# Job planning for substantive senior Emergency Physicians

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## Introduction

Job planning for emergency physicians needs to reflect the nature of the role, its intensity, and adhere to the principles of sustainable working. There is a balance between the needs of the NHS, individual organisations, and individuals. Approaches which ensure that patients benefit from the expertise of senior emergency physicians, whilst those clinicians can enjoy full careers, personal and professional development, and empowerment to run and improve their services, are most likely to prove successful.

## Standards

1. Job plans must reflect the needs of a modern Emergency Medicine service by aiming to both deliver clinical care, and all the leadership and quality orientated activities which go into delivering a service
2. Direct Clinical Care schedules must be designed in a manner consistent with sustainable working
3. For consultants all scheduled time premium time working is by negotiation and must not be imposed without agreement. RCEM recommends that 2 hours per PA after 1900, and 1.5 hours per PA after midnight, are acceptable rates to support sustainable working
4. The role of the on-call Emergency Physician must fit with published RCEM guidance
5. SPA time must adequately reflect
    a. The activity required to run an Emergency Department and to develop the service (see below for examples)
    b. The activity required to train clinicians in Emergency Medicine (see below for detail)
    c. The continuing professional development needs of Emergency Physicians
6. Emergency Physicians must be supported to undertake additional roles within their organisations and systems, wider NHS roles, and external roles

# Recommendations

**RCEM recommends that job plans conform with**

1. BMA Job Planning guidance
2. RCEM medical staffing guidance
3. RCEM sustainable working good practice

**Organisations should support flexible working in all its guises, flexible job planning, and the development of portfolio careers.**

1. Job plans should usually not exceed 12 PAs
2. Consultant Job Plans should contain a minimum of 2.5 SPAs. A minimum 3 SPAs is considered best practice as in Wales
3. Job plans should be annualised, ideally supported by self-rostering
4. Arrangements for sabbaticals should be agreed within organisations
5. Weekend frequency should be considered in workforce planning
    a. For Consultants: Baseline maximum weekend working frequency of 1:8 is considered ideal if only one person is on duty every weekend day. A maximum weekend frequency of 1:6 should be considered if there are two or more consultants on duty each day.
    b. For SAS doctors: weekend frequency should be no more than 1:4.
6. Out of hours working for SAS doctors should be no more than 40% of contracted hours.
7. Consideration of the older consultant should be included in job planning (e.g.)
    a. The proportion of Supporting Professional Activities (SPA) to Direct Clinical Care (DCC) should increase with advancing age
    b. Late night or overnight working, and participation in on call rotas, should reduce or discontinue from age 55. This requires proactive recruitment planning

The high intensity nature of ED working, combined with the shift working pattern, places emergency physicians at high risk of exhaustion and burnout.  ED crowding and understaffing are additional risk factors. Moral distress and injury are also thought to be on the rise as a result of ED crowding and demand-capacity mismatch. RCEM has produced extensive recommendations around sustainable working.

Emergency Medicine Services require a significant amount of non-clinical time in order to function effectively. This usually means that emergency physicians are working a lower DCC: SPA ratio than colleagues in many other specialities. This is a mark of good practice rather than inefficiency. This may be particularly noticeable in smaller departments.

**Direct Clinical Care includes**

- All shop floor time, including CDU rounds and any clinic work undertaken
- All clinical administrative time, whether undertaken as a team or individual. This includes handling complaints
- Multidisciplinary and other meetings about individual patient care
- Undertaking shop floor education where trainees are directly supervised or observed on the shop floor

**Supporting Professional Activity Includes**

- CPD
- Appraisal (own)
- Handling regular emails
- Departmental meetings
- Engagement with job planning
- All teaching and training activity except shop floor educator shifts as above
- All audit and local governance work
- Service management, and quality improvement work
- Research

**It is recommended that as a minimum the following roles are established in each ED, and that they should attract dedicated time**

- Clinical Service Lead (+/- deputy)
- Workforce and Recruitment Lead
  - Wellbeing Lead
- Informatics Lead
- Design and Estates
- Equipment Lead
- Clinical Governance Lead (+/- deputy)
  - May require specific leads for safety, complaints, mortality
- Quality Improvement, Audit and / or Clinical Effectiveness Leads
- Research Lead
- Paediatric Emergency Medicine Lead
  - Safeguarding in Children Lead
- Lead for Emergency Preparedness, Resilience and Response
- Inclusion and Civility Champion
- Environmental / GreenED lead
- Education and Training Leads for
  - Emergency Medicine training (College Tutor)
  - Other postgraduate medical trainees and fellows
  - ACPs
  - Undergraduates
  - International Medical Graduates
  - SAS doctors
  - Portfolio Pathway (was CESR) program
  - Ultrasound
  - Simulation
- Leads for specific areas: resus, ambulatory care, minor injuries, frailty, mental health, major trauma, sedation, safeguarding in adults

Educational supervision is a significant requirement in Emergency Departments. Training capacity is defined by the ability to provide workplace, clinical and educational supervision for specialty trainees. RCEM recognises that there is also a significant training workload and need for quality standards when supporting the wider EM multi-disciplinary team

- **Speciality Trainees:** Trainers should have 0.25 PA per trainee in their job plans to ensure they can deliver high quality training
- **Advanced Clinical Practitioner (ACP) trainees:** There should be at least one consultant per trainee and one RCEM trainer who has completed ACP credentialing training for every two trainees, with 0.25 PA allocated in the job plan per trainee. Please refer to current RCEM ACP curriculum for ES/ACP credentialing trainer requirements
- **Portfolio Pathway Trainees:** There should be at least one consultant per trainee and an accredited consultant trainer with 0.25 PA allocated in their job plan per trainee

Life Support courses rely heavily on emergency physicians because of the skill set. Life Support Teaching should be regarded as additional SPA and not simply part of the role of an Emergency Physician

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