The College of Emergency Medicine

Service Design and Delivery Committee

Contents

Introduction **p1**

Supporting information for SPA time in the Emergency Department **p2**

Tasks and time **p5**
Emergency Department Safety System *p5*
Governance linking with major partners / system integration *p9*
Service development *p11*
Service Management (includes staff experience) *p13*
Education and training *p15*
Major incident / pandemic / CBRN planning and preparation *p19*
Trauma Care *p20*

Appendix 1: Extensive breakdown for Service Development **p21**
Appendix 2: Appendix 2: External duties **p27**
Appendix 3: Generic SPA calculation **p28**
Appendix 4: Link and liaison work **p29**

Published: May 2014

Author: Dr Ian Higginson

Introduction

This is a worked example of how to set about calculating the number of hours of non-clinical (SPA) time that Consultants working in Emergency Departments require.

The College remains convinced that to deliver a safe, effective and efficient service each consultant will need at least 10 hours per week engaged in the activities this document describes. The list of activities described is not exhaustive and each department will have some specific local requirements. Similarly some of the activities listed here will not be relevant (we don't all have a nearby prison!).

Rather than create a generic template which would have lacked the type of detail and specifics essential to proper reckoning of SPA activity the College is indebted to Ian Higginson and his colleagues for allowing us to publish this worked example.

Dr Clifford Mann
President of the College of Emergency Medicine

The department described is a mixed Emergency Department (ED) and Major Trauma Centre which sees 90,000 new patients per year. The senior workforce is made up of 12.95 whole time equivalent consultants.

Elements of this document obviously relate to local practice and agreement, and to local objectives and stage of development. The total time is also more than that currently available to the existing team, and prioritisation will be required. However, I hope that this will act as a useful framework, which can be applied to discussions with hospital management teams across the United Kingdom and Republic of Ireland.

Dr Ian Higginson
Service Design and Delivery Committee Chair

Supporting information for SPA time in the Emergency Department

What we aim to deliver: key departmental goals for next 1-3 years

- Consolidation of recent performance, efficiency and quality gains
- Development of a performance and quality framework. Development of a dashboard to support this. Ensure all key local and national standards, and patient experience, are included. Link to Trust dashboards and strategy. Integrate with Safety.
- Development of an integrated Safety system as per CEM guidance. Aim to involve all staff groups in the ED and fit closely with departmental education and training, and with QI. Link with the performance / quality framework.
- Specific improvement for key processes and clinical pathways. Work streams selected on the basis of national targets and standards, potential efficiency gains, volume, clinical importance, and risk. Link to the performance/quality and safety frameworks
- Understand and standardise our capability as well as our capacity, seeking to reduce variation and improve standardisation. Needs well thought out processes and guidance. Link to the performance/quality and safety frameworks
- Workforce plan / implementation: capacity, resilience and sustainability
- Redevelopment plans
- Informatics upgrade
- Complete the revamp of nursing and postgrad medical education. Continue with excellent educational practice where it already exists
- Continue successful development of academic department
- Nurture successful relationships with medical school, university, and the military.

What time is needed to manage the Emergency Department?

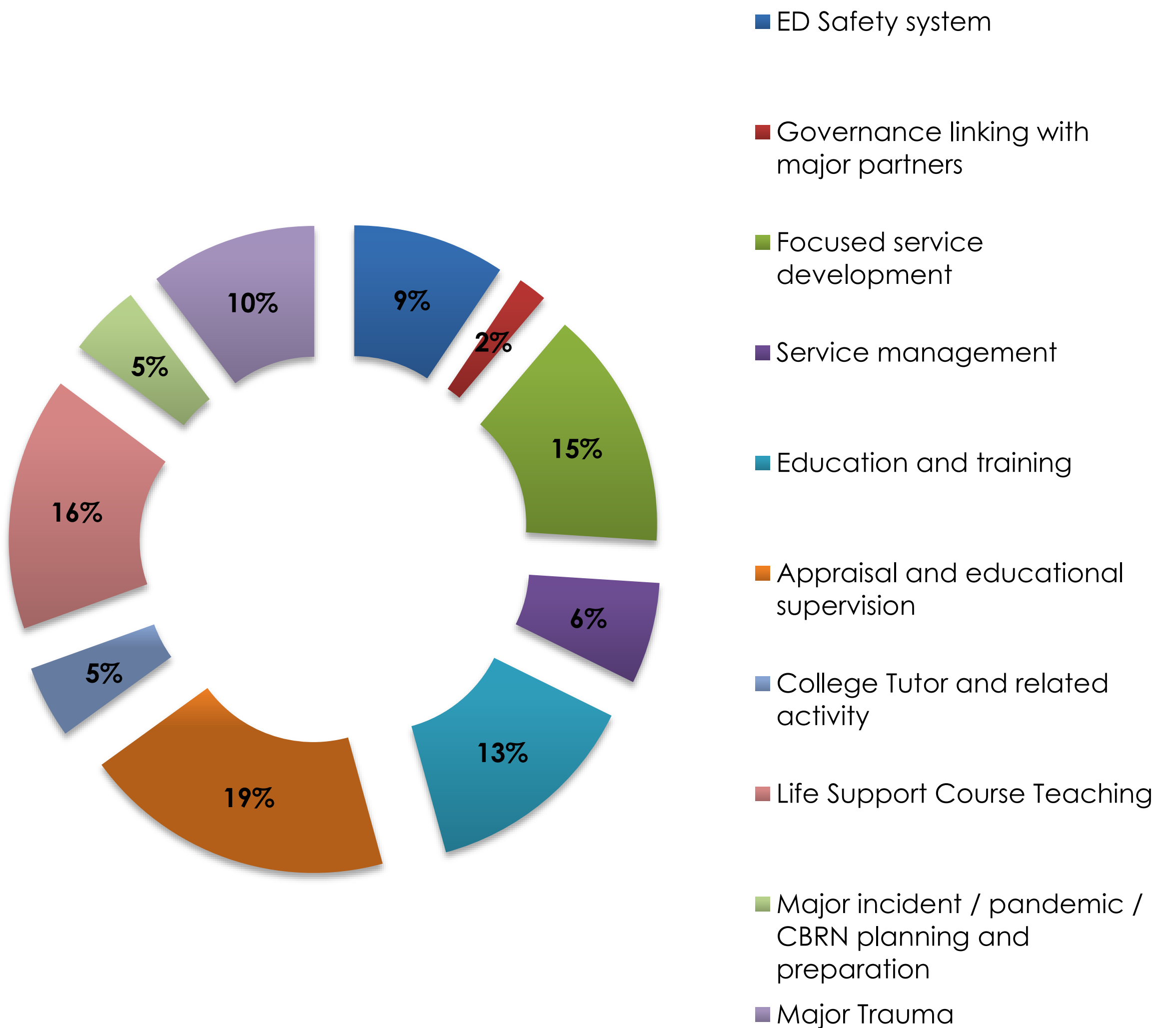
Note: many tasks can also be undertaken by speciality doctors, this document takes a departmental perspective

- ED Safety system: 358 hours = 2.1 PA
- Governance linking with major partners: 65 hours = 0.4 PA
- Focused service development: 555 hours = 3.3 PA
- Service management: 225 hours = 1.4 PA (+ SLD)
- Education and training: 499 hours = 3 PA
- Appraisal and educational supervision: 4.3 PA
- College Tutor and related activity: 1 PA
- Life Support Course directing and teaching: 3.5 PA
- Major incident / pandemic / CBRN planning and preparation: 168 hours = 1 PA
- Major Trauma: 390 hours = 2.3 PA

Other time held with service line Job Plans

- Service Line Director
- Medical School contracts
- X contract
- Research
- Military sessions
- TPD
- Trust MH lead
- Network Trauma Lead

Chart - Breakdown of Emergency Department SPA

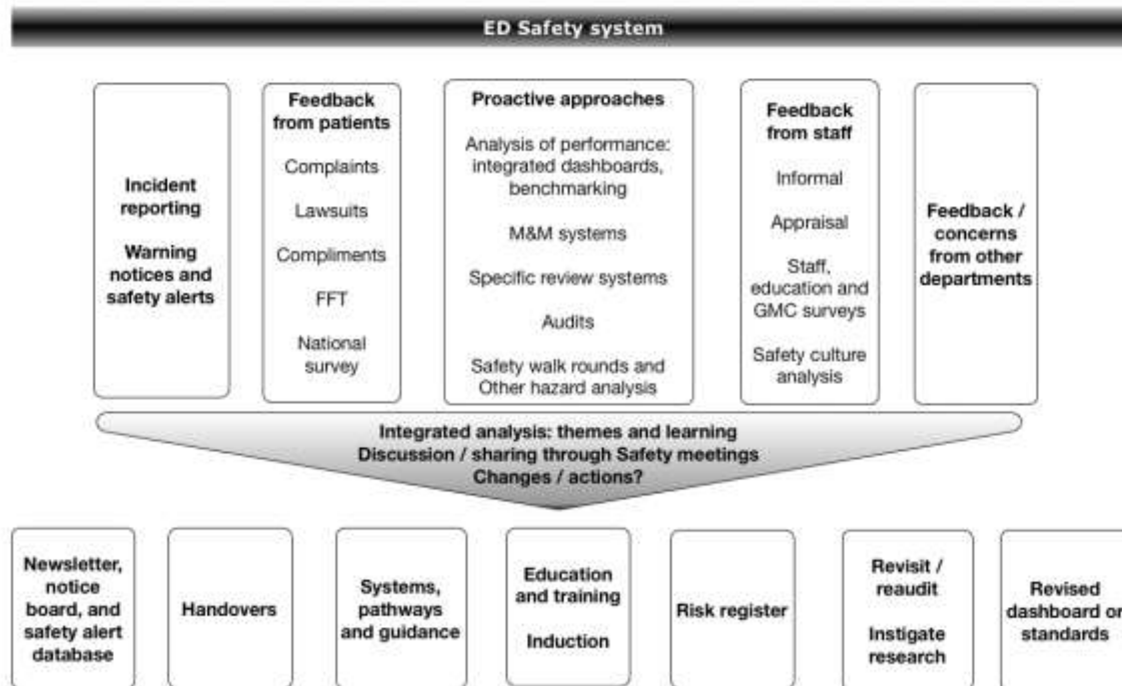


Tasks and time

This section provides an overview of the various activities which are expected to be completed by the consultant EM workforce and the annual hours required for their completion.

Emergency Department Safety System

This diagram illustrates how the ED Safety System works, and the outputs and activities needed to ensure an effective safety system.



The following table presents the key activities required to run an effective ED Safety System and the annual time required.

Safety System Activity	Annual hours
CG / Safety Lead(s). Leading / developing ED safety and quality system as above (draft). Implement CEM Safety checklist and toolkit with emphasis on proactive elements. Developing "integrated" system incorporating traditional clinical governance, risk, complaints, other feedback, and integrating with the CEM Safety framework. Contribute to development of dashboard. Safety team meetings X 4 per year (safety, complaints, risk, informatics, SLD, education)	*63*
Chairing 12 ED Safety meetings per year	*Included in generic SPA*
Co-ordinate material for Safety meetings, minutes of meetings, and organise actions arising	*18*

Safety System Activity continued	Annual hours
Organise and deliver Safety Walkthrough / hazard analysis programme	*Subsumed into Clinical Governance (CG) lead roles and delegated out*
Organise National College of Emergency Medicine audits, complete returns & ensure learning incorporated into practice	*8*
Co-ordinate other local audit activities and ensure learning incorporated into practice	*10*
Develop and implement a coordinated system for dealing with complaints, and compliments. Organise / coordinate investigation and responses, analyse the themes and issues arising and feed into Safety system. Develop standard template for responses. Develop systems to ensure as much of this as possible can be undertaken by non-medical staff as system matures Safety team meetings X4 per year	*Reduce from proposed 72 to 42 in first instance and see how goes: Trust management suggest we become trial site for enhanced management support around CG*
Develop and implement a coordinated system for dealing with incidents / risk. Filter the clinical incidents requiring medical input, organise investigation and responses, analyse the themes and issues arising and feed into Safety system. Develop systems to ensure as much of this as possible can be undertaken by non-medical staff as system matures. Link with senior nurses / SLD to improve / coordinate risk register for ED Safety team meetings X4 per year	*Reduce from proposed 63 to 42 in first instance and see how goes: Trust management suggest we become trial site for enhanced management support around CG*

Safety System Activity continued	Annual hours
Develop and implement a proactive mortality / morbidity reviews system: 3 major streams (1) trauma (2) paeds (3) other. Time uncertain at this stage. Estimate 12 hours trauma, 4-8 hours paeds, 12-16 hours others. Tie in with other systems to maximise efficiency	*28 (likely underestimate)* *Take trauma M&M into MTC.* *Time otherwise unclear. Start with 21 hours for the rest and diarise*
Undertake serious complex incident investigations (using RCA)	*48: leave in for now pending improved system*
Establish and run departmental Safety Newsletter/ notice board / safety database / safety communications	*24 (likely underestimate)*
ICU / ED meetings: Chair quarterly sessions where ED are responsible	*Included in generic SPA*
Trauma meetings: Organise, prepare and present weekly trauma meetings. Actions resulting Meetings occur weekly, and last 45-60 mins, but prior to this review of all trauma calls that come through the ED with TNCs, and in depth review of 3-4 cases prior to presentation at multi-disciplinary meeting to discuss improvements in trauma care. Feedback /actions following meeting with key stakeholders in process development, along with follow up of previous actions	*(100) Housed within trauma*
CVE review: biweekly review meeting with CVE team (stroke lead, stroke matron, neurorad). 1 hour prep per meeting. Systematic improvement of stroke care via this system.	*30*
Infection control (medical input): ensuring up to guide guidance, ensuring compliance with Trust policies, attending Trust meetings	*6*

Safety System Activity continued	**Annual hours**
Informatics: Information governance (4) and webcam / image management (4)	*8*
Informatics: data quality	*Subsume into informatics lead role*
Mandatory training and induction: organising programs, ensuring full adherence. As part of this ensure all medical staff trained in use of equipment	*16*

Governance linking with major partners / system integration

The following tables highlight the annual required time to link with major partners, and for work relating to system integration.

Ambulance service and NHS 111	Annual hours
Significant complaints / events / analysis / feedback : included in trauma meeting work Trauma review / clinical governance and Air Ambulance working group included in MTC allocation and External Duties	0
NHS 111 Clinical Assurance Group	*TBC*

Police and Prisons	Annual hours
All departmental liaison with police. Formulating new pathways around section 136, violent and/or dangerous patients, drug packing / stuffing. Governance around medical advice provided to police custody / follow up and review of incidents involving prisoners Visit cells and meet with nursing staff there. Provide education for staff in this specific field.	*10 and see how goes*
Prison: governance around medical advice provided to prison medical staff. / treatment of prisoners. Improve communications. Visit prison to view facilities and meet staff. Provide education for our staff based on this visit	*10*

Inoculation injury: internal and external Occupational Health departments	Annual hours
Further develop pathways / governance around inoculation injuries, liaison with occ health and other outside agencies	*Work complete: see how system goes*

Offshore medics program	Annual hours
Managing the contracted offshore medics program, ensuring proper governance, ongoing development	*8*

Primary Care	Annual hours
Liaison / communication with primary care providers (see also under minors service development). Following up of specific incidents / problems	*6*
Development of a formal system of linked consultants with primary care providers	*TBC*

Paediatric	Annual hours
PICU roadshow	*4*
Paediatric Emergency Care Network (local meetings only)	*6*

Minor injuries units	Annual hours
MIU (contracted)	*Est at 21 hours per year currently (real commitments may be more). Aiming to get 42 hours written into contract*
Other MIUs: no contract	

Outside events
No specific time requested in this round

Service development

For service development activities the following annual hours are required. Please also read Appendix 1

Service Development activity	Annual hours
High priority clinical topic: sepsis and associated critical care	*30*
High priority clinical topic: pain	*24*
High priority clinical topic: care of the elderly (including falls)	*42(will need revising as role develops)*
High priority clinical topic: paediatric emergency medicine	*74*
High priority clinical topic: mental health	*42*
High priority clinical topic: vulnerable patient groups	*39 (much included elsewhere)*
High priority clinical topic: CVE	*Included in Safety*
High priority clinical topic: acute coronary syndromes	*20*
High priority clinical topic: PE / VTE	*24*
High priority core capability: rare / new procedures Training and kit organisation ED thoracotomy: 6 hours ongoing training + podcast / training material development = 10 hours Peri-mortem C-S: Specific training program to design and implement: time TBC	*Move to MTC*
High priority core capability: airway Evaluate difficult airway tools, liaison with ICU over difficult airway practice	*8: will need revising if significant changes planned*
High priority core capability: safe sedation practice	*16*

Service Development activity continued	**Annual hours**
High priority service improvement: ED process redesign phase 1	*104*
High priority service improvement: Development of POCT testing in ED Development of ED based POCT testing: service spec, business case, implementation if successful. Liaison with lab over ABG machine / other issues (eg labelling, Safety).	*16. Will need revising upwards if case successful*
High priority service improvement: clinic redesign	*Clinic reboot planned for 2014. Will require 8-12 hours work to implement and then 4-8 to audit / analyse success. 16 hours*
High priority service improvement: CDU reboot and ambulatory care	*52: May need revising upwards in response to specific workstreams*

Service Management (includes staff experience)

For service management including staff experience the following annual hours are required.

Service Management activity	Annual hours
SLD	*Included elsewhere*
Senior, middle grade rotas + supporting rota office around junior rotas: Principal goal this year is to integrate and simplify rota design, alongside refining systems to ensure that all commitments are met. Make every effort to set up systems that require less senior medical support to rung. NB: This function pays for itself through efficient use of staff and effective running of the department.	*168 (This is an underestimate of current time involved. Post holder estimates 210)*
Recruitment (consultant, middle grade and senior nursing staff)	*Shared amongst senior consultants in generic SPA*
Leading appraisal of medical staff	*Include in SLD role this year until time commitment established*
Appraisal of medical staff	*See under appraisal and educational supervision*
Exit interviews	*Include in SLD role*
Performance: unplanned re-attendances: need to examine this complex area and unpick / improve our performance. Single area in which we do not meet national indicators. All other aspects of performance currently undertaken within SLD role: this task specifically delegated	*Work being completed*
Infrastructure: facilities redesign: currently submitting a complex and substantial bid for a full front-end rebuild. First estimated time only	*Work currently on hold*

Service Management activity continued	Annual hours
Infrastructure and cost reduction: stock	*Deprioritised. Area of waste requiring attention but prioritising kit and drugs*
Infrastructure and cost reduction: equipment. Includes MDSG	*Est 24*
Infrastructure: IT leading the management development of the ED IT systems, EPRSG	*21 (clinician estimate is at least triple this, therefore will need to be increased if specific procurement is planned) + 12 = 33*

Education and training

The following table highlights the annual hours needed for education and training activities.

Education and Training activity	Annual Hours
Department education lead: coordinating / scheduling / organising the extensive ED education program. Attend Safety meetings X4 per year	*Picked up in College Tutor stream*
Simulation development: • Develop monthly multi-professional simulation program for ED. (includes all sims, resources, and guide to using the kit) (48) • Introduce human factors training into ED education programs (4-8). • Attend regional ED sim meeting, Trust sim meets, and if possible regional simulation group (8-12)	*60*
Scheduled simulation teaching (within-ED simulation programs) • Monthly program (48) • CT3 simulation assessment TBC	*48*
Trauma teaching not included in MTC • Training and signing off primary nurse surveyors (8)	*8*
Junior doctor / departmental education development • Organising and further developing the new junior education program (16) • Annual review and improvement of current teaching material (20) • Podcasting: initial development as contributor and then revision. Aim for 8 short and 2 long per year. 4 hours per short podcast prep and recording, 6 hours per long (44) • Podcast production (editing, getting onto web). 1 hour per short podcast, 2 hours per long (12)	*Modify aspirations. In first year get 4 short and 1 long up on the site and see how goes for time. Aim to review half the material this year and half next. Allocation therefore 54*
Scheduled teaching on departmental junior teaching program	*105*
Induction programs (4 per year) • Organisation included within Safety • Teaching on inductions X 4 per year (32) • Teaching on SWEXI X 4 per year (36) • SWEXI needs rewrite (24) • Inductions for ENT/plastics/max fax; O&G, paeds (6)	*98*

Education and Training activity continued	Annual Hours
Organising and developing the new senior teaching program (8). Lead sessions (24)	*8. Leading the sessions included in generic SPA*
ENP and ANP • Organising, developing material and teaching formal program (80) • ANP education program (early developmental work, working with current ANP) (4) • *Clinical supervision for nurses on BSc TBC*	*Figure reduced to 84*
Regional EM and ACCS Training programs • College Tutor. See notes below • Teaching on regional registrar program (16) and SW critical appraisal (8) • Department commitment to regional mock FCEM exams (24) • ACCS regional program: teaching on local sessions (8) • ARCPs: Included in College Tutor and TPD roles + one other cons per ARCP (16) • ACCS trainees in ED: include in education lead role • ACCS recruitment (national, 2 rounds per year, 2 days, 1 person per day, Bristol) = 48 • CT recruitment (national, 2 rounds per year, 2 days long, 1 person per day, Sheffield) = 64	*Include registrar teaching and ARCPs in College Tutor allocation* *Treat recruitment as EDs*
Foundation program • Formal teaching on Trust F1/F2 Generic program (Major incident F1 and F2, T&O, Diagnostic pitfalls, Major blood loss, Law in action) • Troubleshooting Foundation program and link with Foundation Team : include in lead role	*20*
Simulation training for Trust	*Externally funded 16 hours per year*
Paeds teaching, max fax teaching etc	*10*
Organising and delivering consultant evening program	*No time ascribed*
GP VTS trainees troubleshooting: include in lead role	
Clinical observers: organising, mentoring	*4*
Work experience students coordination	*Delegate to management team*

Education and Training activity continued	Annual Hours
Coordinating dental students (includes one lecture per year)	*Delegate to management team*
Teaching MSc (excluding docs with BASMU sessions)	*Own time*

Appraisal and Educational Supervision	Annual PA
Appraisal of senior medical staff	*4 appraisers, each with a load of 5-6 appraisals = (4*4) + 22 PA = 38PA p.a. = 0.9 PA p.w..*
Educational supervision of junior medical staff	*(1) Foundation Ed Sup * 3 trainees = 0.375 PA p.w* *(2) ED trainee Ed Sup: CCS (2), ED CT3 (2-3) and ED SPRs (4-5) * 9 trainees + at least 1 military trainee = 1.25 PA p.w.*
Clinical Supervision of doctors in training including Trust SHOs	*26-31 trainees at 0.0625 per trainee = 1.75 PA p.w. (4*F1, 5*F2, 7*CT1, 2*Trust SHO, 2-4 CT3, 4-5 SPR, usually 1-3 extra (MOD, remedial), DDRC doc*

College tutor notes	Annual hours
2 School meetings per year	*8*
2 ARCP per year	*16*
Medical Education Committee	*5*
College training	*16*
In-house exam prep	*12*
Global supervision of trainees	*8*
Local solution: within allocation also include Service Line Education Lead, Registrar teaching, and all ARCP work	*additional (72)*
Spare time within allocation for supporting and developing registrar training	*Total 1 PA*

Life Support Course Teaching

Consultants direct and teach on ALS, APLS, ATLS, MIMMS, HMIMMS, and shortly ETC. Also teach on GIC and training the trainers courses. To minimise time commitments with an expanding consultant body each consultant is restricted to teaching on a maximum of 2 of the different life support courses although many are qualified on 3 or more, and are required to teach on one local and one away course per year (the latter taken as professional leave). This places a considerable burden on the consultant professional leave, reducing the amount available for personal CPD. ED have withdrawn from supporting ASCERT, PLS, ILS at consultant level to maximise our input into more advanced courses

Current commitment

Speciality doctors may instruct on advanced or intermediate courses

Allow 3.5 PA as departmental total to include both consultants and speciality doctors

Major incident / pandemic / CBRN planning and preparation

The following table highlights the annual required hours for major incident, pandemic and CBRN planning and preparation activities.

Major incident / pandemic / CBRN planning and preparation	Annual hours
Acute Hospitals Emergency Planning Team (2 hours x 4 times pa) TBC	*8*
EPRR Committee (new) - Senior Clinician (2 hours x 6 times pa)	*12*
Work originating from above (at least) 2 hours per meeting	*20*
Special Circumstances: paeds / burns etc – ad hoc meetings	*4*
Mandatory Plan Testing (table tops, live including preparation and feedback time)	*16*
Trauma and Regional MTC Arrangements	*8*
Mass Casualty Planning Work (2,000) - SWAST and others	*16*
Staying up-to-date with legislation	*8*
Reviewing hospital plan – complete revamp planned for 2014	*16*
Departmental Commitment (department planning, education, training)	*16*
Reviewing ED Aspects of plan / training etc	*16*
ED Walkthroughs	*8*
Pandemic and other ID preparation / planning	*16*
Planning for local organised events	*4*

Trauma Care

Move to MTC	Annual Hours
Trauma Lead (shared) Hard to quantify specific work accrued just for "being" trauma lead: • Picking up ad-hoc governance stuff whilst it is "hot": 20 hours per year • Pathway development: ensuring all ED / Trust pathways up to date and consistent. Est 24 hours. May require more, needs exploring Network Clinical Advisory Group: 4 per year, 2 local, 2 away (20 hours) Network Governance meeting: 2 per year, divided here and away (10 hours + prep) = 12 hours Local Major Trauma Management Committee: monthly, 2 hours plus prep / background = 36 hours per year Local Trauma Governance Meeting leading ED contribution (8 hours) Organising weekly trauma meetings (100 hours per year) Peer Review day prep and presence (12 hours) Ambulance Clinical Governance Meetings (16 hours + EDs where held elsewhere). Monthly trauma review meeting. Rotates between X, Y and Z. Just get to X ones.	*248*
Paeds trauma Troubleshoot and review paeds trauma cases = 8 hours Attend regional meetings / governance related to paediatric trauma: 16 hours per year for regional meeting, governance meetings held in X, 2 per year Attend network CAG, major trauma management committee as required and trauma working parties with paeds "hat" est 8 hours+	*24*
Produce how-to guides for ED thoracotomy and peri-mortem C-S (including podcast) ?Produce how-to guide +/- podcast for arrival / disrobe sequence (10+)	*10*
Undertaking specific mortality reviews: 12 hours (Work comes from MTC, est 1 / month)	*12*
Organising trauma working party: multi-professional development of process SOPS. Developing and implementing output: Est 20 hours	*20*
Trauma teaching • Training and signing off primary nurse surveyors (8) • Trauma training for nursing teams: currently ad hoc. Need to develop further as part of simulation program • Trauma team training course organisation / lead instructing (58) • RSI training for ICU team (6)	*64*
Blood bank: development/ review of massive transfusion policy. Role has subsequently also developed into looking at things blood bank related in the ED. Attendance at quarterly Hospital Transfusion Committee (2 hours, no prep, little actions)	*12*

Appendix 1: Deeper breakdown for Service Development

The following tables explore further the annual hours which are required for Service Development

Sepsis	Annual Hours
Develop new sepsis guidance (including interdepartmental liaison)	*12*
Implement new sepsis guidance (paperwork, training, systems)	*12*
Re-audit new sepsis guidance	*6*
Represent Sepsis work at Trust nationally	*External Duties*

Pain	Annual Hours
Quarterly meetings with X (1 hour for meeting + 1 hour prep and output)	*8*
Review current analgesia guidelines and update	*8*
Audit current pain management of ambulatory patients	*8*

Care of the Elderly
This is a new role brought about by developments in emergency medicine, and emergency care in general. First job will be to review the silver book and undertake a gap analysis of where we are vs. where we need to be within ED, supported by audit. Development of a care of the elderly "dashboard." Specific teaching and training around care of elderly will be required. Working with care of the elderly team to design appropriate pathways for elderly patients (including Frailty). Hard to quantify this time. We estimated 0.5 PA per year to start with, but on review have reduced to 0.25 PA.

Paediatric EM	Annual Hours
Paeds lead: Picking up on paeds focused issues and organising their resolution, review and reorganise paediatric kit in paeds area and resus	*24*
Specific paeds component of Safety meetings	*Included in Safety*
Attend paeds CG meetings ad hoc / PICU roadshow	*Included in Safety*

Paediatric EM continued	Annual Hours
Child Protection: Revise current guidance (processes probably OK): 8 hours (est 4 hours per year thereafter) Liaise with child protection team re errors / misses / problems: 8 hours	*16. Nursing lead to attend Child Protection Committee.*
Pathways / guidance: Further development of integrated pathways involving paeds / neonates and PACOT. Current guidance dated and requires overhaul. Revise out of date pathways / guidance New pathways: resus, gastro, URTIS, UTI, bronchiolitis and pneumonia, high K, ALL management of paediatric trauma, allergy	*24*
Keep paeds drug calculator up to date. Annual check / troubleshoot only included here	*8*
Review paediatric care plans	*2*
To develop: ED US of paediatric hip, Specific training program for CT3s, regional paeds simulation program	

Mental Health (including drug and alcohol misuse)

Follow up of multi-agency complaints/4 hour issues/new care pathways/liaison with liaison teams and immediate care colleagues, establishing novel teams (e.g. adolescent alcohol), liaison with commissioners to encourage new funding. Attendance at Various MDT governance and commissioning, particularly informing novel services. Establish clinical governance framework. Est 50 hours: reduce to 42 hours in first instance

Vulnerable Groups		
Location	**Activity**	**Annual hours**
Safeguarding board	ED will need to be represented on this group but X currently sits with her Trust MH lead hat on	*Currently included in X Trust role*
Frequent attenders	Lead contact for management of Emergency Care plans, and reducing attendance and bed stays. Links with all domains of Derriford liaison team. Imminent publication of savings realised, and to maintain savings for next financial year	*Est 21 hours per year*
Mentally ill		*Under Mental Health*
Drug abuse		*Under Mental Health*
Alcohol abuse		*Under Mental Health*
Homeless		*No specific time allocated*
Prisoners and police custody		*Under Safety*
Child Protection		*Under Child Protection*
Elderly protection		*Under Care of the Elderly*
Learning disabilities (adults)		*No specific time allocated*
Sexual assault		*TBC*
Domestic violence		*TBC*
The dying patient	Liaison with other specialties re EoL pathways development, good palliative care access from ED. Includes EoL steering group; 10 hours Organ donation: Attend organ donation committee. Liaise with relevant parties/ ITU concerning organ donation from ED patients and institute education / practice changes to improve rate of referral of organ donation from ED: 8 h	*18 hours per year*

PE / DVT / ACS / CVE	Annual Hours
Redesign ambulatory PE / DVT pathway and guidance based on latest evidence and changes within ambulatory care framework +/- evolving US practice. Investigate POCT.	*16 hours*
Ensure VTE practice on both CDU and for patients with fractures is up to date and effective: review + audit practice	*8 hours*
Attend Trust VTE committee	*Included in Generic SPA*
Redesign ACS pathway and guidance and based on latest evidence and changes within ambulatory care framework. Investigate POCT. Provide educational material based on changes	*20 hours*
CVE: biweekly review meeting with CVE team (stroke lead, stroke matron, neurorad). 1 hour prep per meeting. Systematic improvement of stroke care via this system. TIA pathway / guidance also requires updating	*Included in CG/Safety*

Sedation	Annual Hours
Ensuring all sedation guidance is up to date. Revise/develop guidance (adult and paediatric ketamine). Pick up ongoing problems. Next year: audit of practice	*4*
Training existing and new staff (Supervise colleagues when not on the shop-floor). Ensuring clinical governance arrangements are robust and that everyone is compliant. Objective: to train all the consultant and middle-grade tier in the use of propofol with a corresponding up-to-date log of all competent practitioners	*12*

Ultrasound and Echo	Annual Hours
US lead: Consolidation of level 1 US capability within the department and surrounding Safety structure. Set up development of the first level 2 capability (DVT) by end 2014, ready to roll out training.	*16*
Attend regional US training meeting (4 hours per 6 months)	*8*

Ultrasound and Echo continued	**Annual Hours**
Consultant US support / sign off for level 1 +/- FEEL: 2 hours per consultant p.a.	*Need to find a less time consuming way to deliver this training. Reduce aspirations to 24 hours in first year and see how goes*
Time required to integrate with Trust CG and procurement not known and therefore not currently included: may require adjustment	

Ambulatory care and acute medicine	**Annual hours**
Progress model of ambulatory care in the ED, and within Trust. Liaison with AC team by email/ phone, attending AC mtgs on adhoc basis; liaison with nursing staff re CDU, complaints re CDU. Progress closer working re SSU / Frailty	
Aim to visit up to three other units with high functioning ACUs to implement good practice, then subsequently audit practice to ensure quality delivery of service	*If happens will arrange for time*
Produce SOP for CDU admissions	*4*
Ensure all CDU guidance is fit for purpose and up to date.	*8*
Specific multispeciality pathways required for amb care and acute medicine: asthma, acute allergy (including systems for epipen prescription and training), syncope, back pain / cauda equina, spinal fractures	*32*

ED process redesign phase 1		
Location	**Activity**	**Annual hours**
Reception / triage processes: phase 1	Delegate to admin team. Require SOP / operational policy	*Delegated*
Minors	Link with registration and triage. Continue current developments around triage (8) and RATs (12). Liaising with OOH docs around diversion and redesign / provision of OOH primary care (12). Development of radiographer led discharge (20). Need SOP / operational policy for minors now new processes bedded in to act as basis for next set of improvements / to inform planning (16), Improvement of ophthalmology pathways (16)	*84*
Paeds	Need formal SOP / operational policy for paeds now new minors processes bedded in to act as basis for next set of improvements / to inform planning. Also required for governance / workforce redevelopment	*Subsume into paeds role*
Majors	Need formal SOP / operational policy for majors now new processes bedded in to act as basis for next set of improvements / to inform planning. Also required for governance / workforce redevelopment. As part of this develop formalised RAT system, linking to FC role for specific clinical presentations and conditions	*Subsume into SLD*
Resus	Expand work on trauma SOP to include all patients. Review equipment / storage / layout. Finalise SOP / operational policy for resus now new processes bedded in to act as basis for next set of improvements / to inform planning. Also required for governance / workforce redevelopment	*20*
CDU and ambulatory care	Integrate CDU / amb care into all of the above	*Included elsewhere*
Rapid assessment systems in minors and majors	RATS in minors now up and running. EPIC quiescent and processes sitting within minors. Ad hoc majors RATS work to be integrated into specific clinical workstreams and majors improvements. No time allocated but may need revision in response to specific workstream	*Included elsewhere*

Appendix 2: External duties

"Externally funded" or Trust commitments

- College Tutor 1PA = 164 hours = 1PA
- Trust simulation sessions = 16 hours per year
- MTC = 390 hours = 2.3 PA
- Life Support Teaching = 3.5 PA

External Duties to be allocated to ED team

- ACCS interviews : (national, 2 rounds per year, 2 days, 1 person per day, Bristol) = 48 hours
- CT4 interviews: (national, 2 rounds per year, 2 days long, 1 person per day, Sheffield) = 64 hours
- Representing PHT at national sepsis forums
- Examining
- Mock FCEM exams
- College duties
- Trauma Care UK Council
- Air ambulance working group

Appendix 3: Generic SPA calculation

Time available per consultant = 252 hours per year

- Keeping up to date clinically: 21-42 hours per year: includes purely educational meetings (36 hours per year available within ED, + grand rounds), reading etc. …
- Reading emails (not attachments): 86 - 140 hours per year (assumes 50-80 relevant emails per week, 2 minutes each)
- Answering emails, reading email attachments: 21 hours per year
- Mandatory training: 17 hours per year
- Appraisal: 8 hours per year
- Job planning: 2 hours per year
- Keeping up to date with Trust issues: included above + 6 hours per year
- Attendance at annual planning meeting = 8 hours
- Departmental management, Trust MTC and ED Trauma, general and ICU CG meetings: assume make 25% of available opportunities: 34 hours per year
  - ED meetings (50), Trauma meetings (50), CG / Safety (18), Trust trauma (6), ICU (12)

= 203 - 290 hours per year

Leaves between 0 and 49 hours per year per consultant depending on your view on CPD, email and number of CG / Safety meetings attainable. This time for:

- Stuff that comes up
- Other non-clinical admin
- Recruitment (Trust SHOs, MGs, consultants)
- Regional Board meetings X2 per year (12)
- Clinical and within-ED supervision and mentoring for clinicians not requiring formal educational / clinical supervision: 15 ENPs, 8 MG, and 2 ANPs (each 2-3 hours per year): 25-50 hours per year

Plus (depending on which guidance we end up following)

- Active "clinical governance"
- Quality assurance
- Clinical audit
- Basic guideline production
- Responding to complaints

Trust committees requiring ED representation

- Resuscitation
- Blood transfusion
- Major trauma
- Child Protection
- Safeguarding EPSRG
- MDSG
- VTE
- Organ donation
- Major incident

Appendix 4: Link and Liaison work

The below table highlights the link/liaison work including ad hoc guideline development which is not ascribed in other areas:

Link / liaison work	Annual hours
Dental and maxfac	*4*
ENT	*4*
GUM	*2*
Obs and gynae	*15*
Opthalmology	*Included in minors*
Neurology	*8*
Paediatric Medicine	*76*
Paediatric trauma	*Included in paeds*
Acute Medicine	*See under Service Devt*
Renal	*0*
Gastro and endoscopy	*4*
Thoracic Medicine	*4*
Hepatology	*0*
ICU	*Included in sepsis / airway etc*
Anaesthetics	*Included in trauma calcs*
Paediatric surgery	*4*
Theatres	*Included in trauma calcs*
Cardiothoracics	*0*
Colorectal	*4*
HCE	*Included in Vulnerable Groups*
Oncology (including attending AOS management group)	*8*
General / transplant / UGI	*4*
Dermatology	*0*
Neurosurgery	*4*
Diabetes and Endocrine	*5*
Urology	*5*
Cardiology	*12*
Pain	*See under Service Devt*
Plastics and breast	*6*
Trauma and orthopaedics and rheum	*12*
Radiology	*8*
Resuscitation committee	*6*

The College of Emergency Medicine

7-9 Bream's Buildings

London

EC4A 1DT

Tel: +44 (0)20 7404 1999

Fax: +44 (0)20 7067 1267

www.collemergencymed.ac.uk