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SUPPLEMENT

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CEM News

With summer in full swing (hopefully), I trust most of you will be looking forward to some well earned holidays with family or friends.

The College is gearing up for a number of key events this autumn, of which the most exciting will be the Exeter conference. This will be a great opportunity to update ourselves on current research in emergency medicine as well as reflecting on best practice and gaining useful CPD. The location, in a purpose built conference centre opened late last year, ensures that we will have the best of facilities, and the conference organisers have worked hard to ensure a great programme with a number of simultaneous tracks to allow the widest possible coverage of current interests. The College AGM will be hosted at this event, and this is an opportunity for each and all to hold the College to account. We hope to update the format this year as the traditional presentation has become less than the sum of its parts. The issues are important and this should be reflected in both the substance and style of their presentation.

The College has been heavily focused on policy issues this year, and recent meetings between College National Board Chairs and myself and government ministers in Edinburgh, London, Belfast and Cardiff have reinforced the fact that the views of the College are accorded high regard. Nevertheless, the challenge of converting agreement into action is a perennial issue when dealing with statutory bodies and the establishment—this can only be achieved by relentless coordinated but constructive pressure at every level of representation.

Returning to the autumn agenda, those of you who are clinical service leads or equivalent will have been invited to our National Clinical Leaders day on 26 November. This will bring together all the emergency medicine leaders from every acute hospital in the UK and Ireland and in effect be a meeting of the people who carry the greatest burden of running an emergency medicine department. The day will celebrate your contributions, inform you of the key messages the College will be pursuing with political parties and present the tools with which we will gather the data to underpin our arguments. For those already weary, the promise of a drinks reception at the end of the afternoon will I hope be sufficient incentive!

Data—as I replied in a recent 'tweet'—is the bane of my life, principally because so much is of such poor quality. Various government departments, agencies and other national bodies abuse these poor data to make the most absurd determinations. Not only are the data poor but the interpretation is equally woeful. Apparently, excluding AAA in a syncopal middle aged man, SAH in a young woman and ACS in an elderly man are dismissed as 'left without treatment' and therefore by implication both inappropriate attenders, and the cause of wasteful resource expenditure. Perhaps I should not be so surprised as almost all of the people who make these statements do not even know what the abbreviations refer to. I do not criticise them for the latter but it ill behoves people to claim to understand the data when they do not know the facts. I could go on...! Set against this, the College has chosen to respond constructively and has launched its Sentinel Sites Project. In its first iteration, it studied over 3000 attendances to 12 emergency departments over 24 hours in March. The results were recently published in the *HSJ*, and the full data set will hopefully be published by *EMJ*. Most importantly, the data show that the number who could be safely redirected from triage, in the opinion of emergency department consultants working in those departments, was 15%. This highlights two issues: first, the 40% figure quoted by some is bogus (which we knew) and second, 15% equals 2.1 million attendances per year that could be safely referred to a co-located urgent care centre. This is not an insubstantial figure, it reinforces the College's position of ensuring all emergency departments have a co-located urgent care centre and, if managed outwith, the emergency department would significantly decongest our departments.

I know this would have tariff implications—that is one of the reasons why tariff reform is a key CEM10 priority!

Another mention for the CEM10 for which I make no apology. The value of this concise priority list has transformed our ability to broadcast our message and ensured we remain constructive and consistent. The autumn will mark the anniversary of the CEM10 launch and the National Clinical Leaders day will allow us to measure success or failure and re-focus our priorities for the next 12 months.

I will shortly be departing to join the presidential launch on the Riviera (Dinghy in Devon). I hope you have as much fun this summer as those who will watch me trying to sail!

Clifford Mann

Choose your future. Choose emergency medicine

Careers Day, February 2013

Just in case you missed it, we have had a crisis in emergency medicine. The College has been working tirelessly to resolve this crisis and many significant advances have been made. The '10 priorities document'[1] outlines what is being done and what needs to be done to help ensure the crisis is well and truly behind us. The achievements so far include the introduction of run through training, the DRE-EM pilot, securing government funding for an additional 75 ACCS posts and the College's sustainability project, to name but a few.

Many, if not all, of the issues are thought to relate to insufficient workforce numbers. In an attempt to find a solution, the College, in conjunction with Health Education England (HEE), has been working to promote careers in emergency medicine. This is where you come in. We need your help to ensure that our specialty is, and remains, a high profile, valued and popular career choice among students and junior doctors.

WHO ARE WE?

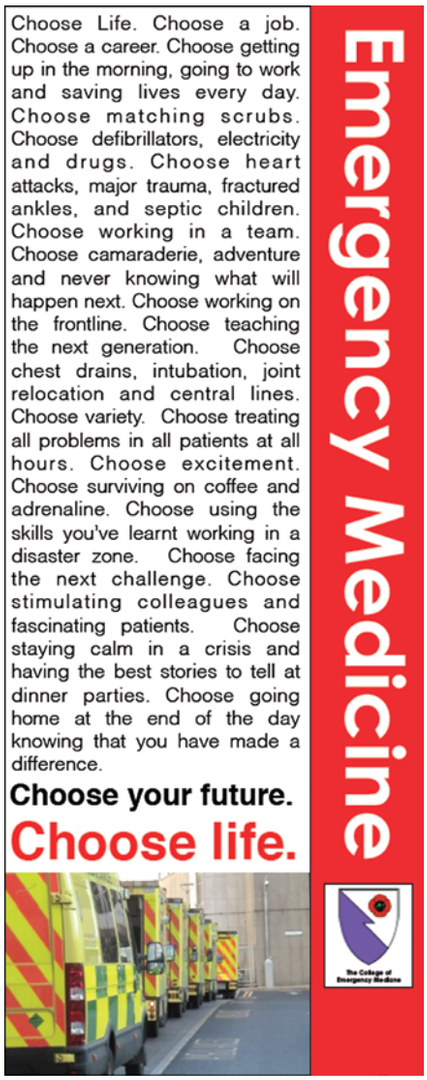
We are two emergency medicine consultants working in North East London. Since the spring of 2013 we have been leading the College careers strategy, with the guidance of Ruth Brown and Helen Cugnoni. You may have spotted us at College conferences manning the careers stand. As with many great things, this all started in the pub. After attending a 'New consultants day' at the College in 2012, during which time the workforce crisis was escalating, we retired to take refreshment with the past College president, the then registrar and the dean. It became clear that any strategy to boost workforce numbers would need to extend to attracting students and foundation doctors, as well as existing trainees. To this end a College of Emergency Medicine Careers Day for students was suggested.

We hosted the first Careers Day in February 2013, and now hold an annual day at the College for students and anyone interested in emergency medicine. The day comprises a morning of lectures to showcase the 'good, the bad and the ugly' of emergency medicine, delivered by existing core and higher trainees, alongside a group of emergency medicine consultants with teeth of varying lengths. In the afternoon we run skills workshops, a quiz and a Q&A panel. It has sold out on both occasions and the feedback has been very positive. We have found it a useful vehicle to promote emergency medicine and truthfully dispel some of the negative myths about the specialty that still linger.

CAREERS IN EMERGENCY MEDICINE GROUP

With further guidance from Ruth and Helen we then set up the Careers in Emergency Medicine Group (CEMG). The main achievement of the group to date has been to produce some emergency medicine career information material. We have also made 'emergency medicine–the Movie', a 30 minute edge of your seat video showcasing careers in emergency medicine, with interviews and sound bites from a range of emergency medicine clinicians across North East London. In addition, we have produced a readymade careers stand package. This comprises a pop up banner and a set of four A1 posters which can be ordered from the College. We have just completed a new careers booklet, which can also be ordered for use at events.

Other activities have included hosting, or at least coordinating, emergency medicine fellows' presence at career events around the country. This can be a fun and inspiring experience, as Alison Walker told us in the April edition of *EMJ Supplement*.[2] We have kept ourselves busy running careers workshops at College conferences, setting up an emergency medicine student and foundation doctor society, creating a library of careers photos and developing the careers section of



the College website. Our work links with, but remains separate from, that of the College's sustainability group, as our focus is perceptibly different. Finally, we have also been working with external agencies such as HEE and the medical careers website (whose material we have been involved with updating).

FUTURE PLANS

We realise that our work to date has been too London-centric, and so we have expanded our scope to include national representation. To widen the project, we are holding a meeting in May with emergency medicine fellows from across the country. We are also hoping to develop further resources, including e-learning modules and an MCQ for students, as well as a mentoring scheme. We hope to introduce a discounted rate for student membership of the College.

HOW TO GET INVOLVED

In order to develop a really strong national and unified message, championing emergency medicine as the best career choice for medical undergraduates and foundation doctors, we need your help. There are a number of ways that you can do this:

- Identify a careers lead in your department.
- Get involved with careers events by contacting your local medical or foundation school.
- Order a 'careers stand pack' from the College by emailing careers@collemergencymed.ac.uk. Use this to recruit within your department or to host a stand at local careers events.
- Advertise the College Careers Day locally.
- Help to develop careers material for niche subspecialty interests.
- Direct interested students/trainees to the College website.
- Get involved with the College Careers Group—we welcome new members!
- Host elective and SSM students within your department.

We recognise that many of you are doing fantastic work in this area already, but we want to help support you so that we can all send out a single strong message. We hope that this has provided some food for thought and we welcome any feedback or suggestions; in the first instance, please send your thoughts to the email address above.

The future is in our hands.

Anna Buckley, Duncan Carmichael

REFERENCES

1. The College of Emergency Medicine. 10 priorities for resolving the crisis in emergency departments. 6 November 2013. http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/10%20priorities%20for%20Emergency%20Medicine/
2. Walker, A. Being a CEM rep at a conference. *EMJ supplement* April 2014.

Reflections after a 10 year career break

After a 10 year career break which involved gaining an MBA and working for four different companies, I am returning to clinical medicine. Currently I am working in an emergency department on the London Deanery Re-Launch Scheme. The emergency department is a good route back to developing clinical skills due to the breadth of patients. Additionally, I enjoyed working as an emergency department SHO 10 years ago and wondered if it could be a potential career option?

So after 10 years out of clinical medicine, what are my thoughts on returning to the NHS?

JOB SATISFACTION AND REWARDS

It is useful to consider the concept of growth and the role of executive managers versus operational workers. Growth is about getting more and more output for a constant (or declining) input. In public companies with shareholders, revenues and profits must rise in order to drive the share price. In the public sector, an increasing number of services must be delivered for a given budget. Executive management is responsible for driving this growth by getting operational workers to work more efficiently, harder or creatively.

Executive managers are under truly enormous amounts of pressure to deliver growth. At every board meeting they are continually pushed to deliver results. They are entering the ends of their careers and just need a few more bonuses. The challenge however is that endless growth is impossible. Shareholders and taxpayers would love to have ever increasing returns but organisations cannot keep on growing endlessly—as I was once told by a wise colleague, the only thing that grows exponentially in nature is cancer!

My time outside of medicine was very much about supporting growth. Unfortunately, none of the organisations I worked in have had any genuine growth opportunities since the downturn in 2008. I have been involved with many fancy sounding projects and made a lot of impressive

PowerPoint presentations and Excel spreadsheets with rather fantastic proposals and projections, but how many ideas and projects have actually delivered real value to the shareholder? Very few indeed. If I'm truthful, my professional satisfaction during my corporate years was limited as I spent most of my time developing the 'spin' that enabled executives to stay in their jobs a bit longer rather than supporting genuine growth opportunities. Additional to reduced professional satisfaction, corporate career progression, remuneration and career stability are all very limited in a low growth environment.

In contrast, as a frontline healthcare operational worker, I am satisfied by helping people on a one to one basis. Medicine also offers a stable career for 40 years—the peaks are not as great but the troughs are not as low. Career risk is not something I appreciated in my twenties but as I have gotten older and realised I will be working until I am 75 years old, career stability and the relatively good remuneration of medicine appear all the more enticing.

Many aspects of emergency department are the same as previously. There is still a great deal of pressure to see patients within 4 hours which results in rushed consultations and stress. The hours of work are still antisocial with a high weekend commitment. However, on the positive side emergency departments are much better positioned—more consultant cover, more staff overall and Clinical Decision Units. The advent of the Clinical Decision Unit as 'emergency department inpatient beds' has helped significantly. Many patients can be managed by emergency physicians (eg, head injuries, overdoses) without requiring an often painful attempt at referral to a specialist team.

IS THE PRIVATE SECTOR MORE EFFICIENT AND 'BETTER'?

It is often assumed that the private sector would be better at delivering healthcare. From my experience, I am not sure this is true. The private sector frequently fails and, when it is unable to make money, the company simply exits the market. To make the NHS an equivalent 'successful', company it would stop unprofitable areas such as the emergency department or mental health, and stick to orthopaedics and ophthalmology (services with healthy growth rates and profit margins).

Some feel that the NHS should be more innovative like big companies. From what I have seen, big public companies do not innovate. They are too large, bureaucratic, siloed and afraid of disrupting their existing practices—very much like the NHS. In order to 'innovate', corporations simply buy the smaller companies in which true market disrupting innovation occurs; in other words, they outsource the risk of innovation to venture capital backed small firms.

I do not think therefore that there is anything inherently more efficient or 'better' about the private sector. Healthcare is fundamentally different than business due to massive information asymmetries between suppliers and customers (doctors and patients) and due to the requirement to provide healthcare to all patients regardless of ability to pay.

WHAT HAVE I SEEN IN THE CORPORATE SECTOR THAT COULD BE APPLIED TO IMPROVE THE NHS?

There are three broad areas in which improvements could be made.

COST CUTTING—OUTSOURCING AND PENSION SCHEMES

If the NHS had shareholders, cost cutting would be aggressive. The NHS is the world's third largest employer, employing 1.7 million people; in a corporation, at least 10% of these jobs (in finance, HR, logistics, administration) would be offshored. The final salary pension scheme would have been abolished years ago. I estimate that the NHS bill could be reduced by 5–15% by instituting these measures, but it is an organisation that runs on a certain amount of goodwill from its employees, a goodwill that could be under threat in the face of outsourcing and pension benefit reduction.

PERFORMANCE MANAGEMENT

In a private company there would be much more reward for performance related pay (eg, number of patients treated, clinical outcomes, clinical competencies, hours worked). Gone would be the days where one consultant is able to see 40 patients in a clinic while another sees 30. Universal pay bands, such as consultant salaries, would go too. The consultant salary for a dermatologist (with very little on call commitment) is the same as that of an obstetrician (with a very burdensome on call commitment); there is no way a business would tolerate this type of pay structure.

CORPORATE CULTURE

Big companies are much better at developing a corporate culture and a sense of belonging. There are many corporate wide annual processes or, 'operating rhythms', which involve the whole organisation and are standardised. Employees are generally more aware of the direction of travel of the executive team and feel ownership of the organisation. If the NHS were to emulate this culture, people would be flag waving employees who could drive forward patient care.

It has been an interesting ride and I have learnt a lot in my time out. However, after my 10 year break, I am very much enjoying doing something practical and being a frontline operational worker again! Emergency medicine has been great training and reaffirmed that my decision to return to medicine was a good one.

Hiren Patel

Correction notice

In a previous newsletter Dr Mohit Arora was listed as having started as a consultant at Leeds Teaching Hospital in April 2013. This was incorrect as the appointment started in September 2013.