The AAGBI and RCoA view of time for supporting professional activities (SPAs)

At the inception of the new consultant contract in 2003 it was decided that a consultant's job plan was to be a minimum of 40 hours a week made up "typically" of 7.5 programmed activities (PA) for direct clinical care and 2.5 programmed activities for supporting professional activities (SPA), each PA equivalent to 4 hours [1]. Over the last 2 years the "typical" 2.5 SPA time has come under increasing scrutiny and has been reduced in an increasing number of hospitals. SPA time has implications for both service provision and training within a department and so it is important that both the AAGBI and RCoA make comment on this trend.

The clear aim of these reductions from the NHS point of view is to save money. It has been estimated that SPA time may account for up to 1% of the NHS budget. The reason it is under attack is that it is perceived by some that consultants do not require 10 hours a week within working time to perform so called 'additional activities' and that this is a cost the already financially stretched NHS can ill afford. There are differences emerging between the devolved nations. Wales has a 7PA to 3SPA split but the first reduction of the typical 7.5 to 2.5 split came in Scotland, where we now hear of 9 to 1 contracts. This does not mean in anaesthesia that 9 fixed clinical sessions are worked, more normally 6 or 7 as on the old contract, but importantly only 1 SPA is given. This trend is now starting to spread to England where the majority of NHS consultants work; it is becoming particularly attractive to Foundation Trusts. There is growing evidence of consultants taking up posts with job plans including 1.5 or even 1 SPA .

So what is our view of this? One myth that we need to dispel is that 2.5 SPAs is a contractual obligation: it is not. Clearly both clinicians and management accept that time is required on a weekly basis for a consultant to update themselves on new and evolving improvements in their chosen specialty, especially with revalidation looming. No one, as far as we are aware, has suggested removing SPA time altogether and we are vehemently opposed to any Trust/ hospital giving differing SPA time to different specialties as this would be wholly inappropriate and professionally divisive. We believe that any additional activity benefiting the Trust / hospital or wider NHS should be added to this basic 1 to 1.5 SPA time.

What sort of activity should count? More enlightened departments have come up with a whole host of posts/ jobs which might require additional SPA time - clinical director, rota organiser, governance lead, audit lead and so on. It is difficult to be generic about this because different directorates in different hospitals work slightly differently, but the principle is the same. We believe that any additional activity should have a set tariff of SPA time agreed by the clinical director and accepted by hospital management. This is happening in some Trusts/hospitals and indeed we know of some who are giving up to 3 SPAs for individuals with high administrative or research/teaching activity. This may occur in smaller departments where the number of 'lead' posts is such that the majority of the consultant staff is responsible for a particular area. In major teaching hospitals with 50 or more consultants it may clearly be difficult for them all to be in 'lead' posts but the emphasis there should be on specialty teaching both of postgraduates and undergraduates.

We support the original view that "typically" a consultant should have 2.5 SPAs in his/ her contract. Clearly, though, this has to be justified but we believe it can be for the majority in our specialty. It is imperative that accurate records of additional activity be presented at the annual job plan review.

Richard Birks, President, Association of Anaesthetists of Great Britain and Ireland

Peter Nightingale, President, Royal College of Anaesthetists

THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland