BACCH/CSAC job planning guidance for consultant paediatricians in combined posts, working across general and community paediatrics

BACCH and the community & general CSACs have developed this guidance to help members in the job planning process. Whilst it is recognised that these standards may not be achievable everywhere in the immediate future it is important that the different needs of paediatricians working across general and community paediatrics be recognised and supported. Such posts have particular challenges. The paediatrician will have to work within two teams, which are often located in different places, and to maintain competence in 4 areas of practice: inpatient and outpatient general paediatrics, community paediatrics and neonatology. This guidance complements guidance for those working solely in community paediatrics available on the BACCH website.

Community paediatric practice differs from general paediatrics in a number of key areas. These include:

- Complex cases that require longer to assess and treat
- An absence of many standard activities such as ward rounds and operating sessions
- A greater commitment to multidisciplinary and multiagency work
- Greater travelling time and a variety of work bases
- A greater proportion of consultants working less that full time

Combining this work with general paediatrics, with its emergency and urgent demands, needs careful job planning to make the job plan safe and do-able and to maintain continuity of patient care in both sectors.

The **overall approach** to job planning should conform to the guidance for other consultant groups.

When **agreeing duties and responsibilities**, the consultant's duties should cover the standard categories set out in the contract guidance. However, the expectations, definitions and norms for paediatricians in combined posts are likely to need adjustment as set out in the BACCH guidance for community paediatricians. Those in combined posts should expect to have the same time allowed for the same type of work as their general or community colleagues. Therefore outpatient clinic templates for general and community outpatient clinics will need to take account of the patients' differing needs. Clinics can conveniently be arranged using the separate Treatment Function Codes (TFC) for each subspecialty: 290 for community paediatric outpatients and 420 for general paediatrics. (Statutory work incl safeguarding should be coded under TFC 291) This should help to keep clinics separate for billing in England and for governance purposes.

Direct clinical care in community paediatrics should include all multi agency work, not just that related to individual named patients as set out in the guidance for community paediatricians.

The proportion of direct care and supporting activities should reflect the norm of 75% clinical care, with the 'clinical management' roles included. This leaves 25% for the supporting activities e.g. CPD, teaching and training, job planning and appraisal etc. 'Service management' and other duties e.g. lead clinician, clinical governance, clinical tutor, College roles should be included in the same way as other consultants. Particular difficulties relating to work outside hospital e.g. the extra time and effort needed to supervise staff based at different locations should be recognised.

In order to maintain competence, we recommend that at least 4 PAs per week is worked in each sector: 1 SPA and 3 DCC. It is therefore unlikely that those working less than 8 PAs per week would be able to sustain a combined post, particularly as at least 1PA per week will be spent on

call out of hours. While there can be some flexibility for individual posts e.g. some general posts may not include neonatal commitments, sufficient time must be available in each sector to allow skills to be maintained and developed to the same standard as those practising solely in one sector.

Community DCC sessions should include on average a weekly general clinic; a special interest clinic less frequently (perhaps 1-2 per month) e.g. special school, audiology, vision assessment; MDT work (1-2 per month, depending on need); child protection examination rota (including attendance at peer review) and admin time (1:1 for the clinical sessions). Those in combined posts should also participate in clinical management in a particular area of community child health (perhaps shared with a colleague, as many require significant input e.g. 2-3 PAs). If they did not, those working solely in CCH would have a disproportionate management workload.

General paediatric/neonatal DCC sessions should include a ward 'on call' week in rotation with colleagues or 1-2 ward rounds per week in both general and neonatal paediatrics; a weekly general clinic seeing new referrals and follow ups from ward work; MDT work; admin; out of hours and on call. They should also contribute to the management of the general/neonatal departments.

The following sample job plan may be helpful:

Full time post with special interest in disability		
Direct clinical care community 4.5PAs	Outpatient clinic (weekly)	3 hours
	CDC assessments / Care planning	1 hour (may be arranged as 1 session per fortnight or month)
	MDT meetings	1 hours (as above)
	Special school	1 hour (as above)
	CDC lead with Assoc Spec support	4 hours
	Pt admin	6 hours
	Travel	2 hours
Direct clinical care general / neonatal 3.0	General paediatrics/neonatal ward round	3 hours (May be as 'hot week')
	Outpatient clinic general (weekly)	3 hours
	Pt admin	2 hours
	On call/OOH	4 hours
Supporting activities 2.5 PA	Revalidation requirements	6 hours
	Teaching and training	2 hours
	Clinical management e.g. dept meetings for both teams	2 hours
Total		40 hours per week