rather than professional leave, irrespective of whether one's own trust is running the course, as this teaching is for the greater good of our patients.

"Do I have to come in at night when called?" provided an interesting debate with strong sentiments. It is up to the individual to make a judgement based on perceptions of departmental/patient safety. "Are referred patients my responsibility when considering safety?" Thoughts included, "I'll come in if the acute medicine consultant is there wanting my help resuscitating his patient" on one side, to "all patients in my department are under my care" on the other. It is worth remembering that consultants (like all doctors) are subject to the European Working Time Directive. This becomes important when job planning, setting rotas and considering coming in at night, as a morning clinical commitment or review clinic ("for those unlucky enough to do them") may fall into a compulsory rest period. Beware the consequences of any errors of judgement made at these times.

There is no obligation to 'queue bust' and the census of opinion supported this. Coming in is a clinical and not managerial decision based on departmental safety. Whereas it is preferable that

there is consultant presence at night and weekends, this is not sustainable in most departments.

(See [www.collemergencymed.ac.uk](http://www.collemergencymed.ac.uk) for document 'The consultant contract and job planning for emergency medicine consultants').

(See CEM website for the 'Statement from Academy of Medical Royal Colleges, February 2010').

#### MIDDLE GRADES (WAYNE HAMER)

There is a national shortage of middle grade cover in emergency departments and recruitment of doctors to these posts is proving difficult. International Medical Graduates (IMGs) are a potential solution but changes in immigration regulations have altered the ways in which they can be recruited. IMGs can now enter the UK through either tier 2 or tier 5 of the points based system. The College of Emergency Medicine is currently recruiting medical training initiative trainees who will get a tier 5 visa. They will obtain GMC registration through College sponsorship. Trusts that recruit doctors from overseas themselves should use tier 2—if these doctors do not have GMC registration then they too can apply for sponsorship by the College.

Some consultants in the audience discussed their experiences of using recruitment agencies that have sourced doctors of varying experience in Dubai and Mumbai. The results seem to have been variable and not entirely positive.

The ethics of potentially depriving impoverished health systems of their resources was raised. MTI trainees can stay in the UK for a maximum of 2 years after which they have to return to their own home country.

(For more information, see [www.nhemployers.org](http://www.nhemployers.org) and [www.collemergencymed.ac.uk](http://www.collemergencymed.ac.uk).)

#### REVALIDATION (JACKY HANSON)

Revalidation is a single process comprising two components: relicensing (from

November 2009) and recertification (all doctors on the specialist register). Although still at an early stage, pilots in Merseyside have finished and further pathfinder pilots will now take place in the rest of the UK this year, using the new strengthened appraisal documentation developed by the Revalidation Support Team (Department of Health). The process will require you to maintain and provide evidence of continuing professional development and this will be linked to eLearning and an ePortfolio. Other components will include multi-source feedback, evidence of participation in clinical governance and specifically a strengthened appraisal.

Consultants are already being appraised annually and these will be required for the 5 year cycle of revalidation utilising the new documentation currently being piloted. The financial impact of revalidation has yet to be fully assessed but is anticipated to be significant.

(For more information, see [www.gmc-uk.org/doctors/licensing.asp](http://www.gmc-uk.org/doctors/licensing.asp).)

#### ENLIGHTENME (TAJ HASSAN)

The Electronic Learning Initiative for Emergency Medicine (ENLIGHTENme) project is the College's eLearning strategy for it is members and fellows. It started in 2007. The two main platforms are now live with individual module sessions available (<http://www.e-lfh.org.uk/projects/emed/index.html>) on the Department of Health platform and a 'blended' programme of activities and materials on the College ENLIGHTENme Hub ([www.enlightenme.org](http://www.enlightenme.org)).

Currently, there are 50 modules on the Department of Health eLFH site with many more on the way, designed to challenge knowledge, skills, judgement and attitudes. The Hub is still in testing mode but colleagues are encouraged to navigate around the site and contribute with ideas. The project aims to be a key part of an evolving competency framework to be a specialist in emergency medicine.

It will also help as evidence to support revalidation through CPD.

Colleagues are also encouraged to direct foundation doctors to the 'education section' of Doctors.net where the College has a collaborative relationship with DNUK and provides a set of modules that junior doctors can complete to support induction and continuing education in the emergency department.

Visit the College Hub at [www.enlightenme.org](http://www.enlightenme.org) to learn more and create an account.

#### CLINICAL EXCELLENCE AWARDS (ED GLUCKSMAN)

The Advisory Committee on Clinical Excellence Awards (ACCEA) provides awards for consultants and GPs who consistently perform over and above the standard expected. Separated into local and national awards, applicants can apply after working for 1 year as a consultant. It is very important to stick to deadlines, follow the instructions and take care over the quality of the content of your application.

A local 9 Employer Based Award (EBA) equates to a national bronze award and awards are reassessed every 5 years—applicants are most likely to be successful after working as a consultant for 8–10 years. On the national scale, applicants may only advance one level at a time (eg, silver can apply for gold but not platinum). Application forms are specific for each annual round and citations can come from anyone. Applicants are more likely to be successful if supported by their Trust plus another organisation (eg, College of Emergency Medicine).

(For more information, see [www.nhsaccea.dh.gov.uk](http://www.nhsaccea.dh.gov.uk).)

**Dr Dane Chalkley**

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#### Supplement editors

This supplement is edited by Mike Beckett (West Middlesex Hospital), Diana Hulbert (Southampton General Hospital) and Lisa Somers (Newham General). To contact the editors, please email: [emjeditorial@bmjgroup.com](mailto:emjeditorial@bmjgroup.com)

# How Lean is your emergency department?

**Atos Origin Consulting have introduced the Lean process into NHS organisations, including Southampton University Hospitals NHS Trust, South Central SHA and Milton Keynes PCT.**

## WHAT IS LEAN?

Lean is both a methodology and a way of thinking. The methodology enables a process to be seen and understood while the thinking promotes the ongoing process improvement. Continuous improvement arises through the removal of waste and variability. Waste, as perceived by the patient, is usually *waiting*, which can be for a wide range of services. Lean encourages stability through standardising where practical and being responsive to customer demand through communication and flexibility. Ultimately it is a state of mind that seeks perfection through continuous improvement.

## HOW CAN LEAN BE USED TO MAKE EFFECTIVE CHANGES IN THE EMERGENCY DEPARTMENT?

Lean can be applied to any process, so all that's required is to map the emergency department processes and identify the waste in them, but this is not always easy. The map must represent the *true* process, not an assumed process. Mapping is often best done by a non-emergency department person whose independence makes it easier to challenge both the mapping and the waste. Examples of changes that we have brought to emergency departments include:

- ▶ Rebalancing resources so that they better match demand (eg, adjusting nursing and clinician rota, flexing diagnostic capacity, aligning bed availability to demand, improving emergency department access to specialists).
- ▶ Bringing forward the point at which clinical assessment and decision making by *senior* clinicians occurs so avoiding unnecessary testing (eg, GP streaming, rapid assessment).
- ▶ Improving visual management systems to help maintain patient flow and to clarify problem ownership for each patient (eg, using whiteboards and IT systems).

- ▶ Investing in supernumerary enabling roles (eg, an experienced sister in charge of allocating nursing staff into areas of demand, a bed manager working out of emergency department).

None of these are easy fixes but the effort can deliver a massive turnaround in performance (eg, 4 hour target from 80% to 98%, sustained for 12 months), some with little expense.

## WHAT HAVE BEEN YOUR RECENT EXPERIENCES WORKING WITH EMERGENCY DEPARTMENTS?

Investigating the root cause of emergency department bottlenecks and under-performance often point to causes outside of the emergency department. Unnecessary presentations are a common challenge and arise both from patients who self-refer and those brought in by ambulance. Primary care trusts and hospital trusts have to work collaboratively to deter people using emergency department as a pseudo walk-in centre. Where this happens it is possible to smooth the flow of patients to avoid queuing at the door and to reduce the stresses this inevitably causes—work with the West Midlands Ambulance Service is a recent example, taking patients to walk-in centres and minor injuries units instead of the emergency department.

## WHAT CHALLENGES DID YOU COME ACROSS WHEN APPLYING LEAN?

Applying Lean thinking requires changes to processes, which can imply new job roles. People are naturally resistant to change so the challenge is in helping those affected to see the benefits to patients and to the organisation's performance. While there may be few objections initially, resistance can build throughout a Lean transformation. Sustaining the new ways of working that are developed through process redesign needs ongoing effort, particularly as team members change over time.

Using Lean to turn around 4 hour performance usually provides the greatest challenge. Change needs to occur not just in the emergency department but has to be trust-wide, with engagement of staff from the board to those in support roles, such as receptionists, cleaners and porters.

For example, when an emergency department is redesigned, it might take several weeks and involve all of the skills of those who touch the process at workshops and communication sessions. When examining hospital-wide systems, community support staff such as social services and ambulance services are invited to contribute. Unless all parties are involved, there is no commitment to sustaining the great ideas for change that are recommended.

## WHAT OTHER ADVICE ASIDE FROM LEAN TECHNIQUES WOULD YOU GIVE TO IMPROVE EMERGENCY DEPARTMENT PERFORMANCE?

Improving the emergency department usually requires a step change followed by ongoing improvement. Both of these are covered by Lean techniques, so it is difficult to put Lean aside, but some suggestions include:

- ▶ Train clinicians and managers in basic problem solving techniques.
- ▶ Protect problem solving time, especially for your senior clinicians and decision makers.
- ▶ Stop doing emergency department clinics at peak emergency department times.
- ▶ The finer points of some improvement techniques require specialist statistical analysis.
- ▶ Make use of appropriate software solutions and consider the way in which IT systems are integrated and deployed.
- ▶ Apply the discipline that comes with formal project and programme management techniques.

To realise its full benefits, Lean is best applied across the whole health economy, which includes primary and secondary care, social care and mental health. When working to improve patient flows across whole systems, consideration must be given to the linking elements, such as the ambulance services, electronic patient records and community nursing.

## WHAT HAVE YOU LEARNT FROM YOUR EXPERIENCE IN THE EMERGENCY DEPARTMENT?

Root causes of problems vary in each emergency department. Diligence in the collection and analysis of data is essential. Equally important is validating conclusions by physically verifying processes and sharing findings with staff.

Good working relationships are critical and it is important to invest time and

effort in reducing tensions, such as those that may exist between management and consultants, as early as possible. The better the communication, the better your emergency department will function.

Change takes time, and it's all about hearts and minds. Without clinical and management commitment, benefits are short term, and behaviour will eventually revert back.

One major point is that the 4 hour target is not just a measure of emergency department effectiveness. Far more, it is an indicator of how the trust and the overall local health economy are balancing supply and demand. As such, the 4 hour target can enable health economies to achieve whole system solutions, which Lean has proven effective at helping to visualise.

A parting thought is that we believe there are strong arguments for the NHS to take the brave step of initiating a debate on charging people, or the commissioners that represent them, for inappropriate use of the emergency department.

**Richard Dovey, Dave Dingwall,  
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## Pres Blog

By the time you read this—hung Parliament option notwithstanding—there will be a new or at least modified administration in place. No matter what the political hue, the NHS, funding and emergency care will be high on the agenda. In the pre-election phase, we have maximised our profile—in a completely apolitical manner of course—emphasising the fundamental expectation of a National Health Service to provide high quality consistent emergency care. You and I would think that this would be right at the top of the agenda for the incoming team but we shall see....

I write this hotfoot (for details see below) from the outstanding success that has been the first College Spring CPD Fast held at the Kings Fund in London. Many congratulations and sincere thanks to Katherine Henderson who, as CPD Director, organised a superb programme of state of the art lectures given by experts in their fields. Sincere thanks also to Chris Walsh of the College office for arranging the logistics. The Maurice Ellis lecture will continue as part of College activity within the context of the spring CPD meeting. This year's lecturer was Professor Simon Carley from Manchester whose talk "Beyond FCEM" was brilliant and provocative. The event was a sell out—next year Wembley?

An integral part of any College event is to ensure networking opportunities. The 3 hour (yes!) drinks reception was

punctuated at mid-canapé point by the Kings Fund fire alarm. Delighted but not surprised, the CEM delegates demonstrated complete unflappability as they ambled from the reception, wine glasses in hand, continuing their conversation into Cavendish Square while fire and rescue arrived at high speed and high volume.

The College CPD programme will continue to include the spring CPD event—2011 will be in Southampton and exact dates will be posted on the website—with a series of CPD days held in London and throughout the UK to ensure that colleagues in all regions and nations have the opportunity to attend.

Any day now, if not already, the new and improved College website will go live. The previous version was fine but time and the College move on and we hope you will agree that the new website is more representative of the College public image for 2010. A more radical complete revamp of the website will take place when (not if!) we become Royal.

Tomorrow I will be attending a College meeting looking at IT, summary care records, casemix, PBR, HRG, etc. These interdigitating topics are of crucial importance to the future of emergency medicine to ensure that our work is accurately reflected in returns to the centre, that suitable funding follows and we are able to develop our workforce and patient care accordingly. For many years

this work has been brilliantly led by Nigel Brayley. In fact, Nigel retired to Bordeaux last year and despite his distant domicile has continued to take a lead role in driving these initiatives forward. Grateful thanks to Nigel for all of this work which has been pivotal.

The College workforce document is now up on the website. As noted in previous correspondence, this will be a document which will evolve ad infinitum and should therefore be recorded as an organic paper. Clearly the more evidence the better, and I would be very grateful indeed for any further reports of the benefits of consultant expansion, both in terms of quality and safety but also in terms of cost benefits to the Department and Trust. We are also keen to receive evidence from those areas currently under-represented so the workforce document can be truly applicable to all constituencies within the College network.

My next dispatch will be from Singapore—tough call, somebody has to etc, etc. I will be working hard out there, not only in the international networking context but also advertising the benefits for international emergency medicine trainees of spending time in the UK. Appropriately, in the current financial climate, the option of a presidential sandwich board extolling the virtues of emergency medicine in the UK, rather than the usual golf sale, was suggested. We have settled for a flyer which will be widely distributed at the Conference. To the Orient.....

**John Heyworth**