



*Improving Working Lives
for Doctors*

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Preface

The main constraint facing the NHS today is that of staffing. There is a clear commitment to increase the numbers of doctors, nurses and healthcare staff. To achieve this the NHS must retain trained and experienced clinicians and offer staff a better deal in their working lives.

The Improving Working Lives Standard summarises the commitment expected from NHS employers to create well-managed, flexible working environments that support staff, promote their welfare and development, and respect their need to manage a healthy and productive balance between work and life outside work. Achieving the Standard means making real and tangible improvements in the working lives of doctors, too.

Doctors play a pivotal role in delivering healthcare. From the newest house officer to the medical director or general practitioner, they are in a unique position to challenge traditional ways of working and champion new flexible working practices for themselves and their colleagues.

This updated booklet outlines important changes to the Flexible Careers Scheme, which was launched for hospital doctors in November 2001. The scheme has now been extended to facilitate more part time opportunities for general practitioners, and help doctors at every level work flexibly while continuing their careers. To work, the scheme needs the support of individual doctors, general practitioners, managers and medical teams. To work well it needs to be part of a wider change in medical working practices that values and harnesses the commitment of those who wish to work flexibly or reduced hours.

There are many instances across the NHS where the needs of the service and the working preferences of doctors combine to provide high quality, accessible care for patients. This document illustrates with practical examples, what can be achieved with a little imagination and a fresh approach. The NHS needs the best doctors, to deliver the best possible services to patients. That means embracing the best employment practices for everyone in the health care team.



Sir Liam Donaldson,
CHIEF MEDICAL OFFICER





Introduction

The Improving Working Lives initiative

The NHS has to be a model employer, not just for the benefit of staff but because it is important for patients to have sufficient well-motivated people in place to provide the care they need.

The Improving Working Lives (IWL) initiative aims to make the NHS a better place to work. It is underpinned by the IWL Standard (see panel) which summarises the expectations placed on NHS employers to support all staff, promote their welfare and development, and enable a healthy balance between work and life outside work. Doctors are as much a part of this initiative as any other group.

All NHS employers are required to achieve IWL Practice status by April 2003. They will need to produce evidence of how they are improving working lives for all their staff — along with policies which promote equality of opportunity and diversity in the workforce.

The evidence will be reviewed by multi-disciplinary teams of trained assessors who will make visits and meet staff at all levels. These teams will include doctors; and all staff, including doctors, will be encouraged to take part through one-to-one interviews and group discussions.

The NHS has been making huge changes since the launch of the IWL initiative. There are now more flexible working opportunities and the Doctors' Forum has been established, bringing together front line clinicians and policy makers in a concerted effort to improve doctors' working lives.

Improving Working Lives Standard

NHS employers committed to improving working lives:

- ◆ Recognise that modern health services require modern employment services
- ◆ Understand that staff work best for patients when they can strike a healthy balance between work and other aspects of their life outside work
- ◆ Accept joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and service with the needs of staff
- ◆ Value and support staff according to the contribution they make to patient care and meeting service needs
- ◆ Provide personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns
- ◆ Have a range of policies and practices in place that enable staff to manage a healthy balance between work and their commitments outside work

Sharing ideas

Improving Working Lives is both a policy issue and an attitude of mind among managers and staff. Across the NHS there are many examples of good practice where fresh ideas about how people work have led to significant improvements in morale, efficiency and the quality of services to users. You can find some of these on the good practice database within the IWL website (www.doh.gov.uk/iwl).

This pack looks at ways of improving the working lives of doctors, from earliest training grades through to Consultant or GP. It includes new policy initiatives which are intended to make it easier for doctors to have career breaks and periods outside full-time professional practice. It also contains specific examples of organisations and individuals who have taken steps to improve working lives — for themselves and others. These examples are not unique; they are simply indicative of good practice that is already going on. They illustrate what is possible.

The motives for change may vary from one situation to another, but there is a consistency in the gains achieved:

- ◆ improvements in recruitment and retention of doctors
- ◆ improvements in professional confidence and job satisfaction
- ◆ improvements in day-to-day working environment
- ◆ and, as a result, improvements in services to users

It is a characteristic of many of the examples in this pack that the initiatives have come from doctors themselves. The “contacts” named at the end of each example are happy to provide more background and share their experiences with others who may be interested in doing something similar.



“...it is essential that the NHS is able to offer the scope of employment opportunities that match the diverse and changing needs of those who want to work within it — and reflect the society that it serves.”

NHS Childcare Strategy

Being both a parent and part of a team that delivers care 24 hours a day, every day, can make combining work and family responsibilities especially difficult. The NHS Childcare Strategy aims to develop good quality, accessible and affordable childcare that is matched to the real needs of NHS staff.

By 2004, over £70m will have been allocated to provide around 150 more subsidised on-site nurseries. The nurseries will have extended opening hours, give emergency cover, and offer care at weekends and bank holidays where there is demand. Staff will also be able to consult their NHS childcare co-ordinator who can offer support and advice on all issues to do with childcare.

For some parents, nurseries located within hospital trusts may not always be the best answer, nor do they provide support for school-aged children. This is why more funding, building up to £100m a year, is being made available to offer other forms of childcare: including after-school clubs, holiday play schemes and childminding networks. One of the priorities for this funding will be to ensure that GPs and their staff are included in the strategy. Another priority will be to offer help to people planning to return to work in the NHS, especially hospital doctors and GPs.

“Two of my children have been through the hospital nursery, my third has just started. I could not have wanted a better place for them to be. The older two have settled quickly and well into primary school. A bonus for a part-time doctor like me is that the nursery will take kids just for an odd hour if I have to come in to attend a meeting.”

Sarah Bhatt, staff grade doctor in G-U medicine

“Because the nursery is open all day Saturday, my husband and I can fulfil our 1 in 4 rota on the same weekend. That gives us three full weekends together as a family. Having a good nursery at the hospital has made my job less stressful.”

Elizabeth Bright, part-time anaesthetist

Working Time Directive

The working patterns of doctors in training will significantly alter when the European Working Time Directive applies to them from August 2004. This health and safety legislation already protects other NHS staff and for doctors in training needs to be viewed with the New Deal requirements of a 56 hour maximum working week.

The key points of the EWTD are

- ◆ 11 hours rest in every 24 hours
- ◆ minimum 24 hour rest in every 7 days or minimum 48 hour rest in every 14 days
- ◆ maximum of 58 hours per week

The changes will not only affect doctors in training but the rest of the healthcare team. They also need to be seen in the context of the other changes in the NHS. The EWTD will be challenging but it will protect NHS staff and help them to deliver care within a modern NHS.

Further information on the EWTB can be found at www.doh.gov.uk/workingtime/

New doctors' attitudes towards their careers

As part of a recent report* on the career guidance needs of new doctors, a survey has been carried out to explore current attitudes. The findings included:

- ◆ 57% of respondents thought that work-life balance was the most important work value
- ◆ 75% of female respondents and 29% of male respondents either planned to work part-time at some point in their career or thought they may do
- ◆ 37% of all female respondents were put off some specialties because of the lack of flexible working opportunities

Improving Working Lives is not just about helping working parents; it's about creating opportunities for all doctors to work more flexibly. Nearly everyone will need or want to work flexibly at some point in their career. In order to create and retain a well-balanced and stable workforce, it is essential that the NHS is able to offer the scope of employment opportunities that match the diverse and changing needs of those who want to work within it — and reflect the society that it serves.

*Jackson C, Ball J, Hirsch W & M Kidd (2002) Informing choices, the need for career advice in medical training. National Institute for Careers Education and Counselling: London.



2.

Working flexibly

For all sorts of reasons, doctors may want to work flexibly at some stage in their careers. Historically, the practice of medicine has made this difficult: a medical career has been assumed to be a full-time commitment, with little scope for interruption. This assumption is based on the need to acquire and consolidate clinical skills and knowledge, and the drive to progress through the training grades as quickly as possible. Continuity of treatment and care for patients is also sometimes suggested as a barrier to more flexible working.

However, these obstacles can be overcome. As attitudes to the work/life balance are changing among many doctors — and as the “long hours culture” acts as a deterrent to young people who might otherwise consider medicine as a career — it is important that all the possibilities of flexible working are explored.

Flexible working can take a variety of forms — part-time, job sharing, acting as a locum. It does raise special issues, especially within the training grades. And some of the very flexible working patterns available to large groups of staff with shared skills and qualifications are not open to doctors. However, it is possible for doctors to work flexibly and effectively, as the examples in this section demonstrate.



Flexible training programmes, support for doctors who want to work less than half-time, varied working patterns for senior doctors, blurring the edges of retirement... In the coming years, the expectation of many doctors will be to have more varied working lives as their individual circumstances and aspirations change. These initiatives and individual examples anticipate some of the options that doctors in the future will have.

The Flexible Careers Scheme (FCS)

Central funding for hospital doctors and GPs working less than half-time

The Flexible Careers Scheme (FCS) increases the scope for doctors to work part-time and return from career breaks. FCS provides centrally funded opportunities for doctors who are able to work up to 49% of full time. Each arrangement is time-limited and is adapted to meet individual circumstances; it will also provide sufficient medical/clinical practice for revalidation purposes.

FCS opportunities are available to doctors at all levels and stages in their careers, including GPs. Because it offers central funding, the scheme supports employers who want to strengthen staffing levels through greater use of staff working flexibly.

Who can join FCS?

- ◆ **Doctors in training grades:** FCS offers an alternative to flexible training for doctors who want to work less than 50% of full time. Time spent on the scheme can not be accredited for training because doctors will be working less than the statutory 50%. However, with the approval of their postgraduate deans, specialist registrars on the scheme can keep their NTN.

Trusts that employ doctors in the training grades on FCS receive central funding to cover 100% of their employment costs.

- ◆ **Career grade doctors:** FCS supports the creation of part-time career grade posts which will increase opportunities for more long term or temporary part-time working.
- ◆ **Returners:** FCS provides a clear re-entry pathway back into the NHS with fully funded refresher training, and the option to work full- or part-time during this period. After completing refresher training there is the option to return to a part-time post supported by the FCS.
- ◆ **Doctors nearing retirement:** FCS gives central funding to support doctors and GPs in reducing their hours in their final years of service.

Trusts and other employers of career grade doctors on the FCS, receive central funding to cover 50% of their employment costs in the first year, 25% in the second and 10% in the third. During refresher training, 100% of returners' employment costs are funded centrally.

Benefits of FCS

- ◆ central funding to encourage the creation of more flexible part-time working, including annualised hours and job shares
- ◆ a fixed annual amount, paid to the doctor, to contribute towards professional expenses (currently £700 - £1,050 depending on circumstances)
- ◆ access to the NHS pension scheme, sickness and maternity leave;
- ◆ an educational CPD element
- ◆ an exit strategy for moving on after being on the FCS
- ◆ it provides sufficient medical/clinical practice to meet the requirements for revalidation
- ◆ career grade doctors, including GPs, can remain on the scheme for up to 3 years; doctors in the training grades can remain on the scheme for up to 2 years

The Flexible Careers Scheme is already helping doctors return to work after a period of absence, work more flexibly and reduce their hours close to retirement.

For further information on the Flexible Careers Scheme, or to apply to join, contact NHS Professionals on 0845 60 60 345

Back to practice after 14 years Returner in geriatrics on FCS

Jenny Friend still vividly recalls her first experience as a PRHO in Birmingham in 1987. "August 1st was a Friday and I remained on call all the way through to the Monday evening. I was shattered." One year later she stopped work altogether. "I was married and planning to have children. I couldn't see any way that working like this could be compatible with family life."

14 years and 4 children later, Jenny has just started working at an Intermediate Care Unit for older people at North Tyneside General Hospital. She is employed under the Flexible Careers Scheme and sees this as a way of picking up her medical career. "I had been doing quite a lot of voluntary work with elderly people, but as the kids got older I started to think about working as a doctor again. We had moved to Newcastle, and I contacted the regional Associate Postgraduate Dean for advice. She was very encouraging and things have developed from there".

"I spent three months coming to the Unit with observer status and unpaid, to see if I felt I could be useful. Now I have started working under the FCS on a timetable that I agreed with my Consultant. I work inside school hours and finish at 12.30 on Fridays. In school holidays I'll reduce my days but won't stop altogether because the continuity is important."

"My Consultant is very supportive as are all the staff, which helps me so much. A physiotherapist on the Unit has just returned after a 10 year career break, so we can compare experiences. I'm aware there are large gaps in my knowledge, especially around new drugs, but I'm aiming to fill them quickly.

Wednesdays have been designated as learning days for me at the Hospital. I have already taken my Advanced Life Support Certificate which was pretty nerve-wracking. Now I'm planning to do the Diploma in Geriatric Medicine."

Jenny's FCS placement is time limited, but she feels much more positive now about the prospect of moving into a training grade post: "I need to spend some time in a Medical Admissions Unit to fill out my experience and skills. I'm not hugely ambitious or desperate to become a Consultant. Coming back into medicine I realise what I want is to do the job I enjoy to the best of my ability."

Contact

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or

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New Consultant. New Mum. A&E Consultant on FCS

At the age of 33, Liz Hobbs has just become a Mum and started her first job as an A&E Consultant at King's College Hospital in London. She competed for the post alongside others in the normal way; what is less usual is that after being selected her actual appointment was under the terms of the Flexible Careers Scheme. "I had looked through all the options before coming across the FCS. This is the only way I could see of combining the family life I want with my work."

"I had been an specialist registrar in A&E for 5 years, fully qualified, approaching the peak of my career... and then looking at the prospect of not having any job at all. The minimum part-time option of 5 sessions a week was more than I was prepared to do: I want to thoroughly enjoy my baby while she's still small. The FCS contract is for two sessions a week with the scope to increase this up to 5 sessions as Rosie gets older.

"Both sessions are entirely clinical, so I'm confident about keeping my skills in shape. It's one full day a week; my travel-to-work time wouldn't make sense of two half days. I'm fortunate that my mother can look after Rosie while I'm away.

"In fact I feel very, very lucky. I'll be able to continue with work I love doing and have the time I want to commit to being a Mum. So when the family is older I would be able to pick up again on a full-time basis much more easily than if I'd had a complete break."

Contact

Liz Hobbs, A&E Consultant

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Silver medal winning pair

Part-time PRHOs on FCS

Stephanie Temperton and Becky Thorpe are a lightweight rowing pair who won silver medals in the 2002 Commonwealth Rowing Championships. Both are graduates of Nottingham University, now working together as part-time PRHOs at Nottingham City Hospital under the Flexible Careers Scheme. They work one day in the medical admissions unit, and one day in the surgical admissions unit.

As Stephanie and Becky say, it's a question of balancing commitments. "We took the decision to try for the Commonwealth Games early in the last year of our medical course. We couldn't know then whether or not we'd qualify, but knew that we would have to fit work around that commitment. The Games would be around the time we were due to start our first jobs, so it was inappropriate to commit to full time work given the demands the games would place upon us.

"We looked around for a scheme that would enable us to start our medical careers and decided that FCS was our best short term option. However, because the scheme does not enable us to achieve training credits, we will be looking at other options — including a job share — possibly around February."

"This scheme is very useful for people in our position. However it is only a short-term solution because of the absence of training credits. Having said that, if it were not for this scheme we would have perhaps had to settle for jobs outside the medical profession which was something we did not want to do."

Both rowers are currently training to qualify for a place in the World Championships in 2003.

Contact

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The Flexible Career Scheme: A Medical Director's view

Declan Flanagan, Medical Director at Hinchingsbrooke Hospital, has three doctors working different patterns under the FCS, and for very different reasons. From his point of view, the scheme has increased the medical strength of the hospital in problem areas.

"As a smallish district general hospital, having doctors on the FCS has loosened things up in giving us more coverage, whilst still protecting our full salary posts. The effort to get on to the scheme has to come from individual doctors, but it can work for the benefit of Trusts as well.

“Like many District General Hospitals, we have a problem with A&E. There was an SpR we’d lost from orthopaedic surgery a year ago because she couldn’t balance the work commitments with looking after her three children. We had kept in touch and let her know about the FCS. She applied on the basis of doing 2 sessions a week in A+E as an SHO. One session is earmarked for CPD, the other is an evening session which is really useful for the rest of the A&E team.

“We also have an SHO in A&E who wanted to combine his work as an osteopath with clinical involvement at the hospital. Again, the FCS opened the way for us to give him the three sessions a week he could work.

“Our third FCS doctor is an anaesthetist who wanted to wind down her work commitments as she approaches retirement. Instead of stopping altogether, she is now doing two lists a week. We have been able to appoint a full-time replacement, so the arrangement gives us an extra resource in surgery.

“All the posts are time-limited to 18 months or two years, so you have to plan for that. But we would have lost our anaesthetist altogether without the FCS, and probably our osteopath SHO as well. For the returner Mum it means keeping some continuity in her medical career. We knew her work of old, and we don’t want to lose her completely.

“To be fair to the doctors at the training grades, there has to be a strong CPD element in the scheme — we have documented CPD sessions for our two A+E doctors, and a Consultant who keeps a close eye on how they’re doing. At any one time, it’s a fairly limited, self-selecting group that the FCS appeals to; but from my point of view it has given us extra coverage and sessions that we couldn’t have funded from our own budgets.”

Contact Declan Flanagan, Medical Director
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NHS Professionals

NHS Professionals aims to be the primary supplier of temporary healthcare staff to the NHS – including locum doctors. All NHS Trusts should be working to NHS Professionals standards for all their temporary staffing requirements. By April 2003, the service is planned to be operational nationwide.

Benefits to locum doctors in working through NHS Professionals include:

- ◆ Membership package to suit individual circumstances
- ◆ Training credits scheme
- ◆ Wider choice of placements
- ◆ Exit report feedback
- ◆ Appropriate placements to skills
- ◆ Support with appraisal and revalidation
- ◆ Competitive rates
- ◆ Support in gaining substantive posts where appropriate

“ ... enables doctors to have a break from full-time work whilst continuing to develop their clinical skills and medical career. It also benefits services, for instance by enabling departments to run extra clinics for patients which would otherwise be impossible.”

For locum doctors, NHS Professionals will provide support and advice with appraisal and GMC revalidation. The annual appraisal will be based on work done and personal development needs will be identified and supported. NHS Professionals will also ensure that exit reports from trusts are in a format consistent with revalidation portfolio evidence, and will ensure completion for every placement however short term.

For trusts, NHS Professionals will provide a cost-effective service with a range of important benefits which include:

- ◆ Locum bank of choice: one-stop shop
- ◆ Cost effective commission rates, facilitating reinvestment in people
- ◆ Supported, appropriately placed, quality assured doctors
- ◆ More effective use of commercial agencies through the national medical locum agency framework agreement

NHS Professionals is a resource for doctors who want to discuss flexible working opportunities at any stage in their career. Administration of the Flexible Careers Scheme for hospital doctors and GPs is also managed by NHS Professionals.

To find out more, call NHS Professionals on 0845 60 60 345 or visit the website: www.nhs.uk/nhsprofessionals

Flexible training

Enabling doctors in training to work more flexibly

Flexible training enables doctors to keep training (as opposed to simply working) part-time, and build up educational credits towards their CCST. Flexible trainees must meet the same requirements in respect of quality and total training time as full-time trainees. This means that flexible trainees will take longer to meet these requirements. They have to contract for a minimum of 50% of the full time requirement (i.e. a minimum of 5 sessions a week). Most flexible trainees contract to work between 5 and 8 sessions a week, plus an agreed proportion of the out-of-hours commitment.

Currently almost 5% of doctors in training are flexible trainees. As with the FCS, flexible training enables doctors to have a break from full-time work whilst continuing to develop their clinical skills and medical career. It also benefits services, for instance by enabling departments to run extra clinics for patients (evening sessions, say) which would otherwise be impossible.

Doctors who want to train flexibly should contact their local postgraduate dean's office, who will arrange for them to discuss eligibility. Deans, clinical tutors and educational supervisors will try to agree educational timetables for flexible trainees which meet their training requirements and personal circumstances, and match the operational needs of their departments.

Managing more of her time

Caroline Mortimer, former flexible trainee, now Consultant Surgeon

Caroline Mortimer thinks the most important thing about being a working mother is having control of your time. "There are deadlines you have to meet: collecting the kids from nursery or from school, being home at the times you say you'll be there, and having your own time for yourself and your family. Plus some kind of back up for the occasions you can't get there." As a recently appointed Consultant in general surgery, she now has enough control of her hours to work full-time. But in the last years of her Registrar grade she was Oxford Deanery's first flexible surgical trainee.

"I had completed two years as a Registrar before having my first child. I knew I didn't want to work as a full-time surgeon while Ben was a baby, and after maternity leave I went into research. Breast cancer surgery and reconstruction was my area of interest. I spent 3 years as a Clinical Assistant in the screening service and working on my thesis. Ben went to a local nursery and my parents were close by, so even in an emergency there was someone there."

Caroline resumed as a full-time Registrar for another 2 1/2 years before having a second baby. "I had 6 months maternity leave and then returned as a Senior Registrar on the flexible training scheme. I had to compete as if it was a full-time appointment, but was then employed as a supernumerary Senior Registrar in the Oxford Deanery. I worked 4 days a week and was on call through Thursday nights. You couldn't exactly call it part-time: about 50 hours a week. But I never worked weekends and was off on Mondays, so I had that time protected for myself and my family."

After 3 more years in flexible training, Caroline gained her completion of training certificate and started looking for her first Consultant's post. "I decided that I would work full-time as a Consultant since I knew that I would have control over my working hours, which is so important as a parent. I am good at managing my time, so finishing hospital work on schedule isn't usually a problem."

Although her years in the training grades were longer than for some of her contemporaries, Caroline has few regrets and sees many advantages. "I loved having the extra time off with my children and I gained more from it both as a parent and as a surgeon. I had the time to consolidate my knowledge and skills so I felt confident with the transition to becoming a Consultant. As a supernumerary Registrar, I could be more selective over my sessions and focus more on my area of special interest. Modern training can easily be adapted to suit flexible trainees. Having time for my family and study whilst I was a flexible trainee, I never really felt tired or in need of a break. I was able to put up with the stress of a busy surgical career much more comfortably than my full-time colleagues. I'd recommend it to anyone."

Contact

Caroline Mortimer, Consultant general surgeon
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Building up experience

Part-time general surgeon SpR, Weston-super-Mare

Anne Pullyblank is a flexible surgical trainee: an SpR in general surgery with a special interest in colopractology. She works 60% of full-time but has been able to maintain a high level of 'cutting time' by taking posts in hospitals where full-time registrars are at a premium. "There are a few opportunistic events that you might miss out on, compared to working full-time — a return to surgery, for example. But because of where I am, I think I get as much actual operating time as most full-time SpRs. In my last post I worked all my time with one Consultant, because he preferred that to sharing the full-time Registrar with another Consultant. Here, I'm working with two consultants and am operating for most of my time at work.



“Flexible training means it will be longer before I get to Consultant grade, but I think that’s a good thing for me as a surgeon. The more experience I get, the better. Getting to Consultant by 40 is early enough. I’ve got other things to do before then.”

Contact:

Anne Pullyblank

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Running two careers together

Flexible GP trainee and athlete, Manchester

John Rogers is an 800 and 1500 metre runner who has represented Northern Ireland at international level. Alongside his pursuit of success on the track, he has also been trying to develop his career as a doctor. After his PRHO period at Belfast City Hospital, he moved to Manchester to take advantage of the coaching facilities with the Sale Harriers club. For 2 years he became a locum in general medicine and surgery, working around 40 hours a week and arranging his athletics training around his clinical commitments.

“After two years I was getting frustrated with working as a locum,” says John. “There’s no training gain, there’s a lack of continuity, and you miss out on the follow-up with patients. Getting a place on the flexible training GP rotation really mattered to me. I was getting near to deciding on another career altogether: one which would allow me to make the most of the time I’ve got left to run at the highest level.”

After a period in general medicine, John now works in paediatrics. “I average 32 hours per week, working Tuesday to Friday with a 1 in 14 on-call. This allows me to fit my training commitments in with my work in a way I could not do if I was working full time.”

He is 29. “Joining the flexible training scheme means it will take me five years instead of three to qualify as a GP. But this has given me the opportunity to pursue my passion in life. Without it I might have dropped out of medicine completely.”

The combination has spin offs. John acts as team doctor with Sale Harriers and is making links with other practitioners in the field of sports medicine. “It’s already a specialty in its own right in some countries, and in the future I’d like to combine it with my work as a GP.”

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“This has given me the opportunity to pursue my passion in life. Without it I might have dropped out of medicine completely.”

A healthy balance for the sick doctor

Part-time SHO in community paediatrics

Laura Bennett is a flexible trainee in paediatrics. After several bouts of serious depression and a year out of clinical practice altogether, she opted to work part-time with the support of her medical team, occupational health and the Southwest Deanery.

“Full time work as a paediatric SHO was becoming increasingly difficult. The long hours and high work intensity were leaving me more and more tired and unfortunately increased my susceptibility to bouts of low mood. It became clear that for me to continue to function happily and successfully in my job there would have to be a major restructuring of my somewhat skewed work/life balance.

“I now work as a 50% flexible trainee, currently in community paediatrics. This allows me the freedom to look after my own health needs. I am able to have weekly psychiatric care but more importantly have time to learn to play the piano and to study ceramics at art college. I love my job and am happy. I am also well supported should I become ill again.

“Flexible training has given me the opportunity to stay in clinical medicine (medical retirement had been suggested as an alternative). There’s a tendency to view going part-time as a step down, but I’ve found that the opposite is true. I definitely get as many training and educational opportunities as when I was a full-time SHO, and I am offered a lot more flexibility. I think I’m gaining a broader learning experience than many of my colleagues.

“It will take me twice as long to train to senior grades but as a well doctor I am able to function effectively at work and at home. I feel satisfied that I am doing my job to the maximum of my ability. Looking after myself has been the first step in caring more effectively for my patients and colleagues.”

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Or contact the Doctors Support Network (see page 35)

Flexible working at senior level

Different approaches to the work/life balance

Steadily, the concept of flexible working at Consultant level is taking hold. The advantages for individuals are self-evident, but there can be important benefits also for delivery of services. Two or more people sharing one full-time role have greater flexibility about how and when the work is done than one Consultant alone. Trusts can recruit Consultants to match demand for services more precisely. It may suit both the employer and a part-time Consultant to work during an evening period which would be difficult for a full-time Consultant cover.

Part time Consultant posts can also be flexed to vary the sessions worked during the course of a year, for example term time working. Where there is a mix of doctors working flexibly, it may be mutually advantageous for those without children to cover more in school holiday periods and then have more time off while those with schoolchildren do more during term time.

As with all instances of flexible working, there are issues of professional validation, skills development and continuity of patient care to be considered. But the evidence is that Consultants in flexible roles pay special attention to these issues, and ensure that good practice is observed.

Dividing work time to raise a family

Community Physician and Consultant Radiologist, Teesside

Mark Aszkenasy became a Consultant Community Physician for Child Health in 1996. His wife, Moira Macarty, had already been appointed as a Consultant Radiologist in 1993. In 1998 their son Daniel was born, at which point Mark and Moira put into action the plan they had made from the start. Both switched into less than full time roles in order to share the responsibilities and rewards of bringing up their child. Mark worked three days a week in his community role; Moira worked two days a week at the James Cook University Hospital.

Four years on, both are glad about the decision they made. "I cram more in than I would for the same three days if I was working full time," says Mark. "We have managed to fit all my clinics into the three days, so I haven't lost any. I get in earlier and leave a bit later, and colleagues have been supportive. I do less audit and research than if I was working full time, but I've had more valuable first-hand learning experience about the realities of being a parent. As a community paediatrician that has to be an advantage for my work, even if it doesn't attract CME points."

For Moira, the decision has meant having less teaching time than she would have liked in her special area of paediatric radiology. Now they are expecting another child, and she is planning to 'retire' temporarily but will be looking to resume working part-time later. Once the family reach school age, Mark and Moira could start to put in more hours at work — especially during term time — and both envisage returning to full-time practice eventually.

"Being a parent is hard physical work and frustrating at times," says Moira. "But I'm glad neither of us are missing out on the experience. We've earned less, but we would rather have the extra time for our family at this stage in our lives."

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"I've had more valuable first-hand learning experience about the realities of being a parent. As a community paediatrician that has to be an advantage for my work."

“The response from colleagues and staff has been very positive. Two heads are always better than one.”

Two separate lives, one Consultant job shared Elderly care and general medicine, Southmead Hospital, Bristol

Nigel Jones and Kyra Neubauer share the role of Consultant Physician in elderly care and general medicine at Southmead Hospital. They first worked together at the same hospital in the early 1990s when Kyra was a Registrar and Nigel a SHO. Kyra moved into a part-time Senior Registrar role in Bristol for 4 years and then took a year off to be with her children. Nigel worked full-time through the training grades at various hospitals in the south west, but felt increasingly uneasy about his next step.

“I started to promise myself I wouldn’t work full time. I was one of the last to go through the old junior doctor system, and I could see that doctors who were my mentors were often unhappy about their continuing work commitments. I wanted an alternative.”

When they met up again at Southmead, Kyra proposed a solution. Unwilling to work full-time, she was by now acting as a Consultant locum doing 6 sessions a week. After two years she was ready for a change.

“Nigel and I had talked about finding different ways of arranging our working lives. He was now a Senior Registrar at the Bristol Royal Infirmary, and my locum job was covering for a full-time Consultant vacancy. I persuaded him that we could take on that job together.”

The pair had to convince the hospital and colleagues that the idea would work, and spent a short period as joint locums to trial the job share. They were then appointed together. Nigel works Tuesday, Thursday and Friday, dealing mainly with in-patient work in the ward. Kyra works on Monday and Wednesday, with a special interest in liaison work on complex needs in surgical and other specialties. Both are pleased with the results.

Kyra: "I had worked part-time for a number of years and there are disadvantages because work spills over into your own time and continuity of involvement is more of an issue. Here, we're two people doing one job, together — and I have three weekdays, just about, when I'm free to be a Mum. It's important that we share the same ethical approach, and can discuss cases openly. We look for agreement from the other, but disagreement can be positive too: producing new ideas. Or one of us might notice something that the other hasn't. It improves care. Patients and relatives appreciate it: getting a consistent view from two Consultants is often reassuring for them."

Nigel: "From wondering whether I wanted to stay in medicine at all, I now feel lucky to have a worthwhile job that leaves me time to enjoy life and pays me enough to live on. A three day weekend, most weekends, is great. We share a similarity of practice and style, and there's a clinical trust between us which is vital. Continuity of care was a concern but we have telephone discussions on each handover day and meet regularly for review sessions. The response from colleagues and staff has been very positive. Two heads are always better than one. And, if we hadn't been able to set up this jobshare, I'm not sure where I'd be."

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Term-time GP

Carolyn Mowat

Carolyn Mowat works 6 sessions a week during term time only at a four-partner GP practice in Cambridge. Since some 40% of its list are students, the arrangement suits the practice well. The post is Carolyn's latest in a series of flexible working roles that have accompanied bringing up three young children. "My family comes first," she says, "but I have been able to develop my career as well."

Having started training in hospital medicine, Carolyn moved towards GP training partly in anticipation of the problems that combining career and family might pose. "In the past I have worked full-time as an SHO in clinical oncology and obstetrics, spent a year in Australia, had a job share for a year, worked as a 3/4 time GP trainee, and done locum GP work. When we moved to Cambridge with my husband's job, I did a year of 4 sessions a week on the GP Retainer scheme, but the summer holidays were a nightmare. We were somewhere new and I had no local family network, so childcare was a big problem. At my appraisal I said I'd seen a term time only post with a GP practice at Norwich; my principal thought a similar arrangement should be possible for me. I now work Monday, Tuesday and Wednesday at the practice, but not at all during the school holidays."

“Making sure that the right information is passed on is vital. I tell all the patients I see regularly about the periods I’ll be away, and will talk through any special issues with their registered GP. But it hasn’t been difficult: the biggest wrench when you come back in after the summer is getting back up to speed with your computer skills. Any urgent paperwork that comes in gets dealt with in the same way as for any part-time working arrangement.”

Carolyn feels comfortable with her balance of family life and career. “In retrospect, deciding not to rush through the training grades to become a Principal has been a good move. I have been able to take more time and gain more life experience. Having children of your own is a real advantage when dealing with parents and children as patients.”

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Options in primary care

For doctors working in general practice who choose not to become a GP principal, other options exist. Working in Personal Medical Services (PMS) can enhance a doctor’s clinical job satisfaction by cutting out a level of bureaucracy and offering a greater degree of flexibility. Many doctors working in PMS are using the salaried GP option to help them balance their work and home life. PMS contracts are negotiated with the Health Authority and therefore give doctors the chance to target specific local issues. New opportunities are also opening up as a result of new roles in PCTs, GPs with special interests and the development of portfolio careers.

Flexible retirement

Options for doctors towards the end of their careers

Various options exist for salaried doctors approaching retirement age who may not want to give up work completely. These options ensure that their NHS pension will continue to accrue.

to wind down: instead of retiring completely, doctors can move into part-time working. Pension benefits for part-time staff are calculated on the whole time equivalent pay, and the time they spend working part-time will add, pro rata, to their eventual pension entitlement.

to step down: doctors with key skills and experience can, with the consent of their employer, step down into less demanding roles while having their eventual pension entitlement protected at the more senior level. Even without this arrangement to protect pension entitlement, final pension income will be calculated on pensionable earnings in the best of the last 3 years of employment.

to retire and come back: in most circumstances, doctors who retire can subsequently resume employment — part-time, full-time, or seasonally — without affecting their pension

a winter register: retired doctors may be happy to work for limited periods, especially in winter when activity levels are at their peak. These periods of work would have no impact on pension entitlement.

A pension helpline has been set up which doctors can call to discuss their various retirement options: 01253 774 440.

Flexible Retirement

A management perspective

Dr Anthony Morgan is Medical Director at Nottingham City Hospital where a number of doctors are working on after retirement in less than full-time roles. They have included surgeons, anaesthetists, histopathologists and physicians. “Typically, they are doctors who have wanted to go at 60 or soon after, but don’t want to cut off completely. It started when one doctor approached me with the idea, and it has grown from there.”

From an employer’s viewpoint, Dr Morgan sees a range of advantages in the arrangement: primarily, retaining the services of skilled and experienced doctors. “First I’ll consult with the Clinical Director to assess whether the arrangement would fit our overall staffing plan in that area. If it does, and I’m comfortable about funding for the post, then we can go ahead.

“The virtue is that we know their work, they know what’s needed, and they stay because they want to carry on working. In histo-pathology we have two part-time consultants who work complementary hours to give us virtually full-time cover. In other areas, the presence of retired, part-time doctors gives us more flexibility in making other appointments or enabling other doctors to reduce their hours.”

The Hospital has specific contracts for these doctors, usually giving a year’s security on both sides. “As with any other role, it’s important to have clear job plans to ensure value for money,” says Dr Morgan. “You also have to recognise that the arrangement will only be for a defined period: some have stayed just a year, others for 3 or 4 years. It can’t be an automatic right for doctors, it has to be compatible with the larger staffing picture. But it can be a worthwhile arrangement for both sides. I’m very happy with their contribution.”

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Working after retirement

Two doctors' views

David Ansell is a histopathologist who, after a short break at retirement at 61, is working 6 sessions a week at Nottingham City Hospital. He has been doing it now for 3 years. "I wanted to let go of my medical career gradually and this way I've gone back to doing the actual clinical things I like best. I work Tuesday, Wednesday and Thursday. Continuity of care is sometimes an issue, but perhaps less so in pathology than some other areas; and my colleagues are aware of the situation and supportive. It's an excellent arrangement for us. My wife is doing an MA at Nottingham University, I'm doing work I enjoy and continuing with professional development activity."

Christopher Howell is an orthopaedic surgeon who took retirement at 60 and — following the statutory calendar month break — resumed working 7 sessions a week: 5 in surgery and 2 in administration and teaching. "After 25 years as a Consultant I wanted to focus more on elective procedures, and I also wanted to commit time to my chairmanship of the Specialist Advisory Committee in Trauma and Orthopaedics which runs for 2 years. This arrangement allows me that scope. It's essential that the colleagues in your team agree with what you're doing and think it's a good thing for the department. What happens to your patients when you're not there has to be considered and the eventualities thought through with the rest of your team. But it is working well — for me and the department."

A flexible career in retirement

Part-time consultant on FCS

Ranjit Mal retired, aged 62, from his full-time post as a consultant otolaryngologist in 2000. He had been a consultant since 1974, but over the years his workload had crept relentlessly up as the service expanded and new treatments became available. 'I was leaving home at 8am, returning at 7pm and then spending two hours a night on paperwork,' he says. He decided that the time had come to relinquish some of the workload. He didn't want to retire completely, just cut down his hours: 'I am very fit with plenty of energy, and I would have liked to have carried on, but at the time there was no possibility of a part-time post,' he explains.

For the next two years Mr Mal had to be content with some locum work, until he received a letter about the Flexible Careers Scheme. He applied and quickly found exactly what he wanted – a substantive, part-time consultant post at one of the hospitals where he had previously worked. 'I do two sessions a week, Mondays and Wednesdays, starting at 9am and finishing at 1.30pm, which includes doing the paperwork.' So, he still has plenty of time to keep up to date by reading all the relevant professional journals and he has also become involved in research since retiring, publishing several papers.

'It find it very enjoyable, and it means that I am not wasting the skills that, after all, take a long time to acquire,' Mr Mal says. 'It would be a great shame to spend all day playing golf.'

For more information on the Flexible Careers Scheme, see page 13



3.

Professional & Personal Support

“Each of these [career] transitions involves significant shifts in levels and scope of responsibility, moving beyond the clinical into realms of management and leadership... It is vital that doctors are supported ... so that they are able to make an effective contribution from the start of each new role.”

“What singles doctors out as a group is the extraordinarily high expectations they set for themselves.”

Continuing professional development, mentorship and access to counselling services are features of good employment practice in any organisation. Structures exist among many professional groups in the NHS to ensure that these support mechanisms are available to staff. In this section are examples of initiatives which set out to address the needs of doctors. Given the cross-service generic nature of much of the content, these programmes draw on resources from outside the medical profession, and often benefit from taking place in multi-professional, multi-disciplinary groups.

By virtue of their role, doctors make decisions every day which have important consequences for patients and their families and friends. Workloads are heavy and there may be limited opportunity to share professional concerns with colleagues. At the same time, doctors in training grades have studies to follow and exams to pass. The pressures are considerable, but can be eased through appropriate support.

Doctors also make a series of marked transitions during their careers: from student to pre-registration house officer, to senior house officer to specialist registrar, to consultant or GP. Each of these transitions involves significant shifts in levels and scope of responsibility, moving beyond the clinical into realms of management and leadership. As doctor numbers rise, especially at consultant level, it is vital that doctors are supported through these transitions so that they are able to make an effective contribution from the start of each new role.

Guidance and support service for doctors

An independent counselling network for all grades, and skills courses for consultants

The Guidance and Support Service in the former Trent region has been in existence since 1994 to provide a confidential counselling service for doctors and dentists at all grades. The service was established by Roger Arkell at the Queen’s Medical School, Nottingham, but operates through a network of 6 independent counsellors located across the former region from Leicester to Barnsley. The network aims to see anyone who self-refers to the unit in less than 72 hours.

The reasons why doctors refer to the service are sometimes professional: stress, anxiety, disciplinary action or failed assessments. Others are more personal: breakdown of relationships, bereavement or health problems. Part of the function of the first meeting is to set parameters for what can be achieved in a four-session brief therapy course. Most referrals find the block of four one hour sessions sufficient to come to terms with the problems they are facing. In a few instances, the service will extend into a second block of sessions. The service is free to doctors in training. A small charge is made to senior doctors, or the cost passed to their department.

The Guidance and Support Service also offers a programme of counselling skills courses for Consultants. These are two day residential courses which set out to improve the inter-personal skills of Consultants in dealing with colleagues and junior doctors, raising awareness of the emotional state of others and the effects of their own behaviour. In the last 10 years over 900 consultants have attended the courses. Many subsequent self-referrals to the counselling service have come through word-of-mouth communication with doctors and dentists who have attended the skills courses.

The Service handled about 170 referrals in year 2001, and the number is growing every year as awareness of its services spreads. Val Evans is one of the independent counsellors in the network: "I think there is still some confusion among doctors and others about the role of personal counselling. Because I'm an outsider, doctors who come to see me can share ideas and thoughts that they couldn't with clinical colleagues... and I can ask simplistic questions which may start to offer another perspective. In my experience, what singles doctors out as a group is the extraordinarily high expectations they set for themselves, and the sense of failure they seem to have if they feel they're struggling."

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Learning to lead

Leadership and management development courses for Consultants, Tees and North East Yorkshire

Since 1999, Tees and North East Yorkshire Trust has run a series of 3 day courses for Consultants and Associate Medical Directors with the aim of improving the leadership skills of participants, and providing a broader picture of their role within the management of the Trust. This is a mental health, learning disability and community trust which has increased in size from 1,400 staff to 3,700 in just 5 years. The course focuses on the importance of the contribution of consultants as leaders, along with issues such as finance and business planning, and personal time management.

The programme starts on Thursday morning and finishes on Saturday afternoon, so participants usually take 2 days out of work time and 1 day of personal time. The course is staged at a hotel, away from work, with 10 - 12 delegates attending each one. This number enables an informal, interactive approach which characterises the programme. The courses are free to delegates, and are funded partly by the Trust and through sponsorship.

Several presentations are made by senior directors of the Trust. Delegates are able to question the directors and develop a fuller understanding of the specific issues that the Trust faces. External speakers include senior doctors, academics, and business and management specialists. An evidence-based session on leadership occupies much of the Friday. The Trust Chief Executive also attends a discussion over dinner on the Friday evening.

Feedback from the programme has been very positive. "The balance between information-giving and discussion around leadership and personality profile was just right," is a typical comment. Almost all Consultants at the Trust have now attended the introductory programme, and further courses on specific topics are now being planned plus possibly a new course developed specifically for training grade doctors.

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Preparing for practice

PRHO shadowing, Yorkshire Postgraduate Deanery

A shadowing programme for medical students in the period immediately after finals is helping ease the stresses that PRHOs feel when they start their first job. Under the scheme, all students due to start as PRHOs in the Yorkshire Deanery area do 3 week attachments in medicine and surgery at the hospitals where they will be working — usually shadowing the teams they will soon be joining.

“It provides a better, fuller introduction to the job and the hospital than a first-day induction can do,” says Steve Gilbey, Advisor to the Postgraduate Dean for the PRHO year. “Many students will already be familiar with the hospital from time they spent there during their course, but the shadowing period gives them the chance to experience the role and reflect on how well prepared they are for it.”

During the attachments, students take courses on Emergency Medicine and Perioperative Medicine to consolidate and practise their clinical skills. “It’s hands-on stuff to confirm what students have learned and help them identify strengths and weaknesses in their practice,” says Steve Gilbey. “Again it helps to prepare for the transition into that first PRHO post.” Performance of students on the attachments is assessed in terms of their professional attributes.

Besides students from its own schools, the Deanery tries to ensure that all new PRHOs coming in from outside the region follow the shadowing attachments. (Historically, these have been more than in most other regions.) Another recent “shadow” was a former pre-clinical academic returning to clinical medicine after a long period away. He found the experience very helpful.

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Mentoring training and networks for peer support North East

Mentoring networks in the North East provide doctors, dentists and nurses with opportunities to review their professional development and find support within a range of work-related situations. The networks have grown out of a mentoring training programme introduced by the Northern Deanery in 1995. Similar networks are also developing for GPs in the region. The networks offer co-mentoring training and support, and individual mentoring sessions. Reasons for seeking out mentoring may vary from stress or isolation at work to seeking a new challenge, or a change in work-life balance.

“My ability to manage my own professional life has improved greatly, particularly in the areas of priority setting, time management and crisis management. I am also much better equipped to help those who come to me for help’.”
Val Bythell,
Consultant
Anaesthetist

“Easily the most important professional development I have done since becoming a Consultant. It has impacted on every aspect of my professional life, dealing with patients, colleagues, meetings and pastoral care of other doctors”

Martin Ward-Platt
Consultant
Neonatologist

The training course is a skills based programme, run on one day per month for 6 months. Skills covered include active listening, exploring blind spots, and challenging in a supportive way. Mentors learn how to help their ‘mentees’ manage change effectively by developing possibilities, and testing commitment to appropriate goals. Mentors learn ways of encouraging their ‘mentees’ to identify different strategies to achieve their goals, before deciding which are most appropriate, and devising plans.

Training takes place in groups and participants bring their own current issues as material for skills practice. The experience helps participants with their own personal and career development, as well as providing insights into the stresses and pressures faced by those in other disciplines. While most participants are consultants, some GPs, dentists and a few senior managers are included in the groups, so learning is multidisciplinary. An annual workshop provides the opportunity for mentors to network with colleagues from other disciplines, hospitals and practices, and to refresh skills and share experiences.

To date, 250 people have been through the training programme. Doctors and dentists with mentoring skills are now helping to set up Consultant appraisal and personal development planning. One large teaching hospital is using its people with mentoring skills to help train Consultant appraisers and support Clinical Directors in making the process more worthwhile. Mentoring has also proved valuable in supporting staff who are faced with health problems or complaints from patients. In these cases, the ability to find a mentor from outside their own specialty and organisation can be of special importance.

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Support for doctors in difficulty

Illness and disability are non-discriminatory: they can affect anyone at any time. Doctors are not excluded, and for some the pressures of their work can increase the risks of mental illness. For doctors who are experiencing difficulties or distress, these networks offer help and support.

Doctors SupportLine

The Doctors SupportLine is an independent, confidential and anonymous help line with all calls answered by volunteer doctors. It offers peer support, encouraging doctors to talk through difficult issues, sometimes perhaps helping to divert a crisis. It is available to all doctors who wish to discuss issues of work or personal concerns relating to their health, work or relationships. An information resource provides details about resources that may be of value to doctors in distress.

Contact:

SupportLine 0870 7650001

BMJ Careers Chronic Illness Matching Scheme

The BMJ Careers Chronic Illness Matching Scheme provides the opportunity for doctors who have a chronic illness or disability to receive informal careers advice from another doctor. The scheme matches users with a doctor who either has the same illness/disability, or to someone who is working in a certain specialty. Users can also state whether they want to be matched with someone in the same grade or locality. Application is through an electronic form. Users' details and preferences are held in a secure database, pending a match with the requirements given. Then both doctors are sent the other's email address. The rest is up to them.

Contact:

Web site: www.bmjcareers.com/chill

Doctors Support Network (DSN)

A self-help group for doctors with experience of mental health problems. DSN aims to reduce the isolation and stigma felt by doctors with mental distress. The group is open to all doctors with problems relating to depression, stress, burnout, psychoses, eating disorders etc. It welcomes all, at whatever stage of their illness or recovery. DSN promotes contact with other doctors, facilitating mutual support. The Network believes that appropriate support can help to defuse a situation before a crisis develops.

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4.

New ways of working.

New support roles

“My main problem with being a training grade doctor wasn’t the number of hours we were asked to work, but the quality of experience we had during those hours....”

*S.J. Louise Nelson,
training grade
doctor, London*

Without changing the essential responsibilities and clinical leadership of doctors in the diagnosis and treatment of patients, it is possible to reconfigure ways of working and introduce support roles which help relieve unnecessary pressures. The examples in this section indicate the kind of initiatives that can be taken. The outcome of these initiatives is that the patient’s experience of NHS care — in the community and in hospital — is enhanced, and that doctors — at every level — feel they are performing more effectively and efficiently.

In many hospitals, significant progress has been made towards reducing the hours that training grade doctors work and ensuring that they get adequate rest. The presence of nurse practitioners, working in specific areas with extended roles, has been an important measure that has helped to achieve progress. Many trusts employ nurse practitioners to share some of the activities of training grade doctors, and they can help cover the night hours when some bleep calls may be routed to the practitioner.

The development and role of the nurse practitioner is a complex topic in its own right. However, there are other new roles being introduced with the specific intention of relieving the workload on doctors. In this section there are examples of these new support roles.

Administrative and clinical support for training grade doctors

Medical Group, King’s College Hospital, London

King’s College Hospital have introduced a new role of Administrative & Clerical Support Assistants to work with doctors in the Medical group. An Assistant has been attached to each of 3 firms for a range of tasks including the preparation of patient notes, collecting X-rays, and arranging for blood tests and other procedures to be carried out. The intention is that training grade doctors will be saved the time that can be spent on administration which requires little medical knowledge or skill.

Although introduced only as a pilot scheme, the idea has been taken up by the Haematology group to support doctors there, and the role of the Assistants is being reviewed to include phlebotomy where appropriate training has been given.



Mary Currie is the HR Planning Manager for the Trust. “The scheme has been well received by doctors; and the time it saves them helps us to achieve compliance with the New Deal. The Assistants do something similar to what a Ward Receptionist would have done in the past. There is an issue that doctors in training grades could miss out on learning what makes a hospital tick — they could get to a senior level without knowing how to order a blood test. But that’s something we’re aware of and will be monitoring. If the scheme is successful, then we will roll it out across other Departments in the near future.”

Recognising the particular needs of PRHOs as they start their first jobs outside medical school, Kings’ College Hospital has appointed a clinical facilitator to work alongside these doctors in developing their practical, clinical skills and to facilitate their transfer from student to doctor status.

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Easing pressure on admitting Medical Emergency Assistants, Southend Hospital

Since 1994, Southend Hospital has employed Medical Emergency Assistants (MEAs) to reduce workload pressure on doctors in training grades admitting emergency cases through the A&E Department. Subsequent reviews indicate that over 30 hours of doctors’ time is saved each week by the work that the two MEAs do. The parallel reduction in stress for on-call doctors has been evidenced in questionnaires. One commented that “the weekends were terrible without them.”

The MEA role was devised by the Medical Directorate as part of the response to the New Deal. Training grade hospital doctors, Consultant Physicians, senior nursing staff, and the Head of Personnel were all involved in designing the role which provides support to the Registrar or SHO when first on-call. The principal duties were initially to:

- ◆ obtain blood samples as directed by doctors, label and despatch for analysis
- ◆ complete non-clinical information on forms for X-ray and laboratory investigations
- ◆ introduce intravenous cannulae and set up lines as directed
- ◆ perform ECGs as directed
- ◆ operate the blood gas analyser
- ◆ liaise with laboratories
- ◆ contact the bed manager to arrange admissions
- ◆ maintain a list of admissions
- ◆ enter test results in patient notes.

The appointments committee for the new post included a training grade doctor. The first appointment was a former nursing auxiliary, who then completed a short initial training programme in the specific skills required. The programme is formulated to match NVQ level 3, and an NVQ assessor has been allocated. The enthusiastic response from doctors prompted appointment of a second MEA within a year, and an expansion of their role to include more procedures and organise refreshments for on-call staff when they are busy.

The role has been extended and an MEA now assists the second on-call SHO in Medicine at night. The MEAs are managerially responsible to the Clinical Director of Medicine, and are managed day-to-day by the on-call SpR or SHO. When there is no work for the Physicians, the MEAs help the on-call surgeons or A&E doctors.

The new roles have continued to be popular with doctors, and with the MEAs themselves. Their duties have been deliberately kept clearly defined to avoid confusion or potential overlap with other staff; their continuing technical competence is audited, with responsibility taken by a Consultant Physician. Initial concern about giving supervisory control of the MEAs to training grade doctors has proved unfounded; the day-to-day management has been important in the development of the posts. The working relationships between MEAs and doctors has been excellent, and the contribution of the MEAs is valued by these doctors.

A more detailed report on this initiative, including survey results, is available.

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5.

Environments that work better

As with all healthcare staff, doctors' clinical effectiveness and morale is influenced by the physical environment in which they work, and the systems that support their activity. One area of concern has been the quality of accommodation provided for on-call doctors who — almost uniquely among healthcare staff — have to spend nights at hospital on duty but not necessarily working on the wards all the time. Funds to upgrade on-call accommodation have led to improvements, and an example of these initiatives is included.

Other issues around the built environment of hospitals and other health centres apply to all staff. Information technology, digital imaging and communications have important consequences for day-to-day practice. They can help save time, reduce interruptions in work, and improve efficiency. Properly used, they become part of the enhancement of health care: enabling clinicians to access data more quickly, and share information and opinions in determining diagnoses and treatments.

The advent of electronic prescribing will make dispensing of medicines safer and more efficient. In varying degrees, the examples in this section will improve the ability of doctors to work more effectively and more comfortably. The impact of any project on the working lives of doctors and other staff should now be a key consideration in assessing the business case for investment in new facilities.

Cordless telephones for training grade doctors The Royal Marsden NHS Trust

As part of a larger project to update and improve telecommunications across its two sites, The Royal Marsden has introduced a digitally enhanced cordless telephony system (DECT) which enables cordless handsets to be provided to key members of staff. The cordless phones have been particularly useful for staff who previously had no fixed extension for receiving or making calls. Training grade doctors have been one of the groups to benefit most.

"The problem with a pager is that you have to interrupt what you're doing, go and find a phone, and make a call to discover whether you really need to be having the conversation at this time anyway. It's the diversion in your work that's often unnecessary; and there's also the measure of delay for the person who's trying to get in touch," says Gary Burkill, Deputy Director of Facilities.

"The problem with a pager is that you have to interrupt what you're doing, go and find a phone, and make a call to discover whether you really need to be having the conversation at this time anyway."

Cordless handsets are not 'mobile phones'. They don't work outside the hospital sites, and don't interfere with medical equipment. They function in the same way as domestic cordless handsets, and a network of 'base stations' has been installed to give coverage across the two sites. Users are able to make and receive internal and external calls, and can divert calls to a voicemail service or other extensions. They can turn the phones off altogether if they want to avoid interruption at critical times. The hospital sites are 20 miles apart — Sutton, Surrey and Chelsea, London — but staff who move between the two sites can use the same handsets on both, keeping the same extension numbers.

The cordless handsets were successfully piloted in 1999 with 30 staff from several disciplines. The Trust has now allocated over 500 handsets, at an approximate cost of £250 each — not dissimilar to a traditional internal pager. The main challenge has been responding to demand and prioritising distribution.

The ultimate aim would be to replace internal pagers altogether. At present, internal pagers are still required for emergency teams.

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Comfort zone

New on-call accommodation, Ealing

By the mid-1990s the quality of on-call accommodation at Ealing Hospital was recognised as a significant disincentive for training grade doctors to work at the hospital. The existing accommodation was remote from the main hospital building and had perceived security risks. Moreover, the rooms and flats were not up to the standards proposed in the "Hospital Accommodation Charter" prepared by the BMA in 1994.

The Trust considered the options of refurbishing the existing accommodation, sourcing accommodation off site, and converting other space, before deciding on a new building attached to the main hospital. A project team, including doctors, was put together to take things forward and a detailed specification agreed. The new block comprises 16 individual bedrooms, each with en suite facilities, telephone, and self-controlled heating. It has an independent access control system which means that on-call doctors don't need to carry keys. And direct access enables doctors to go to wards without having to go outside.

The effect of the new accommodation is to attract rather than deter training grade doctors in choosing Ealing Hospital as a place to work. This is supported by other initiatives taken by the Trust which includes an agreement negotiated with a local leisure club for all staff to have free access to the club's swimming pool, gym, classes, sauna, steam room and

"The effect of the new accommodation is to attract rather than deter training grade doctors in choosing Ealing Hospital as a place to work. "

jacuzzi. Training grade doctors especially appreciate this facility. The hospital nursery has also recently opened a baby unit which extends provision of childcare for staff to children from as young as 3 months.

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Pedal power

Cutting journey times between paediatric and neo-natal units, Doncaster

The general paediatric wards at Doncaster Royal Infirmary are located at virtually the opposite end of the hospital from the neo-natal and labour wards. For most staff this isn't a major problem, and there are plans to bring them closer together eventually. But, in the meantime, the distance between the two is a major issue for training grade doctors in paediatrics, who cover both units as part of their on-call commitment.

To reduce the time it takes to get from one to the other, the hospital supplies the doctors with bikes. The bikes were bought with funds from the Regional Task Force, and the hospital maintains them, arranges for punctures to be mended and carries out other running repairs. The route taken by the cyclists is all under cover, through passageways which are not used by patients. Health and safety factors were considered when the bikes were first introduced, and after 5 years there are no reports of casualties.

The training grade doctors can get from the paediatric ward to the labour ward comfortably in 8 minutes, as against 15 minutes if they had to walk and run. The time it saves can be invaluable.

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6.

Talking points

The IWL Standard requires that NHS Trusts who achieve Practice status by 2003 must be able to produce a portfolio of evidence which shows that they are improving working lives for staff. And it doesn't end here, after Practice status, trusts will be working towards Practice Plus. Here, it is even more critical that all staff are consulted in the process, including doctors. The people who often have the most practical ideas for how the way they work could be improved are staff themselves.

So, rather than a checklist, here are some questions that Trust managers and doctors may like to consider, separately and collectively, to see what progress is being made.

Flexible working

For doctors:

Would you be supportive of colleagues working with you part-time?

For managers:

What proportion of your medical staff are working less than full-time?

For doctors:

Do you feel services to patients could be extended if staff could be found to work outside usual working hours?

For managers:

Have you looked to offer opportunities to doctors who prefer to work outside the typical working day, extending services to patients?

For doctors:

Do you know what your options are around retirement?

For managers:

Are there mechanisms to ensure that doctors are informed about their retirement options?

For doctors and managers:

What mechanisms exist to bring together people whose different circumstances might combine to mutual advantage, e.g. job share, or a consultant nearing retirement who wants to take things easier being paired with a young consultant who wants to work flexibly?

For doctors and managers

How many senior managers and clinicians are there in your organisation who work reduced hours or who have spent periods during their careers working less than full-time, or not at all? What message does this send to other staff?

Professional and personal support

For doctors:

Where would you start with developing an idea that could improve working lives for you and your colleagues?

For managers:

Do doctors feel supported and well-managed in your organisation? And how do you know?

For doctors and managers:

How much multi-professional learning or training goes on in your organisation?

For doctors:

Do you feel sufficiently knowledgeable and skilled in areas outside clinical activity in order to do your job well?

For managers:

What support is available to training grade doctors and consultants as they move into new roles with wider areas of responsibility?

New roles

For doctors and managers:

Have the possibilities of recruiting support staff who could help training grade doctors in particular been explored in your organisation?

For doctors and managers:

Are you using skill mix to its full advantage?

For doctors and managers:

What extra clinical and administrative support have your training grade doctors received in the last two years?

Working environment

For doctors:

What extra administrative and office facilities do you think you need, and how could these best be provided?

For managers:

Do your doctors have access to administrative and IT support that enables them to concentrate on treating patients?

For doctors and managers

What impact has IT had on delivery of medical care in your Trust?

For doctors and managers:

What is the quality of your on-call accommodation? How could it be improved? And how will improvements be planned?

For doctors:

If you're a parent are you aware of your trust's policies and provision for childcare?

For managers:

What is your policy on child care, and how do staff find out about it?

For doctors and managers:

Are you linking in with other IWL initiatives across the organisation?



7.

Further information

For further information on the Improving Working Lives initiative visit www.doh.gov.uk/iwl

NHS Professionals

For further information on the Flexible Careers Scheme for Doctors and returning to work in the NHS
0845 60 60 345

NHS Pensions Agency

01253 774 440

Doctors SupportLine

0870 7650001

This is an independent, confidential and anonymous help line with all calls answered by volunteer doctors. It offers peer support, encouraging doctors to talk through difficult issues, sometimes perhaps helping to divert a crisis. It is available to all doctors who wish to discuss issues of work or personal concerns relating to their health, work or relationships.

BMJ Careers Chronic Illness Matching Scheme

This provides the opportunity for doctors who have a chronic illness or disability to receive informal careers advice from another doctor.
www.bmjcareers.com/chill

Daycare Trust

For information on childcare options
020 7840 3350
www.daycaretrust.org.uk

Doctors' Forum

To contact the Doctors' Forum email DF@doh.gsi.gov.uk

For information on appraisal and revalidation
www.revalidationuk.info

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