The Royal College of Emergency Medicine

EM-POWER: A practical guide to flexible working and good EM rota design

Emergency

Medicine

Positivity

Opportunity

Wellbeing

Engagement

Retainment

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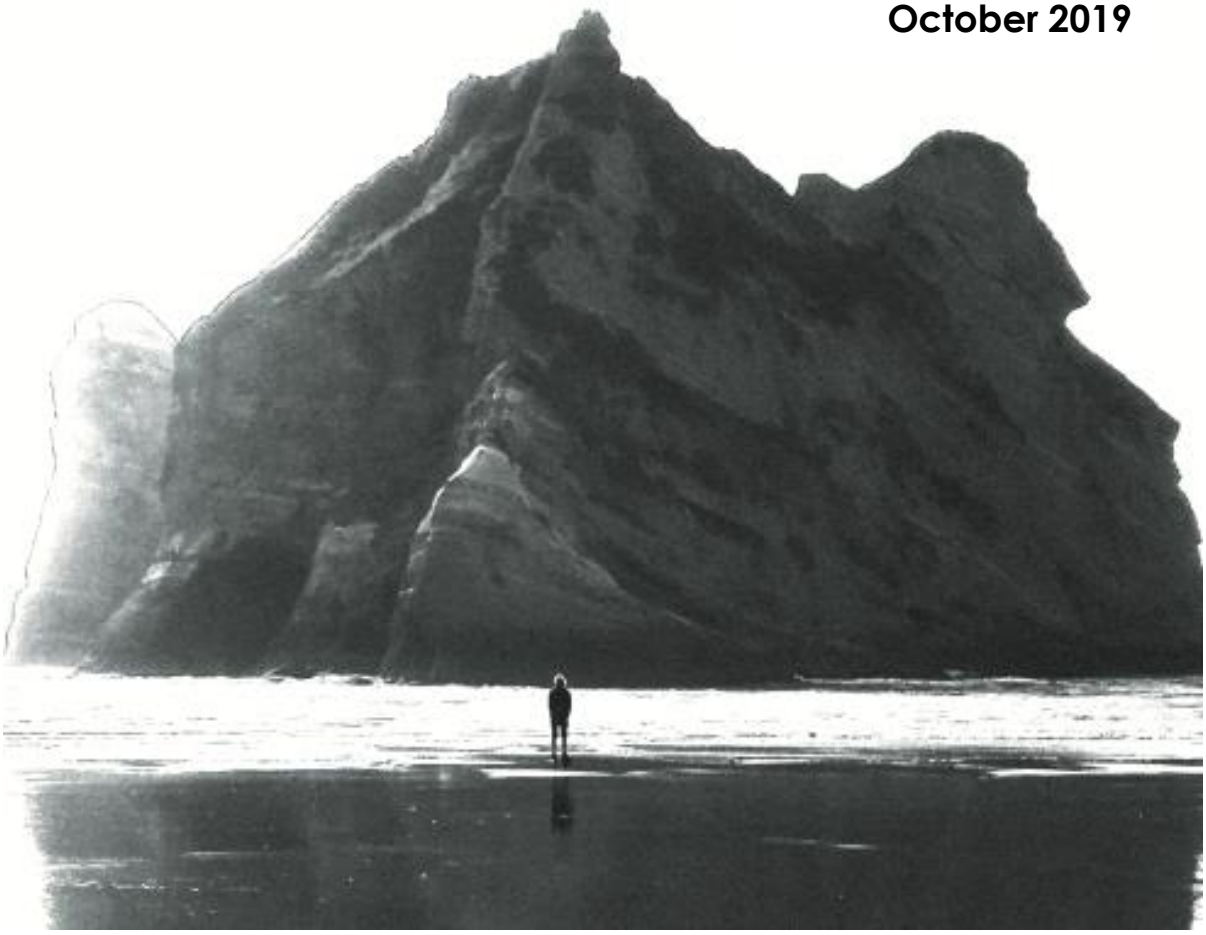

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Introduction

One of the hottest topics for senior emergency medicine (EM) clinicians is how to recruit and retain staff to work in their emergency departments (EDs). Much has been written about how hard medicine is, how challenging EM is, and how impossible it is to retain staff. However, many jobs are hard, many professional roles are challenging, and many professions note staff retention as one of their top priorities.

There are a small number of solutions and some are not within the gift of individual departments. Significant incentivisation (either financial or reward-based) for example.

We know that feeling out of control and having a deranged work-life balance lead to job dissatisfaction and ultimately burn-out. One of the flashpoints is undoubtedly ED rotas and senior doctors' perceived lack of control around their hours. Many of the shifts are antisocial and involve hours that other clinicians are not working.

This guide is written for EM clinicians and managers looking to improve the way they manage clinical rotas and improve retention, recruitment, flexible working, and job satisfaction.

It has been written by EM physicians who truly understand the issues at stake. We are privileged to do the job we do, and we have the potential for great job satisfaction, but as a group, our burn-out rates are too high and our retention levels are too low.

EM shop floor work is hard. It is intense, decision-dense, and care is often provided in inadequate environments. How we organise our shifts and maintain our flexibility is a key to our sustainability.

Those of us working in EM wish to do the job we love in a way which is conducive to a happy work-life balance. We want to ensure that enthusiastic EM trainees become happy, fulfilled EM seniors.

Many of the problems with EM can be overcome with a different approach to rostering. This guide shows how to improve rota design and improve flexible working. This will help to retain and recruit staff, whilst saving locum costs and improving patient care.

Retention of medical staff is just one part of the solution for how to improve that care; equally important is nursing recruitment and retention and utilisation of advanced practitioners.

This guide focuses on medical staff and there is specific guidance for the senior decision makers, whose retention is key to the effective running of EDs.

There have been multiple examples of great practice throughout various departments. This guide uses many of these examples.

The solutions involve blue-sky thinking and may not be appropriate for every department, but they are easy to adopt.

The guide is based on five ideas:

1. Annualisation
2. Self-rostering/Self preferences of shifts
3. Defined clinical shift times
4. A clear clinical/non-clinical split
5. Fairness and consistency for all groups of clinicians

An overview of the role of rotas in sustainability

The future of our specialty depends on recruitment and retainment of our staff. Rotas are key to this. If we get this right then departments can start to thrive, eliminate locum spend and improve patient care.

Annualisation

Annualisation is a concept which is particularly suited to EM working. Essentially the hours available are easy to calculate and the rota is written based on the PAs available. The annualisation model can also be used to calculate future departmental expansion by using the rota to answer the question, what does the department need?

It is probably true that every department needs more hours in the evening, overnight and at the weekends; a clear calculation of departmental needs can help build credible business cases for future clinician recruitment.

Once the hours are clearly defined, everyone can take control over how they work. Some departments have strict rules around the number of each type of shift that all clinicians do to ensure that there is clarity and equality. Other departments allow clinicians to bid for the shift patterns they prefer. Both options have pros and cons.

Egalitarian approach

The problem with the egalitarian approach is that some shift patterns are unpopular for some clinicians. In its favour, the whole team feel that they have been dealt with fairly.

Bidding approach

The bidding method can appear very user-friendly, but quieter individuals may not get what they want when compared to those who shout loudest.

What does annualisation give people?

What annualisation for senior clinicians gives people is a feeling of ownership - real people have real life needs outside work. It may be childcare, looking after an elderly relative, the other demands of a portfolio career, choir on a Monday or triathlon training on a Thursday, but great clinicians are multi-faceted which makes them more able to deal with real patients.

For middle grades and juniors, annualisation offers a truly mature approach to a group of clinicians who traditionally can feel disempowered. The running of the middle grade and junior rota can be a complex role and is best done by a team so that the middle grades and juniors are fully represented, but the rules are followed.

Traditional rotas

Traditional rotas were based on a 9-5 model where everyone worked five days a week and had fixed periods of annual leave and study leave. SPA and clinical work definitions lacked clarity with a lack of distinction between the two.

Traditional rotas are not appropriate for a specialty at the forefront of delivering care during unsocial hours.

Annualisation and transforming clinical care

Annualisation is a solution which revolutionises the way we can deliver clinical care. It can be used for clinicians and SAS doctors (using a PA Period of activity contract), middle grades (using a combination of PAs and hours contracts depending on the specific clinicians' contract) and rotas for clinicians in training (using hourly contracts).

It can be done using the current clinician contract, SAS doctor, specialty doctor contract and new junior doctor contracts.

The key is that direct shop floor clinical care is annualised and used to organise a clinical rota. The team needs to determine what constitutes non-shop floor clinical care, supporting professional activities (SPAs) such as study leave, annual leave and rest days.

Annualisation can be accompanied by self-rostering or self-selecting preferences, along with people defining the amount of clinical work they do; either as clinical PAs or the equivalent of hours if on an hourly contract.

Key to successful annualised rotas

The key to the success of annualised rotas is allowing flexibility and thus improving sustainability. Staff should be able to change the amount of clinical work they do without a big impact on the rota.

For staff who are less than full-time the hours can be used at any stage over a rota cycle or on specific days. This allows people to do part time jobs over a whole year working more intensely at some parts of the year and having more time off at other times of the year.

The benefits of using annualised rotas

1. It allows for less than full time colleagues to feel appropriately valued as all hours contribute to the departmental pot.

2. It also maximises the chances that people get specific time off when they want and work in a way which suits their own outside work life.

3. The system can also be used to allow secondments from department without a big impact on clinical cover and to help fit in non-clinical commitments whether they be other work or non-work related.

4. An annualisation system can also be used to ensure swaps are easy to do; each shift attracts PAs to be taken off peoples' annualised totals. In addition, doing extra work to cover for sickness or working late can be given back as time in lieu which also helps long-term sustainability.

5. There are clear advantages for the department as it is easy to see when people are working on the shop floor.

6. In addition, by knowing how much clinical cover the clinical team can provide, rotas can be planned which ensure that optimal cover is obtained within the total amount of group PAs.

7. As a set number of shifts are filled each day, the day to day variations of shop floor cover are eliminated. This inconsistency is often seen in traditional rota systems due to staff availability; rigid job plans and leave requests. The key is that annualisation goes hand in hand with self-rostering and self-prioritisation of shifts. The whole rota must be covered by staff using the PAs in their job plans.

8. Annualised systems make it very easy to write a business case for additional staff by showing the increased shop floor cover provided by the whole group when the PAs from additional staff are added to the departmental pot.

RCEM cannot recommend or negotiate rates of work (that is the role of the BMA), but they have made recommendations around appropriate remuneration.

Achieving a more sustainable rota in an annualised system

In an annualised system there are several ways in which a rota can be made more sustainable, see table below.

	Ways to achieve a sustainable rota
1	Reducing the annualisation rate from a standard of 42
2	Negotiating enhanced rates of PAs for out of hours work especially night working
3	Attaching additional 'intensity' PAs for specific antisocial shift e.g. night shifts
4	Changing the non-shop floor DCC to shop floor DCC split

Setting up an annualised system

The mechanics of setting up an annualised system can initially seem complex but there are online rota systems set up to work alongside annualised systems and which do all the calculations.

These systems essentially calculate how many PAs need to be delivered within a specific time frame and record each individual's PA tally.

For each clinician in the rota, their contract will tell you the number of weekly clinical PAs or hours they need to do.

The following parameters need to be agreed:

1. The annualisation rate e.g. 42 weeks
2. SPA / DCC split
3. Shop floor / non shop-floor split
4. Shop floor DCCs available to the rota PAs x annualisation number
5. The rota cycle e.g. the year
6. No group of clinicians may be disadvantaged by gaps in rotas. There must be local agreement about sustainability of rotas e.g. 1 in 5 weekend shifts

The way in which these PAs are delivered for the department may differ for weekends and bank holidays. Also, not all days will have the same staffing for example when there is departmental teaching.

The key is that regardless of the week of the year (unless extra cover is required for specific reasons e.g. change over weeks) then there is the same coverage irrespective of leave requests.

The total number of PAs which are needed must be less than availability provided by the group of clinicians.

There should be a 3-5% buffer to cover for extra shifts for sickness, late stays and non-core shifts which may be required at short notice. There may be weekend frequencies within contracts or local arrangements. e.g. with internal cover 1 in 5 for senior clinicians.

The crucial part of an annualised system is putting in the shifts. The key is that people get preferences. Every shift that a colleague works comes off their total. In some departments if they stay late, they get the time in lieu and if they cover a colleague at short notice it comes out of clinical time, not SPA. On the flip side, all shop floor clinical work has to be worked clinically rather than off the shop floor. This means that for very small departments with only 1 or 2 senior clinicians on a rota this system of working may not be appropriate.

The most important thing about an annualised contract is it is fair. Everyone works to their clinical commitment in their contract. No-one can underwork and if they overwork it is paid at locum rates.

Annualisation also works well with hourly contracts for juniors. However, because the current contract does not account for each different types of shift, there needs to be a sense check for different shift patterns.

However, self-rostering rota meetings are much harder for people working in the department for less than a full year (e.g. 4 or 6 months). The best way of rostering them is to calculate the number of hours they need to do and use a template but take into consideration when they want time off.

Innovative posts and programmes

In many departments, annualisation and self-rostering have had great success in terms of recruitment and retention for consultant and specialty clinicians on PA contracts.

For many junior and middle grade clinicians with a need for full time pay, full time rotas can be incredibly onerous and demoralising. Therefore, standard junior and middle grade doctor non training jobs which are 100% clinical are rarely attractive, hence many departments have large locum spends. If non-clinical components are offered, then permanent jobs become very attractive.

The key is that the hours are calculated in the way described in the annualisation section and then further reduction in hours for non-clinical time based on agreed local % off the shop floor. However, they still can do the same weekend numbers and nights as other juniors to allow effective departmental cover.

Unless the non-clinical component has specific requirements of when they need to be at work, non-clinical time does not need to be rostered and just line managed.

Finally, no other group of clinicians must be disadvantaged if there are gaps in more senior rotas. There must be local agreement around sustainable rotas for all groups and what this looks like on paper e.g. 1 in 4 weekends.

	Innovative posts and programmes
1	Simulation
2	Ultrasound
3	Undergraduate education
4	Clinician education/educational support
5	ENP education
6	Resus/trauma
7	Leadership
8	CESR (Certificate of Eligibility for Specialist Registration – become a senior doctor without going through an established training programme)
9	Medical School education

Practical details about rota writing

Rotas can be organised by rota meetings or via a coordinator. The way each type of rota is sorted out is explained below:

	1. Rota meeting method
a	When the rota meeting method is used weekends are sorted out before the rota meeting by the coordinator.
b	During a rota meeting where everyone is represented every shift is taken.
c	The rota coordinator must make sure shifts are given out fairly and everyone is getting to the PA balance at which they need to be.
d	If an individual would like annual leave, they don't offer to do a shift. This is marked on the rota before the meeting in case there are disputes about who is going to fill unpopular shifts.
e	Each individual decides when they want to work. As their name is put into the rota the PAs get removed from their individual and the total number.
f	People should do shifts up to the PAs that they owe to the department. But the individual can over or under work in a time period. The rota cycles link in with each other and so over work or under work is added into the next cycle.
g	Each department works out what is appropriate to have as an under or over roll into the next period. A good example is you can't under or over work by more than 50% of the PAs you need to do in the time period.

After the meeting swaps can be made and the PA count adjusted appropriately.

	2. Rota coordinator method
a	The rota co-coordinator asks for all days that the clinicians want off regardless of why. This is done well in advance so that people coming into their job know their planned shifts months in advance.
b	This is marked as 'off' on the rota, so they do not work then.
c	Rota coordinator organises rolls of rota with weekends arranged so that they fulfil their maximum weekend frequency but are not working when they want to be off.
d	Shifts are organised in a forward roll e.g. early, late, nights.
e	For every shift done, the hours come off the individual's totals.
f	There can be cover shifts which make it easier to allow swaps, cover for sickness etc.…

Time away from work

For either system of rotas, there is the need to think about time away from work such as: annual leave, sickness, maternity leave, extended paternity leave, the need for secondments away from clinical work and career breaks.

Sickness

Sickness can be easily and effectively managed in an annualised system.
Essentially no individual is penalised for taking sick leave and there is no payback of shifts lost for sick leave.

For the purposes of sick leave recording whatever the shift each day of leave is counted as a day of sick leave.

If the sickness lasts for longer than an agreed period of time (e.g. a week) the PA count for the individual can be decreased overall.

The clinician who covers the shifts lost to sickness can either be paid as a locum for those shifts, swapped for other shifts later in their rota or their PA count can be increased overall. When the sickness lasts less than a week the individual does not lose PAs for the shifts, but those who do the shift get it added to their columns as an extra.

Paternity leave

This is worked out in exactly the same way as sickness, greater than one week.

Maternity leave / extended paternity leave

The number of weeks the member of staff will be away for is agreed. This will be a combination of when they are on maternity leave and accrued annual leave. The PA calculations stop when they go away and restart when they come back.

For example, if someone is away for a year, then they may be on maternity leave for 46 weeks and annual leave for 6 weeks. Their rota calculations would be paused for a whole year, but they would be back to getting full pay and back from maternity leave after 46 weeks'.

Annual leave/study leave

Leave is when you have not self-rostered and are doing no other clinical/non-clinical work. If pre allocating all study leave, there needs to be evidence of what is done in that time.

It should be clear which staff are doing SPA as opposed to those who are on recovery days, days off or on annual leave, in case there is a need for extra staff to come in e.g. during a major incident.

About this document

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Acknowledgments

RCEM Sustainable Working Practices Committee.

Review

Usually within three years or sooner if important information becomes available.

Conflicts of interest

Rob Galloway has helped develop an online rota system (healthrota.co.uk) which uses the systems explained in this document. This is commercially available for use by any department.

Disclaimers

External website links: RCEM makes no warranties, representations or undertakings about any content including, without limitation, any as to the quality, accuracy, completeness or fitness for any particular purpose of such content of any external websites.

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Research recommendations

None.

Audit standards

None.

Key words for search

Rota, sustainability, annualisation, shift.

Contact us

If you would like more individualised support for your department's rotas, please email RCEM here.

Appendix A: Negotiating contracts using an annualisation system

Introduction

There are multiple advantages of an annualised system, but one which is often forgotten is how easy it is to negotiate transparent terms and conditions.

An annualised rota and appropriate terms and conditions for 24/7 working, can mean that if people wish to stay on a standard 10 PA contract, they may get more rest days. However, they could choose to take on more PAs and get the proportional increase in pay. Or they can choose to get additional pay via locum payments.

There are several changes that can be negotiated which can increase sustainability, these are:

Intensity negotiations

It is known that EM shifts have a greater intensity of work. Therefore, an intensity supplement can be added to each shift or specific shifts e.g. nights.

This could be at a PA bonus or a % increase on standard PAs. For example, doing 3 hours per PA at night with a one PA bonus is virtually the same as doing 2 hours per PA.

Shop floor DCC vs Non shop floor DCC vs SPA time

On an annualised system it is shop floor DCC that is timetabled and non-shop floor DCC is fitted into other times along with SPA activity. But historically SPA and non-shop floor time is often done in people's own time. It is important to negotiate appropriate recognition either individually or as a department for an accurate reflection of non-shop floor DCC activity.

Annualisation

The standard annualisation rate is 42 weeks a year. This accounts for 8 bank holidays a year 32 days a year of annual leave and 2 weeks of study leave. This is increased slightly for those with length of service increase in annual leave.

PA on call supplement

There should be PAs attached to each on call done and this should reflect the amount of work done. This should be separate to any on call pay supplement

PA rates for each shift

This is key and the standard contract is not acceptable for those who work nights. Locally negotiated rates between 10pm and 8am vary between 1 hour per PA and 2 hours per PA; 7pm to 7am during the week and weekends are usually considered as out of hours.

Covering unfilled middle grade shifts

This could be done at a supplement to standard PAs. In addition, if a senior clinician would normally work with a registrar on a shift but they are the sole senior decision maker due to unfilled shifts then this should attract a locally negotiated rate for acting down. A suggestion is case is to double the PAs for that shift.

Note: Covering senior clinicians or senior decision makers should be done at a standard PA rate but if there is a last-minute request this could attract a premium.

PAs for staying late / being called in to help in extremis

There must be the assumption that if an individual stays late, they get paid standard PAs for this. If called in in an emergency when not on call, then this attracts standard PAs onto a total. This must be made explicitly clear, and it must not come out of SPA.

Appendix B: Requirements for an on-line IT system

Annualised rotas can be managed through excel. But this needs a departmental geek!

Online systems are much easier to run and take out much of the stress of rota-writing. The system you choose needs to fulfil several criteria. It needs to have the following functions:

1. Ability to allow self-rostering (with or without a rota meeting)
2. Ability to be able to easily rota staff with variable PAs dependent on their contract
3. Ability to annualise and vary this according to different job plans
4. Ability to roll over any over worked PAs into a next roll period
5. Ability to change the PA calculation for out of hours/ intensity of work based on local negotiation
6. Ability to have non shop floor clinical time calculated specifically and taken off total amount of shop floor
7. Ability to add/ subtract PAs when someone works additional hours / intensity of work based on local negotiation
8. Ability to have a flexible rota
9. Ability to have a locally negotiated PA bonus added for intensity
10. Ability to have a PA bonus for on call added to people's totals
11. Ability to have some shifts worked as locum shifts if there are not the staff employed to cover all the shift requirements
12. Ability to view an individual's and the departmental rota on home and work calendars and update them both in real time on to individuals' calendars
13. Ability to have a summary of previous Christmas and other Bank Holidays to make it easier to plan these shifts
14. Ability to have each shift's hours/PAs worked come off total requirement for their contract
15. Ability for people to take on those shifts without having to do a swap but just get the hours/PAs added on to their total

16. An app so that you can do swaps which are compliant without having to go through a rota administrator

17. A mechanism by which any non-compliant shift is automatically highlighted, and so non-compliant rotas are made an impossibility unless doctors agree to work them specifically

18. A day view so that the team who is working can be seen very easily, where it is shown how many people are working at any one point in time and where there are gaps

Appendix C: Limited PA jobs

One of the advantages of an annualised system is the flexibility to employ senior clinicians on limited PAs. This is different from traditional contracts and can be very useful for people who are in the later phase of an EM career and want extra experience in a second hospital e.g. in a major trauma centre or those who work abroad for a number of months a year but still want a UK based job.

These senior clinicians contribute to the departmental PA pot and often proportionally cover more out of hours shifts thus enabling a more even spread of cover.

It should be noted that this type of post has no SPA allocation except for CPD. Those who want part time work but also contribute SPA time to the department should apply for normal senior clinician part time posts and negotiate a personal SPA/clinical split.

Below is an example of a job description of this type of job:

Job description:
Senior clinician clinical posts of between 1-4 PAs clinically. Appropriate for people who want a clinical only job.

Requirements of candidate:

1. CCT in Emergency Medicine.

2. Minimum of 4 PAs of clinical Emergency Medicine work in centres which have similar health care systems to the NHS. The minimum 4 PAs can be made up of work solely in the centre you are applying to work in or a combination of various centres. The appointments team locally must determine if the candidate fulfils the criteria.

3. Agreement to take part in mandatory training, appraisal and revalidation, complaints and clinical governance issues relating to candidate's clinical care.

Requirements of Employer:

1. Pro-rata (based on a 10 PA contract) annual leave, study leave, full complement of bank holidays.

2. Minimum of 6.25% of clinical PAs to be off the shop floor clinical work e.g. coroners' cases, complaints, clinical governance, following up patients etc… (Based on a standard of 0.5 PAs for every 8 clinical PAs worked).

3. For every clinical PA worked, 0.1 PA is given for CPD.

4. Flexibility of when PAs can be worked.

5. Consistent PA shifts tariffs.

6. No expectation of non-clinical work but can be negotiated as extra PAs.

7. A departmental senior clinician mentor/ buddy to provide any additional support required.

Example job plan:
2 PAs. 1.8 PAs clinical. 0.1125 PAs off the shop floor. PAs per week = 1.6875 Annualised to 42 weeks per year = 70.875 PAs to be worked over a year.

Appendix D: Advice for managers

It is vital to involve your managers - this is a complete change in working patterns.

What is an annualised / self-rostering system?

- An annualised rota calculates the number of PAs required and worked over one year.

- Individual's annual PA commitments to the department are individually calculated. This is worked out by the number of DCCs a clinician is contracted for, and the DCC split of shop floor versus non-shop floor work e.g. clinical administration time. This can be calculated as a % of the DCC or specific amount of PAs of the DCC.

- When clinicians are rostered for the shop floor the number of weeks worked is the annualisation number; this is often taken as 42/52.

- The needs of the department have been worked out based on what the staff can deliver depending on the PAs they have as a total.

- Core shifts have to be filled. As they are filled, each person's PAs that they 'owe' to the department are reduced.

- Senior clinicians' self-roster when they want to do shifts - and the lead senior clinician or rota manager ensures that all core shifts are filled. Leave is when the clinician is not doing clinical or non-clinical work.

- Weekends are organised prior to the meeting ensuring staff work when they can at weekends as long as all weekends are filled, and the weekend frequency is kept to.

- Ability to offer opportunities to work a pattern which may have been difficult to offer in the past e.g. term time only/ fixed days.

- There is a small surplus of PAs available for department above the core shifts. These are used for covering sickness, compassionate leave and extra shop floor cover for when middle grades are at teaching or for when there are unprecedented extra pressures.

Why do this?

- Ability to attract new staff and retention of existing staff due to improved job satisfaction.

- Offers an ability to the clinician's senior team to plan life and know when they are working as well as choose to do shifts when available and build in specific evenings or mornings off each week. Annualisation, also means that as long as core shifts are covered, people can take extended leave without impact on service provision.

- Ability to work outside the ED shop floor. As staff self-roster, they can do work which helps department and hospital e.g. teaching, deanery work, pre-hospital etc.…

- Easy to swap shifts, as each shift attracts a PA payment, people can swap shifts easily. This helps people get to their non-clinical commitments ensuring staff also provide a first-class service to the Trust in terms of non-clinical work *without* impacting on shop floor work.

- Incentivisation of bank holidays, weekends and nights. This encourages people to select to do nights and weekends as they are getting the PAs. Bank holidays can be worked as normal days in terms of shop floor cover.

- Ability to offer part time work e.g. to do nights/weekends, to people in other trusts i.e. the 1-4 PA contracts.

Other points include:

- Cover for sickness/paternity leave/compassionate leave

- Cover for planned times of extra demand e.g. New Year's Eve without the need for locums

- Cover for planned problem times e.g. August handover – saving a considerable cost in locums

What you need to implement the changes

- Need complete buy in from everyone that as a group you will cover all the core shifts. This may mean changing job plans and working non fixed days for some.

- Need to know how many PAs available and then can work out how best to offer that cover to the department.

- Need to agree on the amount of non-shop floor clinical work that is not rostered. However, you can still create clinical admin shifts to be done as a clinical shop floor shift e.g. for X-ray reports, complaints etc… The amount of non-shop floor clinical time within a job plan should be considered if some clinical admin is counted as clinical DCC time which comes off totals when the shift is done. This needs to be locally agreed.

- Need an agreement on annualisation. Standard is 42/52 but could be locally negotiated e.g. because amount of professional leave EM clinicians often take.

- Need to agree a night premium rate. Variability around the UK from 1-2 PAs/ hour from 10pm to 8am.

Creating flexibility

- Self-rostering allows significant flexibility
- There has to be group agreement that all shifts will be covered
- Offers ability to do fixed days / fixed work schedules

Adhering to principles of good job planning

- Group agreement that you don't do more than 3 nights in a row
- Agreement that there is appropriate compensatory time off after a night shift etc…
- Allow staff to do the number of clinical PAs they want to do which is personally sustainable

Who is it for?

Can be used for all permanent members of staff – senior clinicians/ middle grade/ GPs working in your department. Also, could be used for nursing staff and hourly versions used for junior clinicians.

Measuring its success

- Shop floor coverage
- Retention
- Job satisfaction surveys/ quality of life surveys
- Better patient outcomes are hard to prove

Appendix E: Additional Resources

Podcast on transforming rotas and retention:
https://www.youtube.com/watch?v=BVoVyT0FR-w&feature=youtu.be

Video on transforming Junior Doctors' Rotas:
https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/medical-rota-gaps-report

Department of health blog piece on self-rostering annualisation for senior clinicians:
https://dhscworkforce.crowdicity.com/blogpost/629828

Blog piece from St Emlyn's on self-rostering annualized hours:
Blog Piece from St Emlyns on self rostering annulised hours
http://stemlynsblog.org/self-rostering-annualised-hours-keep-everyone-happy-time-st-emlyns/

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