Association of British Neurologists

JOB PLANNING FOR NHS CONSULTANT NEUROLOGISTS AND CLINICAL ACADEMIC NEUROLOGISTS

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JOB PLANNING FOR NHS CONSULTANT NEUROLOGISTS AND CLINICAL ACADEMIC NEUROLOGISTS

The purpose of this document is to guide neurologists and clinical directors in structuring new posts or reviewing existing job plans. In order to ensure clinical safety, good governance, and welfare of consultant staff, it is a basic premise of this document that all relevant work performed as part of their role should be recognised within job plans, whether or not remunerated.

Neurologists should not work in isolation and should be attached to a specified Regional Neuroscience Centre (RNC), or be a member of a neurosciences network. If the expansion of consultant neurologists in a district general hospitals (DGH) means that it will be equipped to deal with the more complex patients, and supported in terms of specialist investigations (neuroradiology, neurophysiology, junior staff and appropriately staffed beds), such a unit is designated as a Neurology Centre (NC).

Neurologists should have a base hospital at which the majority of their clinical work is undertaken, and other duties performed. Preferably none should work at more than two trusts including their base hospital. Days split between two sites should be minimised whenever possible.

PROGRAMMED ACTIVITES

The consultant contract in England and Scotland (for Wales and Northern Ireland, (see Appendix 1) consists of 10 programmed activities lasting 4 hours (3 in premium time outside 7am to 7pm Monday – Friday in England and 8am to 8pm in Scotland) and a full time consultant will generally be expected to have 7.5 direct clinical care (DCC) and 2.5 supporting professional activities (SPA) in a working week of up to 40 hours.

These activities comprise:

- Direct clinical care & travelling time
- Supporting Professional Activities
- Additional NHS Responsibilities
- External Duties

For individuals working contracts with less than 10 PAs, the ABN takes the view that SPA activities should be proportional to the number of clinical sessions with a minimum of 1 SPA session per week required for a consultant to enable them to undertake employer's mandatory training, internal CPD, audit, appraisal, job planning and clinical governance activities to support revalidation.

Members should also refer to the Academy of Medical Royal Colleges (AoMRC)

advice on minimum SPA requirements for revalidation purposes (link). A minimum of 1.0 to 1.5 SPA is needed for revalidation activities with additional SPA allocated to activities described below.

Any additional activities, such as training or education responsibilities, undergraduate teaching, examining and lecturing, educational supervision, management meetings and activities (eg consultant/directorate business meetings, service improvement, rota management) required by the employer and agreed by the consultant, need to be recognised by the provision of additional SPA time in the job plan.

For clinical academic neurologists (Senior Lecturers/Professors), the 10 sessions are commonly divided in to 5 clinical (Trust/Health Board) and 5 University (research) sessions (see Appendix 2)

DIRECT CLINICAL CARE

Work directly relating to the prevention, diagnosis or treatment of illness including emergency duties (including emergency work carried out during or arising from on-call), ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, multi-disciplinary meetings about direct patient care and administration directly related to the above (including but not limited to referrals and notes). Time spent supervising specialist nurses and non-consultant career grade staff e.g. clinical assistants and GPs with Special Interest should also be included. Clinical supervision of trainees (eg discussing patients seen in a consultant's clinic) are DCC not SPA, and should be identified explicitly.

DGH based post.

The split between DCC sessions in the DGH and RNC will vary with each job.

No DCC sessions at RNC: If the neurology post is based at a larger DGH ("neurology centre") with:

1. A minimum of 4 consultants based on one site, with adequate local neuroradiology and neurophysiology services
2. Neurology registrar and junior staff, with a number of designated neurology beds with suitably trained nursing and support staff (eg located on a stroke unit)
3. Regular interaction with neurosurgery
4. CPD and audit activities

For more complex patients admitted to RNC, there would have to be agreement for RNC-based neurologists to provide cover for inpatients. It is the ABN view that working in a DGH without links to a specialist centre is not recommended. At a minimum, all neurologists should be linked to the RNC for their CPD, even if all other sessions are based elsewhere. This helps maintenance of good practice and shared learning.

0.5 – 1 DCC sessions at RNC: if there was no ward cover of inpatients at RNC or if the neurologist provided regular tertiary opinion on inpatients at RNC

1.5 DCC sessions at RNC: for example if neurologist did a sub-specialist clinic at RNC

2 DCC sessions at RNC: for example running a tertiary clinic, providing inpatient review or all the neurologist's inpatients were in the RNC with no agreed mechanism to cover those patients by RNC neurologists. Also needed for access to neuroradiology MDT.

More than 2 DCC sessions: this higher number of sessions at the RNC would have been agreed in advance between the DGH and RNC eg running a national or major tertiary service in addition to overseeing inpatients. Some DGH-based neurologists will have on call duties at the RNC which also need taking into account as DCC.

RNC based post with some DGH clinical duties

The sessions at the DGH are most likely to be delivering OP clinics with or without specified time to see ward referrals (all DCC),
Split days should be avoided where possible to minimise travel time.
Where travel time between sites is significant, it needs to be factored into the job plan (as DCC).

RNC or NC based post

When the post is solely based at the RNC or NC, the structure of the week is straightforward on a recommended 7.5/2.5 (DCC/SPA) split.

Outpatient clinical activity

The number of outpatient clinics will depend on other duties, in particular the amount of inpatient work. The ABN recommends that a job plan of 10 PAs should normally contain between three and four outpatient sessions in a week including subspecialty clinics, each of which will normally be a full (4 hour) programmed activity. The ABN recommends that an additional 50% (2 hrs) per clinic is included in direct clinical care for:

- Dictating and signing off clinical correspondence pertaining to the outpatient episode
- Time taken in administration relating to patients attending clinics, including arranging and reviewing investigations and giving any further opinion/advice between clinic visits to GPs, other colleagues or patients.

- Some trusts may have formalised "virtual or phone clinics"; these should count as DCC where the time taken is equivalent to that for an outpatient follow-up. It would be unusual for new patients to be seen in this way, but where this is done, the new patient time equivalent should be used.
- Grading referrals, triaging, email advice and correspondence or other activity related to this should be counted as additional work (DCC). It is recognised that this may be performed by a subset of consultants.
- Such administration may vary significantly between general neurology clinics and subspecialist clinics and some complex subspecialty clinics may need up to 1DCC per clinic for admin time by local agreement.
- The time allocation may also vary depending on the level of admin support provided, and the time requirement for electronic management systems. Local audit would be the appropriate mechanism to allocate this.

It is expected that the number of clinics per year would take account of other clinical duties including ward work, attending weeks, teaching, holidays and study leave and be between 38 and 42 clinic weeks per year. Cover for colleagues, particularly when working in teams where this impacts workload should be taken into account.

Definitions of new and follow-up patients are found in Appendix 3. The recommended minimum time per general neurological out-patient is:

• New patient	30 minutes for a consultant
	40 minutes for a specialist registrar
• Follow-up patient	15 minutes for a consultant
	20 minutes for a specialist registrar
• Complex follow-up	30 minutes for a consultant
	40 minutes for a specialist registrar

It is anticipated that sub-specialist clinic appointments would be of longer duration, and up to 60 minutes should be available for a new patient referred to a defined sub-specialty clinic, with 30 minutes allocated for follow-up slots in these clinics.

If there is a trainee in a clinic, the consultant's list should be reduced by 25%. For example, in a 4h training or teaching clinic, the altered template should be:

6 new patients, or equivalent NP/FU mix) for the consultant and
5-6 new patients, or equivalent NP/FU mix for the trainee (depending on experience)

Proscribed new to follow-up ratios should be discouraged as they will depend

very heavily on the type of clinic being done. There will be a very different new to follow-up ratio for a general neurology clinic than for a specialist clinic for a chronic disease such as epilepsy or Parkinson's disease and the ratio will clearly also be dependent on the quality of the GP referral (for example, a low quality referral that requires no follow up will result in a low ratio).

The complexity of cases seen should also be considered. It is recommended that individuals with long-term neurological conditions and complex needs be allocated more time where they are seen for annual follow-up. These patients should be allocated a double follow-up clinic slot (complex follow-up).

The time requirement for electronic ordering of tests and use of other digital systems should be considered. This is anticipated to be at least 5 minutes per patient, but should be validated with local audit. The number of patients per clinic will need to be adjusted appropriately.

Specialist clinics

These maintain and enhance consultant expertise and development. They also provide a core to train Specialist Registrars and to develop and interact with support services – for example nurse specialists, therapists and so improve patient care. They should be encouraged in job plans.
With more complex cases being seen, longer appointment slots may be required, depending on the specialty (40 -60 min rather than 30 min). Similarly, specialist clinic follow-ups likely to require 30 minutes for follow-up (equivalent to complex follow-up). New to follow-up ratios will be different depending on the clinic, and therefore of little value as a monitor of patient care.

Some specialist clinics – eg Parkinson's, epilepsy and MS clinics will be organised in the DGH where specialist nursing support is available as the conditions are common, and they could easily link with similar clinics in the RNC if desired. Networking with other similar clinics is important to maintain high skill levels.

Other specialist clinics may only be possible in the RNC, for example epilepsy surgery and deep brain stimulation for Parkinson's disease, because of their rarity, multi-disciplinary nature and requirement for specialist investigations.
As part of the regional governance structure, specialist MDTs e.g. multiple sclerosis disease modifying treatment MDTs where patients within the region are discussed should be included as part of DCC for the DGH.

Advice and guidance

Where a large volume of queries by email or letter for advice and guidance in preference to a GP sending an outpatient referral are received, or are set up as part of a formalised system, the time taken for this should be accounted for separately as part of a job plan. It is anticipated that this will become an

increasing part of the neurologist's workload. It is estimated that a completed advice letter will take a minimum of 10 minutes for the purposes of job planning.

Travel

Where consultants are expected to spend time on more than one site, travelling time to and from their main base to other sites must be included as working time within a programmed direct clinical care activity, either as additional paid time or by a corresponding reduction in clinical activity to allow for travelling. Working at more than 2 sites is not advised, and should be considered exceptional. Arrangements should be made for consultants returning to site during the day following external clinics.

Electronic records

Electronic clinical management systems vary, but may require significant time commitment to use effectively and safely. The requirement for electronic dictation, investigation ordering and results checking is particularly marked for outpatient activity. Systems should be in place to account for this. Additional DCC time should be added to clinic activity where local audit identifies an additional time requirement.

Inpatient clinical care

This may take the form of ward rounds, consulting on other inpatients (ward liaison) and care of emergency admissions. Most job plans will include 1 – 3 direct clinical care PAs for this purpose, including all administration consequent upon this work. Ward liaison sessions and accompanying administration should be included to take account of the average number of patients seen. An average ward referral may take between thirty to sixty minutes depending on circumstances. On average therefore, 4-5 ward referrals will be equivalent to one PA.

The following activities should also be included

- Liaison with multidisciplinary teams including neuroradiologists, neuropathologists, nurse specialists and other staff.
- Discharge planning including writing discharge summaries or letters on ward reviews seen
- Family meetings

Emergency and on-call clinical activities

Predictable emergency work takes place at regular times, e.g. as a consequence of a period of on-call work. The number of hours regularly worked whilst on-call is assessed prospectively and built in to the consultant's weekly direct clinical care PAs. If on-call work takes place during premium time, three hours of work

will count as one PA, rather than four. To illustrate this: if when on call for the weekend a consultant normally does a 3-hour in-patient ward round and review of referrals each day, then as these hours are in premium time these 6 hours of work will count as 2 direct clinical care PAs. These will then be averaged over the rota cycle so if the on call is 1 in 4 this regular, predictable, weekend work will count as 0.5 PAs per week; for a 1 in 8 this would be 0.5 PAs per fortnight etc. A similar calculation can made for predictable on call work done on weekdays such as an evening ward round.

Unpredictable on-call work ("emergencies") is work done whilst on-call and associated directly with the consultant's on-call duties e.g. recall to hospital. This should also be assessed prospectively and built into the direct clinical care PA allocation in a similar fashion.

Where 'Consultant of the Week'/'Attending' arrangements apply, local circumstances of the working pattern will need taking into account and annualisation of DCC and SPA may be appropriate. One model is where 'attending' consultants routinely cover inpatients and all ward referrals at the RNC (or NC/DGH if based there) for a week at a time; and/or do daily MAU retrieval rounds or ward rounds; and/or cover stroke thrombolysis for fixed days/weeks at a time. There may also be 'hot' clinics through the week and 'routine' clinics may be cancelled in favour of this acute work. In these patterns of work such weeks may include long days (eg 8-6, 8-8) and a different DCC:SPA ratio than 'normal' working weeks – eg rather than a 7.5:2.5 'normal' week. Such "attending' weeks might perhaps be 9:1 or 10:1 or 10:2 depending on local arrangements. If such weeks do include a higher proportion of DCC than usual then this must be annualised and balanced out with lower DCC proportions in other weeks, depending on rota frequency.

Example:

10 consultants do an 'attending' system, which needs cover 52 weeks of the year.

Each consultant therefore does 5.2 weeks/year 'attending'

Annual/study leave will only be taken in non-attending weeks hence all of these 5.2 are delivered by each consultant each year

If there are 10DCC in an 'attending' week then 52 DCC are worked per annum

Taking a notional 10 weeks of annual, study and Bank Holiday weeks (more if professional leave is granted above this) then on a standard 10 PA contract of 7.5:2.5 then (7.5x 42) DCC = 315 DCC sessions must be delivered in total each year (and 105 SPA sessions).

(315-52) = 263 DCC available for the other 'standard' weeks, of which there are (42-5.2) =36.8.

Thus in each 'standard' week, 7.1 DCC sessions are required not 7.5 in order to deliver the annualised total of 315.

Additional direct clinical care PAs
These should include time for administration, i.e. one extra clinic would be equivalent to 1.5 PA.

Multidisciplinary Team (MDT) meetings
Multi-disciplinary meetings are an important aspect of clinical care, particularly in relation to patients with complex treatments and care needs, requiring liaison of multiple professionals. This activity is counted as DCC, not SPA. The time required will depend on the number of patients, their complexity, frequency of such clinics, the level of specialist input needed, and the urgency of clinical decision-making that the clinic supports. These meetings should include time for administration, and should also have administrative support.

SUPPORTING PROFESSIONAL ACTIVITIES (SPA)
Advice from the Academy of Medical Royal Colleges on minimum SPA requirements for revalidation purposes is attached. The BMA recommends that 2.5 PA be allocated for SPA; the ratio for those who do not work 10 PAs should be 7:3, with a lower minimum of 1.0 PA allocated to SPA. SPAs underpin good clinical care and include:

Continuing professional development
Continuing medical education must be included in the job plan. We recommend as a minimum the equivalent of 1 PA or 2 half PAs for attending post-graduate educational meetings and for private study. On occasions, attendance at such meetings will involve the neurologist in teaching colleagues and neurological trainees. The provision and funding for 10 days per annum study leave for consultant neurologists is mandatory. Journal reading is acceptable CPD.

Clinical governance, audit, appraisal/revalidation and administration
Provision must be made in the job plan for local clinical management, governance, unit meetings, audit and other meetings to support patient care and service development. Time has to be allocated to update personal appraisal portfolio and complete the revalidation process. There will also be a requirement to complete Trust mandatory training programmes (infection control, manual handling, fire training etc. (0.5-1PA). Where neurologists act as appraisers of other medical professionals, the time should be acknowledged and accounted for

in the job plan.

Education and teaching of neurological trainees, other health professionals and students

Allowance must be made for educational supervision and training needs for neurological and other trainees. The extent of this allowance will vary considerably depending on the role and seniority of a participating trainee, whether non-participating health professionals are present and whether undergraduate students needing teaching are present (0.5-1PA). Elective students and supervision of other health professionals (e.g. physician assistants) should be recognised appropriately. There should be provision for supervision of new consultants as required.

Recognised roles may include the following:
Named educational supervisor (0.25 PA/week/trainee)
Named clinical supervisor (0.25 PA/week)
Training programme director (1 PA MINIMUM/week/40 trainees)
Foundation programme director (1 PA MINIMUM/week/30 trainees)
Director of medical education/clinical tutor (3-5 PAs/week)

Research and development

Consultants should be encouraged to continue research and PAs should be made available for this activity through appraisal and the job planning process. The time allocated for this purpose can be calculated from NIHR portfolio templates (or equivalent) identifying consultant activity. Responsibility for direct management of clinical trials should be counted as DCC, not SPA.

Undergraduate education

This varies e.g. between University NHS Trusts and "non-teaching" trusts, but should be an identified component of the job plan if it is delivered on a regular basis (1 PA/week). Supervision of undergraduate research projects should be recognised, and should typically attract 0.25PA per fortnight. A similar role may be performed for postgraduate research supervision where appropriate.

Examples of SPA allocation

The distribution of SPAs will vary between jobs, also depending on the size of the DGH (see above for definition of "neurology centre"). Job planning should accommodate the whole department, and allocation should take account of this at an individual and departmental level.

1.0 SPA: for CPD/interaction with colleagues. A number of factors have to be in place to make this acceptable in a job plan. This would be a larger DGH, effectively a neurology centre with 4-5 neurologists and regular internal CPD meetings.

1.5 SPA: as above, with additional duties such as audit and governance, undergraduate or postgraduate teaching being undertaken at RNC, NC or DGH
2-2.5 SPA: if fewer than 4 neurologists are allocated to the DGH or there was minimal access to supporting activities available in the DGH. Depending on activities performed, this could be divided into: 1 SPA for CPD, 0.5-1.5 SPA for audit, governance, teaching, research, educational supervision and appraisal
3 SPAs: In Wales, the standard job should have 3 SPAs with a designated commitment to teaching in addition to other activities.

ADDITIONAL NHS RESPONSIBILITIES

These responsibilities, which are not usually undertaken by the generality of consultants, should be agreed between a consultant and their employing organisation and which cannot be absorbed within the time that would normally be set aside for Supporting Professional Activities and could include:

- Medical Director or Director of Public Health
- Clinical Director or lead clinician
- Caldicott guardian
- Clinical audit, or governance lead
- Undergraduate or postgraduate dean
- Clinical tutor or regional education adviser
- Trained appraiser

Some of the above will have allocated sessions. The benefit to the local service of this type of activity should be recognised, and taken into account in job planning.

EXTERNAL DUTIES

These might include trade union duties, inspections for the Care Quality Commission (CQC), acting as an external member of an Advisory Appointments Committee, undertaking assessments for the NHS Resolution Service, work for the Royal Colleges in the interests of the wider NHS e.g. examining or SAC, work for a Government Department, NICE or specified work for the General Medical Council and work for the ABN. These duties should be agreed between a consultant and their employing organisation

LOCUM CONSULTANT POST

It is recognised that trusts will appoint locums for the short or medium term to deal with workload pressures or as part of a process of establishing a substantive post. For a short period, these posts may contain more clinical activity than in a substantive post. The ABN feels strongly that

1. Locum posts should not continue indefinitely and that their occupants should be offered the opportunity to progress their careers.
2. The substantive post created following a locum period should conform to job planning recommendations as described above.

In employing a locum there should be provision for a minimum of 1 SPA session for CPD, audit and clinical governance. Other requirements such as teaching and supervision would attract additional SPA sessions.

APPENDIX 1: ARRANGEMENTS IN WALES AND NORTHERN IRELAND

Wales

The basic working week will consist of 37.5 hours on average, consisting of 10 sessions of 3-4 hours duration (hence depending on each individual PA length recommendations for booking clinics will need adjustment appropriately).
There should typically be 7 direct clinical care and 3 supporting professional activities PAs
Only the first 3 hours of predictable on call work per week can be counted as a direct clinical care PA.
There is no clear definition of times when premium rates for emergency work shall apply and no premium rate is set for non-emergency PAs scheduled outside normal working hours. The existing scheme for out of hours intensity supplements will apply, at enhanced rates, rather than the new availability supplement.

Northern Ireland

The current consultant contract of a minimum of 10 PAs of 4 hours each, with typically a split of 7.5 DCC and 2.5 SPA.

APPENDIX 2: JOB PLANNING FOR CLINICAL ACADEMIC NEUROLOGISTS

For Clinical Academics (Clinician Scientist Fellow holding an Honorary Consultant contract/Senior Lecturer/Reader/Associate Professor/Professor), the division of weekly PAs will vary and be agreed between the employer (typically a University) and the relevant NHS Trust, taking into account the requirements of the primary funding stream (e.g. UKRI, NIHR)

Typically, there will be at least 50% of the job plan dedicated to research activity.

Where the consultant is doing clinics, ward referrals or any on-call commitment, it is vital that there is access to a weekly neuroradiology MDT and to a clinical departmental meeting including governance meetings.

It is expected that 1.0 to 1.5 SPAs are required for continuing professional development, audit, governance including local 'mandatory training' elements, appraisal and medical student teaching

Examples are given below:

Example 1
2 outpatient clinics – 1 general and 1 specialist (3 DCC)
neuroradiology MDT (0.5 DCC)
Audit/governance/appraisal/teaching (1.5 SPA)

Example 2
1.5 clinics (2.25 DCC)
ward referrals/thrombolysis (0.5 DCC)
referral management (electronic advice) 0.25 DCC
neuroradiology MDT (0.5 DCC)
Audit/governance/appraisal/teaching (1.5 SPA)

Example 3
1 clinic/week [e.g., 1 general clinic weekly alternating with specialist] (1.5 DCC)
2 ward rounds/referrals/MDT (1 DCC)
On call, predictable and emergency (1 DCC)
Audit/governance/appraisal/teaching (1.5 SPA)

All the recommendations for NHS consultant job planning apply (clinic template, travel etc) as do those regarding additional duties.

APPENDIX 3: DEFINITIONS OF "NEW", "FOLLOW-UP" AND "COMPLEX FOLLOW-UP" PATIENT

"New patient" - new to the local neurology service or previously known but not been seen for over 12 months. Patients referred within centres to a neurologist not previously involved with their care, and patients previously seen by a locum will be new to the neurologist, and should be counted as new patients.

"Follow-up patient" - known to the local neurology service and had contact with the service in one form or another in the last 12 months.

"Complex follow-up patient" – known to the local neurology service with a long-term neurological condition, and ongoing complex needs, where the neurologist remains the primary healthcare professional providing care and the patient has had contact with the service in the previous 12 months.

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USEFUL LINKS:

http://bma.org.uk/practical-support-at-work/contracts/job-planning

https://www.aomrc.org.uk/reports-guidance/advice-on-spa-in-job-planning-0210/