Supporting Professional Activity – a cause of confusion

History

The 2003 Consultant Contract allowed for a 'typical' contract agreement for consultants to include 10 periods of paid activity each week (Programmed Activities [PA]) for their NHS employer. These periods were based on 4 hours of daytime activity and, therefore, a standard week was expected to be 40 hours of paid activity. It was clear the varied demands on consultants prohibited the entire 40 hours being spent in direct care of patients.

Mr C J McLaughlan

Director of Professional Standards, RCoA

There was then, and continues to be, a considerable burden on consultants requiring dedicated time to service the employer's needs for: training, research, development, good governance and patient safety. The agreement between the DH, employers and the BMA, among others, was that 2.5 of the periods of activity would be a fair allowance for such work and the standard contract consisted of 7.5 direct clinical care (DCC) sessions and 2.5 sessions for this related administrative time (Supporting Professional Activities [SPA]). The 10 PA requirement still pervades in DH documents; however, SPA periods are clearly no longer defined as a standard, or normal, requirement of 2.5.[1]

Purpose

The purpose of this paper is to provide anaesthetists with an up to date position of all key players in the SPA debate and to suggest areas where clarification would benefit doctor and employer. Many of the boundaries are being confused between: clinical programmed activity, support for that clinical activity, personal study leave, professional leave, and external and additional duties. The current situation is one of personal and organisational confusion with increasing bad feeling on both sides of the employer-employee debate.

This paper particularly acknowledges the position statement from the Academy of Medical Royal Colleges of February 2010[2] and the joint statement from the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Anaesthetists[3] – both statements see the typical 7.5:2.5 split as being the basis for a safe contract, whatever the financial pressures on the NHS.

Exclusions

This brief paper considers a standard consultant role and does not explore those areas of employment such as regular or programmed off-site working, academic posts or deployed employment etc.

In addition, private work and employment in unpredictable emergency and on-call areas are not considered here, nor is the issue of extra PAs which are 'temporary and short term'[4] local considerations against variable activity pressures.

Contract variation exists across the UK and this paper centres on the English contract; it will not explore all four country-specific variants, but notes the contract agreement across all of Wales has produced a 7:3 split in activity which more than meets the minimum SPA recommendation of the AoMRC. However, time for revalidation and national commitments are issues considered to be equally applicable to all.

Programmed Activities (PA)

Direct Clinical Care (DCC)

This relates to activity in theatre, intensive care, emergency rooms, wards, clinical

departments or out-patient settings etc as required by the post. This would also include time directly supervising trainees and SAS/Specialty Doctors in the same clinical environments and also reviewing patient notes, managing patient pre-op visits and post-op care as well as report writing/letter completion.

Supporting Professional Activities (SPA)

It was considered that SPA time would be available for all consultants to allow adequate and identified periods of time for the following activities, which would underpin the direct clinical care work of their department and look to the long-term maintenance and development of that service.

- Continuing professional development (CPD) time, to ensure the individual remained current and informed of all specialty related developments, which in turn ensured the department was up to date with specialty advances and improvements. The Academy of Medical Royal Colleges directed a minimum for each individual for CPD of 50 hours per year as an average.[5]
- Clinical teaching and mentoring time, as part of the clinical supervision and teaching expected of all doctors, normally delivered out of the direct clinical environment and usually to individuals or very small groups informally and as required.
- Training for self and others on new equipment or techniques.
- Department meetings for audit, patient safety, revisions to procedures, hospital policy discussions, clinical governance etc.
- Communication issues within the department and with other areas of the hospital/trust/board including various committees and working groups.
- Conducting or managing clinical audits/quality improvement projects.
- Appraisal meetings and supporting administration – to be considered as preparation for revalidation (see Note 1).
- Clinical research related to the work of the department.
- Management of the department and its composite functions.
- Development of the clinical service and associated quality enhancements.

This list is not comprehensive.

A useful tool for approximating such activity was provided in the *Bulletin* of the RCoA in November 2010.[6]

Additional NHS Responsibilities (ANR)

To include those tasks and responsibilities outside the standard contract of work, but still within the employing organisation and undertaken by agreement between consultant and employer. They are considered to be major NHS responsibilities, e.g. Clinical Director, Medical Director, College Tutor, Educational Supervisor, Clinical Tutor etc. Time for such roles may be identified from a specific increase in the SPA allowance, i.e. greater than the standard 2.5, and defined in the job plan. However, it can be more clearly defined by an agreed reduction in DCC commitment with separate identification of the specific time requirements for the additional post(s) held. This has been seen to work well in some hospitals where the time is separated from both SPA and DCC and referred to as an ANR allowance, e.g. a 10 PA contract could be: 6.5 DCC, 2.5 SPA and 1 ANR.

Until now the funding for many of these roles has come from the undergraduate or postgraduate teaching allocation or from a separate funding source via the relevant strategic health authority. However, this is now unlikely to continue and the position of this subsequent to the dissolution of SHAs in 2013 is another area of uncertainty.

External duties

*Release of consultants for work necessary for the broader benefit of the NHS.**

External duties are individual in nature and many consultants will not have any. Such duties are those that cannot be included or considered as direct clinical care, but are formally recognised healthcare roles away from the employing organisation. They should be included in job planning and agreed between consultant and employer. For example: Regional Adviser, Training Programme Director, Union Representative, Examiner or other recognised medical Royal College roles, and external formal advisory responsibilities for the DH,

* Department of Health website, Consultant contract – external duties, 8 February 2007.

GMC, NICE, NCAS, courts of law, etc. External duties are not included within the definition of Fee Paying Services or Private Personal Services.[7] In January 2012 a supporting letter for 'national duties', undertaken by NHS doctors, was signed by all Chief Medical Officers of the UK[8] and sent to all employers in the NHS; this has been followed up with a CMO Scotland specific letter with more detailed direction in support of trainers and examiners. It may now be prudent to recognise and refer to such activity as 'national duties' to mirror the terminology of the combined CMOs' letter.

Study leave and professional leave

Both areas are usually now considered together by hospital management and NHS Employers continue to state the maximum professional/study leave allowance is 30 days in a three-year period, additional periods being at the discretion of the employer. In addition, NHS Employers emphasise that study leave is a separate issue from SPA time.[9] As this is time allotted to the individual doctor to pursue approved postgraduate activity, there is a wide scope for what may be included.

In general terms, this would include personal study, research and career development in areas of wider medical interest which would contribute to a broadening of the knowledge and skills of the individual, or to colleagues across healthcare. This area would also include external duties which do not directly contribute to the NHS or are outside the UK.

Job Plans (JPs)

A study of JPs received through the Advisory Appointments Committee (AAC) section of the College over the last year revealed a key aspect of the confused contract.

It is certain that increased clinical service tasks and reduced NHS funding will create even greater pressures on the consultant's time.

Several JP challenges were made by the College directly to employers or via Regional Advisers in their role of reviewing job descriptions for AACs. In the main these challenges originated from JPs advising applicants the role attracted less than the desirable 2.5 SPAs, and, in some cases, less than the essential 1.5 SPAs. However, in almost every case, the simple numbers did not actually tell the whole story.

On more detailed analysis of the paperwork supporting the JP it was often found the job actually required less than 7.5 PAs of DCC activity and, therefore, the sum total of SPA and DCC time fell short of the 10 PA contract attached to the job. In a significant number of cases DCC commitment was indicated at only 6 PAs. When human resource (HR) departments or hospital directors responded to these challenges it frequently became obvious the missing time actually carried an expectation of management, research or training activity which more appropriately belonged in the SPA allocation.

In addition, there was considerable variance in the recognition of anaesthetist engagement with patients immediately before and after time in surgery. The College recommends that where a surgical list is actually four hours in duration the PA allocation should be 1.25 to allow for the time to see patients before the start. Increasing limitations on pre-

admission checks highlight this time for patient engagement as an essential tool in list management and risk reduction.

This particular difficulty appears to be increasing with an expanding number of foundation trusts in England where the Department of Health direction on consultant recruitment[10] can be ignored – resulting in HR departments creating non-standard JPs which vary considerably between employers.

A further complication exists in the non-standard terminology in JPs – particularly the attempts to use lists, sessions or PAs interchangeably. There is some drift from each of these being considered as a four-hour unit of activity and in some cases a 'list' was actually six hours in duration, thus requiring recognition of at least 1.75 PAs of DCC activity. The ongoing debate on 'daytime' or 'normal' working hours serves to complicate this still further.

Conclusions

There are many and varied calls on the time of a medical consultant, both clinical and managerial. Some contributions are clearly visible to employers and colleagues, e.g. direct

clinical care, whereas others are less so, e.g. external duties.

Despite the undoubted value of much of the non-DCC activity listed above, its worth is often lost on the employing organisation as it is not local and immediate. A College Assessor attending an Advisory Appointment Committee at another hospital provides a valuable service in ensuring the correct recruitment of a high value specialist who will support patient safety, benefit the NHS employer and develop the specialty. However, this value may be lost on local colleagues who feel they are filling the gap and on the Assessor's employer who is paying for an 'absent' consultant. It is certain that increased clinical service tasks and reduced NHS funding will create even greater pressures on the consultant's time.

Successful job planning supported by written agreements, good diary evidence, openness about time commitments – both within and outside the employing hospital – and frequent discussions with close professional colleagues have been found to be the best route to maintaining these local and national commitments and preserving local good will. Clarity for DCC, SPA, ANR and approved external activity is essential for the employee and employer and provides the base calculation for job planning.

HR departments and those presiding over AACs need to ensure applicants, and their assessors, are clear about how all of the time commitments in the contract are to be met. It is essential to identify all SPA activity expected within the allocated SPA time on the JP. This is particularly important for new consultants in their first appointment where they are wholly reliant on the employer defining the expectations; good employers also ensure an appropriate review of time commitment occurs at least six months after appointment.

The GMC aims to have revalidation in place by the end of 2012 and the Academy of Medical Royal Colleges continues to stress 1.5 SPAs as the minimum requirement to support individual revalidation activity. However, a 1.5 SPA contract makes no allowance for the contribution and benefit consultants offer beyond clinical service delivery, and neglect of this valuable resource can only harm service delivery and clinical development.

NOTE 1

Revalidation

The specific requirements on individual doctors for revalidation are still under development by the DH, the Academy of Medical Royal Colleges and the GMC, but will include:

- Maintaining a portfolio of supporting evidence for revalidation, including: CPD, audit, multi source feedback (MSF), critical incident review etc.
- Providing a service to colleagues by contributing to their evidence collection and providing MSF input where necessary.
- Developing processes for assessing clinical skills for the purposes of revalidation.
- Developing criteria about the CPD evidence required for revalidation.
- Developing quality assurance mechanisms for the revalidation processes, in particular relating to evidence from CPD and MSF.

References

1 NHS Consultant Contract, Terms and Conditions – Consultants (England) 2003 (Version 8, September 2009). *DH*, London 2009 (www.nhsemployers.org/SiteCollectionDocuments/Consultant_Contract_V8_Revised_Terms_and_Conditions_220808_aw.pdf).

2 Advice on supporting professional activities in consultant job planning. *AoMRC*, London February 2010 (www.rcoa.ac.uk/node/1440).

3 The AAGBI and RCoA view of time for supporting professional activities. *Anaesthesia News*, February 2010 (www.rcoa.ac.uk/node/1439).

4 A guide to consultant job planning, Version 1. *BMA and NHS Employers*, July 2011 (www.nhsemployers.org/Aboutus/Publications/Pages/AGuideToConsultantJobPlanning.aspx).

5 A Review of the Ten Principles for CPD in the Context of the Proposals of the Donaldson Report. *AoMRC*, October 2007 (www.aomrc.org.uk/component/docman/doc_download/9327-10-principles-of-cpd.html?Itemid=33).

6 Sneyd JR, Wrigley S. Supporting professional activities (SPA) time. *RCoA Bulletin* 2010;**64**:43–46.

7 External duties for consultants in England. *BMA* 12 July 2007.

8 CMOs' letter to all employers in the NHS, dated 23 January 2012. (Available at: www.rcoa.ac.uk/node/2294).

9 NHS Employers consultant contract – frequently asked questions (pp 17). *NHS Employers*, March 2009 (www.nhsemployers.org/SiteCollectionDocuments/NHSE_Consultant_Contract_FAQs.pdf).

10 The National Health Service (Appointment of Consultants) Regulations – Good Practice Guidance, January 2005 (www.rcoa.ac.uk/node/1445).