

Job Planning

**Report from the working party of The Society of Cardiothoracic Surgeons of
Great Britain and Ireland**

Chaired By James C Roxburgh

February 2003

Introduction

The Central Consultants and Specialists Committee (CCSC) of the British Medical Association is responsible for dealing with Terms and Conditions of Employment for all doctors in the UK and represents the profession in negotiations with central government. Various sub-committees handle the work of this committee, and these represent the major sub-specialities within medicine. The Surgical Sub-Committee (SSC) represents all surgical specialties and all the specialist societies are able to nominate a member of their respective Executives to sit on this committee. James Roxburgh represents the Society of Cardiothoracic Surgeons.

About 18 months ago the CCSC asked for speciality specific job plans as part of the “new contract” negotiations. Although this was not an area the Society had traditionally been involved in it was felt by the Executive that job-planning was a matter of increasing importance for all cardiothoracic surgeons and it was important that we were involved at an early stage.

The plan was that cardiothoracic surgery would be divided into 5 major areas:

- i. Pure adult cardiac surgery
- ii. Pure thoracic surgery
- iii. Mixed adult practice
- iv. Paediatrics
- v. Transplantation.

The lead for each of these was chosen from the Executive and they were asked to co-opt two non-executive members of the Society to join them in producing a job plan for their area of experience. The make up of the initial working groups was as follows:

Adult:	<u>J C Roxburgh</u> , G E Venn & U Trivedi.
Mixed Adult:	<u>M Jones</u> , G Tsang & D Hopkinson.
Thoracic:	<u>A Thorpe</u> , R Steyn, J Duffy & R Page
Transplant:	<u>R Bonser</u> , J Dunning
Paediatrics:	<u>L Hamilton</u> , M Haw & D Barron.

However shortly after work was started Roger Vaughan and Pala Rajesh a submitted draft job plan for Thoracic surgery that they had already been working on. This job plan became the backbone of the document that is put forward by the Society to the membership for discussion; input from the original working party has also been incorporated. It soon became apparent that the ongoing discussion with central government about the provision of paediatric cardiac was going to seriously limit the ability of the Paediatric working group to produce a substantive document. The outline document is presented but it is expected that future changes in this area will require the paediatric surgeons to look at this in more detail. The Transplantation working group concluded that there was so much variation between units that a single job plan to cover the whole sub-speciality was impossible. Others have shown an interest in trying to produce a uniform job plan but to date the Executive is not in a position to put forward a Transplantation job plan. As might be expected the Mixed Adult job plan was the most difficult to produce and there were many reasons for this but there were 2 major ones:

- i. The mixed practice of the so-called cardiothoracic surgeon is actually a spectrum of practices from the predominately Thoracic cardiothoracic surgeon to the predominately Cardiac cardiothoracic surgeon.
- ii. The need for dedicated time for Thoracic surgery (MDTs, Theatre Lists, Outreach clinics etc.)

Mark Jones' group spent a lot of time trying to produce a job plan that fitted into a 37.5/40 hour working week but concluded that, although Cardiothoracic surgeons undertake a significant proportion of the Thoracic surgery in the UK, a single job plan was not possible. It was agreed that a cardiothoracic surgeon should be able to use the pure Cardiac and Thoracic job plans as the basis to produce a job plan taking into account his/her Cardiac: Thoracic workload.

There are thus only two job plans that the Executive felt able to put forward to the membership but it is hoped that this provide all cardiothoracic surgeons with the information needed when it comes to job planning both for annual appraisals as well as new posts.

Areas of concern

Fixed sessions

It was anticipated by the BMA that the “new contract” would be accepted and so when the job plans were submitted for review it was pointed out that the “fixed session” would no longer exist. However the “fixed session” is with us for the foreseeable future and so it is important to clarify its definition.

“ A fixed commitment is a commitment which a consultant must fulfil, except by agreement with local management or in an emergency, because otherwise the use of other Health Services resources would be adversely affected”. Secretariat CCSC.

“... definition is also to ask whether you might be disciplined for not doing a session in your job plan – if so then it is definitely “fixed”!” Deputy Director Hospital Consultants and Specialists Association.

The question has asked as to how fixed is a “fixed” session. . The Executive asked the BMA and the HCSA for clarification on 2 matters relating to this.

- 1) Does the Management have the right to say that the ‘fixed sessions’ are no longer on predetermined days but that on average, over a period of time, a surgeon will undertake 6 fixed operating sessions, however, the actual days of the week and the times at which they occur may not be known until a week or 2 weeks prior (or some other time frame).
- 2) If, indeed, the management are allowed to move these fixed sessions around at will, are they allowed to do so for all the fixed sessions or do a proportion of those ‘fixed sessions’ have to be actually fixed in time and place.

The view of both bodies was that “fixed sessions” are fixed in time and changes cannot be unilaterally imposed. Job plans are fixed and are subject to annual review and cannot be

changed at one or two weeks notice, indeed HC (90) 16 allows consultants a 3 month period to draw up their own job if requested to do so by their manager.

It is though quite permissible to have a job plan that covers more than 1 week, say 4 weeks. The fixed commitments may vary for each of those weeks but the key is that they are all pre-determined commitments and are subject to job plan review.

Local arrangements are of course possible but consultants should ensure that they can withdraw and revert to their original job plan should they so wish.

On-call

This is a difficult issue and with the failure of the “new contract” the BMA may well have to revisit this area. The proposed job plans have not been able to solve this problem but solutions are proposed, and along with the views of the BMA and HCSA (see below) it should be possible for local negotiations to produce a satisfactory arrangement.

The BMA view:

“ In recognition of the rota frequency, most consultants would have 1 or 2 NHDs allocated in the job plan, although we presently recommend 3 NHDs for a 1 in 3 rota, and 4.5 for a 1 in 2. This should be supplemented by temporary additional NHDs as appropriate to recognise the workload undertaken during the commitment. If temporary additional NHDs are not contracted, we recommend the following to recognise the totality of on-call frequency and workload:

1 in 2	3-4 NHDs
1 in 3	2-3 NHDs
1 in 4	1-2 NHDs
1 in 5	1 NHD

The HCSA view:

This comes from their position paper “ The Work Sensitive Contract” .

“A ‘night’ consists of 16 hours – or 4.5 NHDs . A ‘weekend’ will consist of 16 hrs for the Friday night plus 48 hours for the Saturday and Sunday – or 18 NHDs.

If a Consultant has to be resident on-call, this equates to 4.5 NHDs per night (but paid at a premium rate)

If a Consultant is ‘on call’ from home and has no intermediate grade support (i.e. SHO or below), it is recommended that this should equate to 75% of the resident rate – 3.5 NHDs. If a Consultant has intermediate grade support, it is recommended that this should equate to 50% - 2.25 NHDs.”

It is very important for management to realize that even when surgeons are not on-call many feel they have a professional responsibility for the patient. This may simply mean the provision of telephone advice, albeit out of hours, but may extend to returning to the hospital. In an era when individual results are to become public knowledge but that surgeons will be limited in the number of hours they can work, and thus be contractually responsible for their patients, this produces an interesting

paradox! Job planning and the fair application of intensity payments must recognize this.

Sessions and all day lists

The view of the BMA and HCSA seem to be that this is a matter that they would expect guidance from the Colleges or Specialist bodies. The Society discussed this matter at the Annual Business Meeting (Islington 2000). A theatre session does not equate to a NHD but is often used by management as such. A standard all day list is more than 7 hours from start to finish, especially if one includes time to review the patients in Recovery/ITU, and as such will equate to 3 NHDs. Extended all day lists and half day lists are difficult to calculate but the above figures should help with local guidelines.

The Society hopes that the work done by all of those involved has produced a document that will be of use to all Consultant Cardiothoracic Surgeons and it is also hoped that those applying for jobs will find it of use. The Executive would welcome comments and/or constructive criticism.

Web sites

Hospital Consultants and Specialists Association www.hcsa.com

British Medical Association www.bma.org.uk

Comments to:

James C Roxburgh MS FRCS(CTh)
Consultant Cardiac Surgeon
St Thomas Hospital,
Lambeth Palace Road
London
SE1 7EH

james.roxburgh@gstt.sthames.nhs.uk

Telephone 020 7960 5777

Adult Cardiac Surgical Job Plan

Graham E Venn
Uday H Trivedi
James C Roxburgh

Introduction

The impact of both the Bristol Royal Infirmary (BRI) Inquiry into paediatric cardiac surgical practice and the Calman report on junior doctor training has dictated an increasingly consultant-run service. It is hoped that this will allow a better delivery of health care to patients.

In order to deliver such a service, the role of the consultant had changed dramatically and the nature and volume of the consultant's work has increased. In order to meet the Government plans with regard to quality, as dictated by clinical governance, and efficiency, as outlined in the National Service Framework, changes in the now outdated Consultant contract are necessary.

In recent years much more emphasis has been placed on:

- Clinical Effectiveness & Audit
- Clinical Governance
- Professional Development and Training (Including assembly of Continuing professional development portfolio and appraisal in protected time)
- Service Targets (Waiting lists and Waiting times)
- Training of young surgeons

These requirements have to be incorporated within the consultant working week.

Fixed Sessions

Operative Surgery

The immediate impact of the BRI and Calman reports has been to dictate a greater proportion of surgery being performed by consultants rather than trainees. The implications for a 'high-tech speciality' such as Cardio-thoracic Surgery has been the increasing proportion of an operation and operating list being performed by the consultant, losing the ability to run parallel operating sessions under the supervision of one consultant.

The impact on the anaesthetic service has been to slow down turn-around time between surgical cases. The typical turn-around time in major Trusts for a typical adult cardiac surgical operation is now 4.5 hours. Two operations on a typical operating day therefore take 9 hours, excluding time allocated for immediate post-operative management. A typical operating day, therefore, now utilises 3 Notional Half Days (NHDs). Two such days will equate to 6 NHDs

Outpatient work

Outpatient work should be in balance with operative capacity to ensure Charter standards and avoidance of increasing length of pre-operative wait. The typical surgeon will achieve 4 non-emergency operations in 6 NHDs during one week and will therefore need to assess 4 new patients per week. The increasing emergency and in-patient nature of the service will mean that not all of these will be seen in outpatients, perhaps 60%. The immediate post-operative follow-up requirement will similarly be 4 patients per week. A proportion of patients will need more than one follow up appointment, perhaps 2 per week.

A new patient requires 30 to 40 minutes to include, assessment of pre-operative investigations, reading of correspondence, introductions, consultation, decision-making and subsequent dictation of correspondence. A follow-up patient may typically take 15 minutes.

The above workload equates to one NHD per week, assuming the support of appropriate medical or Para-medical staff in reviewing both new and follow-up patients.

Ward Rounds

The typical cardiac surgeon will need to perform one formal ward round per week assessing those patients on the ward and those awaiting imminent surgery. The patients will require varying amounts of deliberation and care on the ward round. This workload equates with one NHD per week.

Flexible sessions

There are continually increasing demands on flexible sessional time including:

- Pre-operative surgical assessment
- Joint Clinical meetings with cardiologists and other disciplines
- Post operative ITU and allied patient care
- In-house Clinical Meetings
- Audit
- Study leave and Continuing Professional Development
- Clinical Governance

Leave Implications

In practice the 52 week year is reduced to 42 weeks or less by:

- 6 weeks (32 days) annual leave
- 1 week bank holidays (no elective operating)
- 2 weeks (10 days) study leave (Continuing medical education and continuing professional development)
- 1 week Xmas & New Year (no elective operating)

Teaching & Continuing Professional Development

The educational contract held by each surgical trainee dictates a specific amount of non-service training per week. This training is the responsibility of each consultant. This teaching is mandatory to ensure the retention of the educational approval of the trainee posts.

Further time is also devoted to teaching of nursing and other Para-medical staff. Preparation for these types of teaching sessions is usually done in the Consultant's own time.

Patients have a right to expect high standards of care. "Life long learning" is essential if these high standards are to be maintained over 25-30 years of consultant practice. The Trust annual appraisal should include a plan for continuing professional development and at least two weeks per annum should be allocated for external Continuing medical education to include training courses, national and international meetings, visiting other centers etc.

Both the Government and the GMC have indicated that the medical profession must have life-long learning and Continuing Personal Development must be part of any Consultant job plan.

Cross Cover for Colleague absence

This represents variable additional work and should *not* form part of the job plan and should be contracted for, and funded separately. Ideally there should be a nationally negotiated standard for an individual discipline although locally agreements are an alternative.

On-Call

This has been handled poorly in the past. On-call has been handled as a virtually free additional extra to the Consultant Contract possibly dating from when consultants seldom had to attend the hospital as a result of being on-call. This is now not the case with many providing substantial work in hospital whilst on-call. Even when not actually in the hospital on-call is a significant commitment encroaching on the consultant's family life and lifestyle. This has not been appropriately addressed in the present contract. The equivalence of on-call to full time work needs to be discussed. It must be remembered that Cardio-thoracic Surgeons are expected to return to the hospital immediately in cases of emergency and may be in the hospital for protracted periods when operating on-call.

The on-call commitment included in the job plan has traditionally been linked to the size of the department (e.g. a two-man department on 1:2). This is an historic structure relating to a time when units were much smaller and on-call cover could be provided by experienced in-house senior registrars. This is no longer appropriate with the workload now shouldered by the consultant staff, in keeping with government's 'consultant run service' policy. Accordingly the on-call rota has to be achievable and sustainable both for the service and the consultant. There needs to be a rethink on how this is included in new contracts. A rota of 1:5 or 1:6 is more appropriate to contemporary practice but it is important that this should be structured in a way that will accommodate changing practice and changing consultant workload in the foreseeable future.

If we look at a typical 168-hour week 38.5 hours are covered by the consultant's base contract (11/11ths). Depending on the on-call rota the consultant covers the additional hours detailed in the table below depending on the intensity of the rota. The NHD equivalent is calculated next to the average additional weekly figure with a calculation for on-call equivalence at 50% and 30% of a conventional NHD for illustration.

On-call Commitment	Average additional weekly hours covered	Additional NHDs per week at 100%	Additional NHDs at 50%	Additional NHDs at 30%
1:6	21.6	6.2	3.1	1.85
1:5	25.9	7.4	3.7	2.22
1:4	32.4	9.3	4.65	2.77
1:3	43.1	12.3	6.15	3.69
1:2	64.8	18.5	9.25	5.55

Previous attempts seem to significantly undervalue on-call time. It is highly likely that on-call will become more onerous for the consultant with time and that the consultant will have less support from experienced junior staff whilst performing on-call duties.

Previous attempts to value on-call have significantly undervalued on-call with proposals ranging from:

1:6 equating to 1NHD to

1:2 equating to 3NHDs.

These calculations value on-call time at only 16% of normal NHD time.

The present valuation of 16% for on-call time is inappropriate. The exact equivalence needs to be discussed but should be in excess of 30%

Other On Call Options

- Treat as normal hourly contact or session. One night is from 5pm to 9am and therefore represents 16hours or 5NHDs etc.
- Allocate a somewhat arbitrary NHD or hour equivalent for a night or a weekend (16% at present).
- Alter rota and working practice so that on-call period is an equal part of the working week, i.e. if working at night one will not be working for an appropriate period during the day and vice versa.

Medicine is probably the only profession where on-call is provided as a virtually free contractual extra. It is probable that this needs careful redress for the future.

Proposed Typical Job Plan for Pure Adult Cardiac Surgery

Fixed Sessions

Operative Sessions

- Two days operating.
- This means a conventional day starting at 8am and finishing at 5 to 6pm rather than an extended operating day finishing at 8 to 10 pm. This will equate to 3 NHDs or 8 –10 hours per day. 2 operations are more than two NHDs
- Half day operating is messy in NHDs as each half-day exceeds one NHD and becomes 2NHDs, which is inefficient. It only becomes cleaner if and when the contracts cease to use NHDs. With an operation lasting 4.5 hours at least 5 should be allocated contractually. Even this is a bit thin if any significant post op care is required or expected.

Outpatients

- One NHD or 3-4 hours should suffice, but will require the assistance of additional trained medical or Para-medical support. The consultant alone cannot see all new and follow-up patients in this time.

Ward Rounds

- One NHD or 4 hours to include pertinent per and post-operative evaluation of patients

Flexible Sessions

- There is an increasing amount of work, some mandatory, to fit into the limited flexible sessions left (2-3). We will have to discuss what is realistically achievable within the contractual limits available.

On-call

- This has not been included in the NHD calculation and requires further consideration on how this should be handled for the future.
- A rota of 1:5 or 6 is sustainable with current working practices but these may change with time.

Summary

- The above fixed sessions amount to 8 NHDs representing more than the 6 to 7 NHDs currently recommended by the B.M.A. for consultant contracts.
- The above recommendations are those for an acceptable base line job plan, representing the fixed and flexible commitments that a consultant should achieve as a minimum to fulfil their contract.
- Should individual circumstances dictate there should be flexibility for both the employer and employee, should they wish, to negotiate additional fixed sessions in either the short or longer term. Individuals should be able to drop such additional commitments and return to a base line job plan after giving appropriate notice.

Thoracic Job Plan

Mr R.Vaughan
Mr P.B Rajesh

Background

There are 31 pure thoracic surgeons in England and Wales with a further nine in Scotland and Northern Ireland. They are supported in providing the Thoracic surgical services to the country by an additional 61 cardiothoracic surgeons. In the recent report, Thoracic surgical services in the UK, there is a recommendation to increase the establishment by 50 surgeons. Further 4 to 8 surgeons are expected to retire in the next 5 years.

The distribution of the thoracic surgeons is such that there are six surgeons who do not have a thoracic colleague; three of these are supported in their units by cardiothoracic colleagues the others do not have this support. Three units have 2 surgeons with no support from cardiothoracic surgeons. The other surgeons are either in teams of three to four or are two or more supported by cardiothoracic colleagues. In this respect any job plan must take into consideration the on call commitments of the consultants who are in single or in small units.

Changes in practice

In the last five years the publication of the Calman Hine report into lung cancer has produced changes in the management structures of lung cancer. Multidisciplinary teams have been formed and the thoracic surgeon has had to increase the workload as a consequence. In most regions thoracic consultants have to attend two multidisciplinary team meetings in lung cancer and additional ones in oesophageal cancer. In some regions i.e. West Yorkshire, North West several MDTs do not have a thoracic surgeon or cardiothoracic surgeon in attendance. The length of MDTs varies being from 1 hour to 2½ hours.

Workload

Workload in thoracic surgeon covers over 240 different procedures for all lung diseases and oesophageal disease both malignant and benign. Although lobectomy is the most common operation a large component, 50% of the work is composed of benign lung, pleural chest wall and oesophageal problems. An estimated 15% of work is produced by patients being transferred from other units, or from other specialities, with conditions needing urgent treatment (i.e. haematological patients requiring diagnosis, pneumothorax empyema & dysphagia). (Audit figures Sheffield, Birmingham). Emergency treatments include thoracic trauma and the emergencies from medical and surgical referrals. All thoracic units cover more than one hospital

and consultants are required to go to peripheral hospitals for clinics, for consultations in wards, intensive care units and for emergencies. Also individual patients have a need for continuity of care

The future changes in the cancer plan will mean having to treat patients with cancer within a fixed time period i.e. 8 weeks from initial referral to chest physician to surgery. The waiting times are usually met by most units but will come under the constraints of the local contracts. Any variation will have to be borne by the local employer and renegotiated if the demands mean that the waiting times have to be met. The surgeon is not to undertake extra work without local negotiation. The same will apply to waiting list problems when all patients have to be treated within 6 months.

Outpatients

The majority of outpatient referrals are from other consultant colleagues but all thoracic patients are going to need major operative procedures. In this regard full assessment must be made for each patient not only for their suitability for the surgery but also their fitness. Consideration has to be made to the outcome with regard to lung function and for lung cancer regard to the British Thoracic Guidelines on Lung cancer and complete staging must be made for all lung and oesophageal cancers. Sometimes it is the thoracic surgeon who has to counsel the patient about malignant disease.

For new patients therefore the following are necessary:

1. Review of all scans x-rays
2. Full history
3. Full examination and assessment of fitness.
4. Full informed consent
5. Details of admission
6. Referral to support nurses if have cancer

For return patients:

1. Review of x-ray films
2. History
3. Examination

For some return patients they may be told the results of biopsies tests requiring referral to oncology or need for further surgery.

For a new patient the time required is 30mins (includes administrative time)

An old patient being informed of diagnosis and treatment plans the time required is 30 minutes. A review patient requires 15 minutes.

Travelling time

The furthest clinic any thoracic surgeon does is suspected to be that in Carlisle from Newcastle 80 miles but travelling time can be at least an hour in most regions.

Thoracic surgeons will often combine clinics with theatre sessions or MDTs. in the peripheral hospitals for this reason.

Theatre

Thoracic anaesthesia from 1988 to 2002 has changed considerable with a mean increase in anaesthetic time by 22 minutes, the median time now being 48mins for preparation of a surgical case for any major procedure (58 mins for oesophagectomy) (Audit of 18,000 thoracic procedures) This means that the median times for the cases have increased.

A lobectomy takes 3hrs 35mins Median time from anaesthetic room to time the patient leaves theatre (total time) an oesophagectomy takes 5hrs 20mins total time.

For smaller procedures mediastinoscopy takes 47 mins, vats pleurectomy 1 hr 20. Therefore in a day realistically only 2 major procedures should be carried out to fill more than 2 sessions, but the care and time needed before and after an operation are not included in this situation i.e. the surgeon has to present in theatre before anaesthesia starts, the patients have to be seen afterwards on the ward and looked after, therefore the operative day should be the same for the anaesthetist and surgeon i.e. 3 or 10 hour day sessions with a limitation of cases to 2 majors and minor, or 1 major and 2 intermediate operations.

Audit time in theatre does not take long in institutions with databases but will take 10 to 20mins and should form part of the theatre time. Analysis of data is done outside theatre and forms part of audit time.

Ward work

Preoperatively

All patients for theatre have to be reassessed and now re-consented 24hrs prior to surgery as well as in outpatients. As they have malignant disease the x-rays have to be re-reviewed prior to surgery and now re-consented 24hours before an operation.

Postoperatively

It is essential that all postoperative thoracic patients are cared for properly requiring intensive physiotherapy, pain relief. Many are elderly and require further assistance. The major operations of oesophagectomy and pneumonectomy carry a mortality of greater than 5%. Complications of the major operations are many. The consultant thoracic surgeon therefore has a regular need to review patients postoperatively and to supervise the junior staff carefully in these situations.

Teaching

All consultants have a duty to teach in theatre outpatients and wards and this inevitable impinges on the time available to treat patients or all processes take time. This has been compounded particularly for clinics as SHO's are now considered supernumerary in trusts so if they are to see patients they have to be supervised at all

times and not carry out service work. SPR's in the first three years are not necessarily skilled and will need more time for the surgery. Teaching therefore is part of the time worked and should be built in to a local contract or paid for if extra.

Research.

Any time spent directing research or running research programs is also to be considered for any individual but must be a substitute for any time in a given programme or paid for in addition.

OnCall

In July 1999 the society recommended that on call should be 2 NHDs for a 1 in 5 commitment which is in accordance with the BMA recommendations. With the changes taking place in junior doctors hours consultants are taking on more of the care of the patients. If this continues this will have an additional effect on working patterns. The European Working time directive does not consider on call as work but at the same time on call is a disruption to home life. However the working time directive has built in rest periods to compensate.

The basis of on call is approximately 2 NHDs for 1 in 5 or 6 with 5 NHDs for a 1 in 2.

In a standard job plan with NHDs these are the following guidelines:

Activity	Comments	NHD allocation
Outpatient clinics For each clinic.	4 new patients for 30 minutes each. 6 old for 15 minutes each.	1NHD
MDTs	2 MDTs in base hospital	1 NHD
	1 MDT peripheral hospital (includes travelling)	1 NHD
Theatre	Per full day (2 majors plus smaller case, see above figures and addendum)	3 NHD
Ward work		0.5 to 2 NHD
Teaching, Training, Examining & Accreditation		0.5 to 1 NHD
Research	as required	
Management		1 to 2 NHD
Medical Audit		0.5 to 1 NHD
Laboratory imaging Special interests		0-2 NHD
On call	1:2	5 NHD
	1:3	4 NHD
	1:4	3 NHD
	1:5 & 1:6	2 NHD
	1:7 or greater	1 NHD

What is a reasonable working week?

In drawing up a job plan for a thoracic consultant then consideration has to be made of the above position. The main problem is on call which is variable in each unit and so can only be defined locally but one can assume that there will be in most units an on call of 3 to 4 sessions (1 in 3 or 4). This is difficult to define given the constraints of the European directive and compensatory time rest periods, the decrease in the input of junior medical staff and also the fact that on call from home is now not considered work unless called.. Cancer waiting may in the future have a local impact (see above). Also anything done for the hospital /unit /country is now considered work under working time directive.

For a full time contract then the conclusions are bound by the working times including on call and local constraints. **The normal working week is defined as 37.5 hours**, (11 sessions at 3.5 hours is equal to 37.5 hours).

The working week would be for a full time surgeon in thoracic surgery **could** be:

1 Outpatient for 3.5 hrs seeing 4 new and 6 follow up patients	1 NHD
2 MDTs in local hospital or 1 MDT in a peripheral hospital	1 NHD
2 days operating and post op care . **	6 NHD
Ward work	1 NHD
Administration including audit, analysis	1 NHD
On call**	1 NHD
	11 NHDs

** If on call more onerous then theatre time would be less i.e. 16 hrs or 12 hours.

Any teaching, lectures, research, administrative duties clinics or additional operating is in addition to the above, or instead of these sessions/hours.

Any time spent travelling to other hospitals would count as work and have to be included so if travelling time is 2 hours then this is to be included.

If a consultant works more than the contract of 37.5 hours this would be payable as extra sessions/ hours and be superannuable .

Also if the time spent is outside the proposed hours of 09h00 to 17h00 this is to be paid as extra and superannuable.

References:

Working party in Thoracic surgery 2002
 Audit of 10,000 thoracic procedures R. Vaughan
 Audit of Admissions Sheffield & Birmingham,
 Calman Hine Report (Policy document for commissioning cancer 1995)
 BTS guidelines Lung cancer Thorax 2001: 56:89-108
 BMA model workload document.
 Letter from Peter Hawker.
 Recommendations of workload SCTS 1999

Addendum

Anaesthetic times and surgical times for common procedures: (median for all grades of staff).

Procedure	Anaesthetic time 1988 to date	Surgical time	Total start to recovery
Lobectomy	47 minutes	2hrs 55	3hrs 35
Pneumonectomy	55 mins	2hrs 41	3hrs 27mins
Oesophagectomy	58 mins	4hrs 35mins	5hrs 20
Mediastinoscopy	22 mins	46 mins	1hr 16 mins
Vats Pleurectomy	26 mins	46 mins	1 hr 20mins
Vats lung biopsy	26mins	48 mins	1hr 20 mins
Oesophagoscopy Dilatation	7 mins	15 mins	25 mins
Bronchoscopy	7 mins	8 mins	22 mins
Lung volume reduction	59 mins	1hr 45	3hrs 10mins

Median time for anaesthesia for all operations is now **48 minutes** compared with **26 minutes in 1988**, this is accounted for by more use of epidurals and arterial lines and fibreoptic intubations.

Audit 10972 operations 1988 to date.

Mixed Practice (Adult Cardiac and Thoracic) Job Plan

Mark Jones
G Tsang
D Hopkinson

Consultant Programme – Job Plan

Fixed	
Operating theatre (2 days/week)	6 NHD
Out-Patient clinic (once weekly)	1 NHD
Ward Round	1 NHD
Flexible	
MDT	1 NHD
On-Call	2 NHD
Administration	1 NHD
Post-Graduate Education (audit, teaching, clinical governance, quality assurance, mortality and morbidity meetings)	1 NHD
	13 NHDs

Obviously this number of NHDs is in excess of the recognised job plan, and this represents the gap between hours worked and hours remunerated. This will need to be addressed at a local level at the time of job planning and appraisal.

Paediatric Job Plan

Leslie Hamilton
 Marcus Haw
 D Barron

POTENTIAL JOB PLAN FOR PAEDIATRIC CARDIAC SURGEON (40 HOURS)		
		HOURS
OUT-PATIENTS	<ul style="list-style-type: none"> ❖ 4 hours ❖ 30-45 minutes need to be set aside for discussion with each new patient as this is the initiation of the consent process. If 3-4 cases per week are being done and a third of these will be in-house patients, then this would equate to 3 patients per clinic at 45 minutes each. ❖ Major cases undergoing surgery should ideally come back for one post operative surgical review – partly to check on recovery but also to “close” the surgical episode and ensure that parents understand what has been done and what the future holds. 	4
OPERATING	<ul style="list-style-type: none"> ❖ 2 days at 10 hours per day = 25 hours ❖ Includes pre-operative review of investigations ❖ Pre-operative discussion with parents and signing of consent form ❖ Close involvement in immediate post operative care 	20
REFERRAL MEETING	<ul style="list-style-type: none"> ❖ Joint meeting with full team of cardiologists and other surgeons – 4 hours 	4
ON CALL ROTA	<ul style="list-style-type: none"> ❖ 1 in 3 (following DOH review of national service likely to be a minimum of 3 surgeons per unit) (8 hours work estimated per week) 	8
CPD/ADMINISTRATION		4
TOTAL		40

NB This is based on the “new contract” of 4 hour sessions. There is thus already 2.5 hours extra which must be allowed for in local negotiations. This has not been translated into NHDs as this would hide the extra “routine work”. JCR

