Association of British Neurologists

JOB PLANNING FOR NHS CONSULTANT NEUROLOGISTS AND CLINICAL ACADEMIC NEUROLOGISTS

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ASSOCIATION OF BRITISH NEUROLOGISTS

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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 hospital (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.

Mentorship and/or support should be provided for consultants who are new to a role or returning from extended leave, where appropriate.

Programmed Activity (PA)

The consultant contract in England and Scotland (local arrangements may vary for Wales and Northern Ireland) consists of 10 programmed activities lasting 4 hours (3 hours in premium time outside 7am to 7pm Monday – Friday in England and 8am to 8pm in Scotland). There is a minimum requirement of 1 session supporting professional activities (SPA) to support revalidation. For those working full-time or following a traditional career path a consultant will generally be expected to have 8 direct clinical care (DCC) and 2 supporting professional activities (SPA) in a working week of up to 40 hours. If additional SPA activities are undertaken beyond this allocation, this would be expected to come with additional payment or appropriate reduction in clinical activity.

These activities comprise:
- Direct clinical care & travelling time
- Supporting professional activities
- Additional NHS responsibilities
- External duties

Job plans should also consider those with non-traditional career paths, such as part-time work or those returning from career breaks, ensuring that they are equitably supported in their professional development. For individuals working part-time with contracts of fewer than 10 PAs or with other flexible arrangements, the ABN takes the view that SPA activities should reflect the activity and not necessarily be proportional to the number of clinical sessions. These individuals should be supported to meet their professional obligations. The minimum of 1 SPA session per week is 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. Additional activities are discussed in detail later in this document.

Members should also refer to [LINK]:
https://www.england.nhs.uk/wp-content/uploads/2022/05/consultant-job-planning-best-practice-guidance.pdf

For clinical academic neurologists (Senior Lecturers/Professors), sessions are commonly divided into clinical (Trust/Health Board) or university (research) sessions (see Appendix 1).

For appointments across sites (see below), the SPA could be shared proportionately between the two sites or could be at the site at which the primary contract is held.

Direct Clinical Care

Work directly relating to the prevention, diagnosis or treatment of illness including: emergency duties (as well as 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, advanced care practitioners, allied health professionals, physician associates and non-consultant career grade staff such as clinical assistants and GPs with Special Interest should also be included. Clinical supervision of trainees (e.g. discussing patients seen in a consultant's clinic) are DCC not SPA, and should be identified explicitly.

Newer aspects of DCC include advice and guidance and active triage/remote management of cases for "new" patients not currently under neurology.

In addition, the number of contacts between appointments for existing neurology patients has also increased, whether from GPs, allied health professionals or patients directly. This has been driven by the introduction of Patient Initiated Follow-Up pathways, increasing complexity of treatments used in neurology and the perception of a reduction in ability to contact primary care.

1. EMPLOYMENT MODELS FOR NEUROLOGISTS

To ensure equity, it is important that workload and opportunities for professional development are balanced across all neurologists, regardless of their base location. Job plans should be reviewed regularly to prevent the overburdening of certain individuals, particularly those in more isolated posts.

DGH-Employed Post:

The split between DCC sessions in the DGH and RNC will vary with each job. Some DGH-based neurologists will have on call duties at the RNC which also need taking into account as DCC.

- *No DCC sessions at RNC:* This would only be recommended if the neurology post is based at a larger DGH ("neurology centre") preferably 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 (for example, located on a stroke unit)
3. Regular interaction with neurosurgery
4. CPD and audit activities

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. For more complex patients admitted to RNC, there would have to be agreement for RNC-based neurologists to provide cover for inpatients.

- *0.5 – 1 DCC sessions at RNC:* for ward cover of inpatients at RNC and/or if the neurologist provided regular tertiary opinion on inpatients at RNC

- *1.5 DCC sessions at RNC*: as above and a sub-specialist clinic at RNC

- *2 DCC sessions at RNC:* this might be job-planned to run a tertiary clinic, providing specialist inpatient reviews and for cover of inpatients transferred from DGH. These sessions may also be needed for access to neuroradiology MDT or to lead specialist MDTs such as epilepsy surgery or MS DMTs.

- *More than 2 DCC sessions:* this higher number of sessions at the RNC would have been agreed in advance between the DGH and RNC and might attract a joint contract.

RNC Based Post with DGH Clinical Duties:
The sessions at the DGH are most likely to be delivering outpatient 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 usual 8:2 (DCC:SPA) split.

2. OUTPATIENT CLINICAL ACTIVITY

The number of outpatient clinics per week 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 three to four outpatient sessions a week including subspecialty clinics, each of which will normally be a full (4 hour) programmed activity. The ABN recommends that at least an additional 50% (2 hrs) per clinic is included in direct clinical care for time taken in administration relating to clinic attendance, either immediately after the appointment or with a delay. These include:

- Providing outcomes from clinic
- Issuing one-off prescriptions
- Dictating, editing and signing off clinical correspondence pertaining to the outpatient episode.
- Arranging investigations
- Reviewing and communicating investigation results

The time required for this may vary considerably and could be adjusted by local agreement for specific clinics. In other clinics such as some botulinum toxin injection clinics less administration time may be required. Administrative support should be equitably distributed based on individual workload and needs.

Some trusts may have formalised virtual or phone clinics; these should count as DCC where the time taken is equivalent to that for a face-to-face outpatient follow-up. While unusual for new patients to be seen in this way, the new patient time equivalent should be used.

There should be flexibility in scheduling out-patient sessions, particularly for those with caregiving responsibilities or other personal needs. Job plans should be adaptable, allowing for adjustments in clinic scheduling.

Clinical Contacts in Between Appointments:

This includes advice and guidance, recurrent prescriptions and medication monitoring, PIFU contacts, letters for example for education, work, transport, benefits.
Additional time should be allocated in job plans identified by local agreement, depending on, for example, the patient cohort, duration in post, availability and expertise of specialist nurses /advanced care practitioners. Because of the variable factors contributing, it is difficult to dictate a set time allocation. However, as a guide, 30 minutes of clinic time per week should be reserved for urgent/PIFU queries.

Clinic Numbers and Templates:

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 affects workload should be taken into account.

Definitions of new and follow-up patients are found in Appendix 2. The recommended **minimum** time per general neurological out-patient is:

- New patient: 30 minutes for a consultant, 40 minutes for a specialist trainee
- Follow-up patient: 15 minutes for a consultant, 20 minutes for a specialist trainee

It is anticipated that sub-specialist clinic appointments (for patients referred from a consultant neurologist to another) would be of longer duration, and 40-60 minutes should be available for a new patient referred to a defined sub-specialty clinic, with 20-30 minutes allocated for follow-up slots in these clinics.

If there is a trainee in a clinic who is not supernumerary, the consultant's list could be reduced by 25% for very junior trainees where a consultant face to face review is also needed. For example, in a 4h training or teaching clinic, the altered template should be 3 hours rather than 4 hours for the consultant and 4 hours for the trainee. However, for more senior trainees, this may be counted as DCC outside clinic time.

Prescribed new to follow-up ratios should be discouraged as they will depend very heavily on the type of clinic being done and the number of years someone has been in post. 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 Parkinson's disease. The ratio will clearly also be dependent on factors such as local triage/advice and guidance provision and the pattern of GP referrals (for example, a referral that requires no follow up will result in a low ratio). The guidance from GIRFT on discharge and follow up should be used to help guide appropriate discharge/follow-up (link on page 11).

Specialist Clinics:

These maintain and enhance consultant expertise and development. They also provide a core resource to train Specialist Trainees 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.

Cohorting of patients with Parkinson's disease, epilepsy and MS into clinics can be organised in the DGH as the conditions are common. There should be specialist nursing support available, and they could potentially link with similar clinics in the RNC. Networking with other similar clinics is important to maintain governance, share learning and provide more uniformity across a region.

Sub-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 neurologist where appropriate and relevant.

Patients not under Care of Neurology - Advice and Guidance/Referral Triage/Remote Management:

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 if referrals are managed with advice rather than an allocated appointment, 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. The time taken for this will vary depending on, for example, the local system employed, local referral patterns, local pathways for investigation or remote advice and management. This should be counted as additional work (DCC). It is recognised that this may be performed by a subset of consultants. Audit should identify time spent per patient.

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.

It is critical that travel arrangements and job plans consider the needs of those with disabilities, those who cannot easily travel or those with care giving responsibilities.

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.

3. INPATIENT CLINICAL CARE

This may take the form of ward rounds, consulting on other inpatients (ward liaison and specialist review for colleagues) 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 20 - 40 minutes depending on circumstances for example local referral patterns, whether or not remote advice is possible, hospital size, support from allied health professionals, whether the patient is new or known to neurology. Complexity may vary between RNCs and DGHs.
For all these factors, local audit should identify the number of and time spent per referral and job plan time allocated accordingly.

The following activities should also be included

- Liaison with multidisciplinary teams including neuroradiologists, neuropathologists, nurse specialists and other specialist staff.
- Discharge planning including writing discharge summaries or letters derived from ward reviews
- Pharmacy queries and prescribing time

- Discussion with relatives
- Supervision of trainees and other health care professionals for direct patient care

Emergency and On-Call Clinical Activities:

Predictable emergency work takes place at regular times as a consequence of a period of on-call time. The number of hours regularly worked whilst on-call should be assessed prospectively and built into the consultant's weekly direct clinical care PAs. If on-call work takes place during premium time, three hours of work (rather than four) will count as one PA. Flexibility in on-call schedules should be offered, where possible, to accommodate individuals with disabilities, caregiving responsibilities, or other personal circumstances, ensuring that these requirements do not disproportionately affect any group. This might include for example job-sharing arrangements for on-call duties or flexible scheduling.

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 weekend in 4, this regular, predictable, weekend work will count as 0.5 PAs per week; for a 1 in 8 this would be 0.25 PAs per week etc. A similar calculation can made for predictable on call work done on weekdays such as an evening ward round. Local arrangements to take some of the predictable activity as "time off in lieu" may be negotiated.

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, the local working pattern will need to be taken into account and annualisation of DCC and SPA may be appropriate. If such weeks include a higher proportion of DCC than usual then this must be annualised and balanced with lower DCC proportions in other weeks. Annualising activity in job plans will aid with these calculations.

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 10 DCC in an 'attending' week then 52 DCC are worked per annum
Assuming 10 weeks of leave per year and a standard 10 PA contract of 8:2, then (8x 42) DCC = 336 DCC sessions must be delivered in total each year (and 84 SPA sessions).
(336-52) = 284 DCC available for the other 'standard' weeks, of which there are (42-5.2) =36.8.
Thus, in each 'standard' week, 7.7 DCC sessions are required not 8 in order to deliver the annualised total of 284.

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 and the frequency of meetings. These meetings should include time for administration and should also have administrative support.

4. SUPPORTING PROFESSIONAL ACTIVITIES (SPA)

Advice from NHS Improvement on minimum SPA requirements for revalidation purposes is referenced below, namely 1--1.5 SPAs with additional SPA for extra responsibilities. For consultants working less than full time, the number of SPA sessions should be in proportion to responsibilities rather than a pro rata system.

The distribution of SPAs will vary between jobs. Job planning should accommodate the whole department, and allocation should take account of this at an individual and departmental level; team job planning may be in place in the trust.

Continuing Professional Development:
Continuing medical education must be included in the job plan. We recommend as a minimum the equivalent of 1 PA for attending post-graduate educational meetings and for private study. The provision and funding for 10 days per annum study leave for consultant neurologists is mandatory.

Clinical Governance, Audit, Appraisal/Revalidation, Job Planning, Mandatory Training and Administration:
Provision must be made in the job plan for local clinical management, governance, department meetings, audit and other meetings to support patient care and service development. Time has to be allocated to update the personal appraisal portfolio and complete the revalidation process. There will also be a requirement to complete Trust mandatory training programmes, such as infection control, manual handling, fire training etc. 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, junior doctors, medical and elective students, and other health care professionals. There should be a transparent system for assigning teaching and supervision roles that considers individual workloads and personal commitments. Teaching responsibilities should be equitably distributed where appropriate, and reflect the diversity of the consultant team. There should be provision for supervision or mentoring of consultants new to these roles 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 (generally 1 PA, depending on numbers in programme)
- Foundation programme director (generally 1 PA, dependent on numbers in programme)
- 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 may be counted as either DCC or SPA depending on circumstances.

Undergraduate Education
This varies, for example 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 and the time

allocation should depend on the role. Supervision of undergraduate research projects should be recognised, and accounted for, ideally through annualised job planning. A similar role may be performed for postgraduate research supervision and should be recognised in job planning.

5. 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. They may not 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
- Local NHS liaison roles
- 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.

6. 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, membership of the SAC, work for a Government Department, work for NICE, specified work for the General Medical Council and work for the ABN. These duties should be agreed between a consultant and their employing organisation.

7. LOCUM CONSULTANT POSTS:

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:

- Locum posts should not continue indefinitely and their occupants, particularly those from under-represented groups, should be actively supported in progressing their careers and securing a permanent position.
- The substantive post created following a locum period should conform to job planning recommendations as described above; providing the same mentorship and professional development opportunities as to permanent staff.
- 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: 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, at least 50% of the job plan will be dedicated to research activity.

All the recommendations for NHS consultant job planning apply (clinic template, travel, appropriate governance activity such as MDT meetings etc). Similarly allocated SPA time should follow the above job planning guidance but may come out of the NHS and/or university contract, depending on the roles undertaken and local negotiation.

APPENDIX 2: DEFINITIONS OF "NEW" AND "FOLLOW-UP" PATIENT

"New Patient"
New to the local neurology service, or previously known but not to that consultant, or presenting with a new problem to a consultant to whom they were previously known. Time elapsed since last appointment may influence appointment duration at the discretion of the consultant triaging.

"Follow-up Patient"
Someone known to a specific consultant, but whether to count as a new or follow-up will depend on the reason for contact and time elapsed since last contact, as discussed above.

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USEFUL LINKS:

- Consultant job planning: a best practice guide NHS Improvement 2017
  https://www.england.nhs.uk/wp-content/uploads/2022/05/consultant-job-planning-best-practice-guidance.pdf

- GIRFT Neurology – Developing Local Guidelines for Neurology follow up versus discharge
  https://future.nhs.uk/connect.ti/GIRFTNational/view?objectId=148772485