The "3 out of 4" plan: New-look consultant roles, with potential benefits for primary care

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Much has been written about the role of the specialist diabetologist within the confines of the modern NHS. There is a growing realisation that having a specialist rigidly based in hospital is becoming difficult to sustain; instead, flexibility is now crucial as primary and specialist care look to work together to improve diabetes care. With the challenges of the *Five Year Forward View* (NHS England, 2014) upon us in England, and similar pressures elsewhere, this article looks at nuances within the existing consultant contract that would allow us to develop specialist roles for the future. And, as I argue below, the potential abounds for improving the way in which specialists work with primary care.

Redefining the role

In the main, the consultant contract is pretty straightforward, consisting of 10 sessions (each session being worth 4 hours) – with trusts giving extra sessions to individuals depending on work, activity and need. Of those 10 sessions (i.e. 40 hours), about 2.5 sessions, or 10 hours, are supposed to be allocated to non-patient-facing activities, also known as "supporting professional activities" (SPA) and discussed later. The approximately 30 hours a week that remain are called "direct clinical care", and, at face value, it could be argued that a lot can be done in this time. And, taking this a step further, we can then think of how the hours might be used as a department (in one with four consultants, say, there are 120 hours available for patient care a week).

One size does not fit all

Although this will depend on local hospital dynamics, there are, broadly speaking, four areas that a diabetologist needs to get involved in:

- Specialist diabetes care (e.g. antenatal care).
- Community diabetes care (e.g. education).
- Endocrinology.
- General medicine.

Among these, there may be an area that a particular individual would prefer not to focus on, and even for someone looking to cover all of these areas, it may not be possible to do so without an overall drop in quality of care. As such, a novel alternative for the consultant role would be to give individuals some level of choice.

Choose "3 out of 4"

Forcing people to do things achieves little other than creating a disgruntled workforce and low productivity. So how about having consultants pick three of the four core clinical areas outlined above, within their job plans?

The prospect of working in the community may appeal to some while others may prefer to focus efforts in other areas. Giving the latter group the choice to pick the other three options may actually improve job satisfaction and morale.

So how could it work? Choosing three areas out of four would give approximately 10 hours a week (or 2.5 sessions) to each. One scenario would be to have 10 hours of endocrine-related clinical work, 10 hours of community diabetes work and 10 hours of specialist diabetes work (*Table 1*) – a clear demarcation of work time that would help to improve specialist care as well as supporting the community setting.

An additional benefit of the idea is that individuals would get to focus on areas where

Table 1. "Choose 3 out of 4" (example choice for a proposed new consultant job plan).

Subject	Hours	Choose
Endocrinology	10	✘
Specialist diabetes	10	✘
Community diabetes	10	✘
General medicine	10	
Supporting professional activities	10	✘
TOTAL	**40**	

they feel they could contribute most – and to do so well, rather than over-stretching themselves.

Thinking as a team

The NHS needs strong teams dedicated to improving care, rather than siloed, and ultimately personality-dependent, individual brilliance. If the principle of "3 out of 4" gets embedded, the concept can be taken a step further by thinking as a unit: pooling each consultant's sessions into one pot and then deciding how the team would like to split the defined areas. The team could choose to deliver all four streams, through complimentary selections, or choose as a team to focus in on three of them. *Table 2* illustrates how, in a team with four consultants, 120 hours a week would break down. Within this, the hours per stream could be increased or reduced depending on the dynamics and ethos of the team and on the need of people with diabetes.

How to use time assigned to SPA

As any consultant will tell you, how best to use time assigned to SPA has always been an area of debate. For me, the answer lies in planning. For instance, keeping one session, or 4 hours, separate for professional development, including making provisions for revalidation, would be reasonable. The way the remaining 6 hours were used would then depend on the three areas chosen. If community diabetes has been chosen, these hours might, for instance, be used for education of GP trainees or for running specific sessions for practice nurses. Once again, if one extends this principle to the hours that are pooled within a team, there may be even greater opportunity for benefit, through a coordinated approach.

Other benefits for primary care

Thinking about what else this idea might offer from the point of view of the community setting, it is clear to me that the potential for helping primary care and improving diabetes care is substantial. There are some new ideas proposed in the *Five Year Forward View,* such as "multispecialty community providers" (MSPs; following an integrated out-of-hospital care model). Here, the diabetologist could: be a source for advice and support; be responsible for governance of diabetes care; help separate the treatment pathways for type 1 and type 2 diabetes; contribute skills as a general physician and endocrinologist; and even look at helping to reduce the burden placed on primary care by the condition. This vision is worlds apart from the cynical system of Payment by Results, and could help eliminate the artificial dichotomy between primary and secondary care.

Table 2. Example weekly breakdown of a consultant team's hours in the proposed model.

Consultant	DCC*	SPA*
A	30	10
B	30	10
C	30	10
D	30	10
TOTAL	**120**	**40**

*Hours per week.

DCC=direct clinical care; SPA=supporting professional activities.

Going beyond artificial boundaries

The opportunity to redesign diabetes specialists' jobs is upon us and we must start to think about where things sit. With the *Five Year Forward View* talking about MSPs, there may come a time when acute trusts are no longer the default employers of diabetes specialists. If such opportunity for change does arise, the flexibility of choosing "3 out of 4" – within the ambit of an acute trust, a community provider or a GP federation – provides a means of improving job satisfaction and benefiting diabetes care wherever it is delivered.

The fundamentals are simple. They are flexibility, choice, and treating qualified professionals as adults, all of which could contribute to a happier workforce and in turn attract more trainees.

Consultants must never forget that the hospital is but a part of the community. And we must all remember the benefits of a team approach. In the words of the legendary basketball coach Phil Jackson: "The strength of the team is each individual member… the strength of each member is the team." ■

NHS England (2014) *Five Year Forward View.* NHS England, London. Available at: http://bit.ly/1rr78ja (accessed 21.05.15)

Send us your thoughts

The author and the journal are keen to hear how people working in primary care feel about this proposed idea. In particular, we would like to know what your views are on the following.

1 Would you value being able to approach your local consultants to get them to share some of their time on network education sessions and community clinics or to get their input into clinical commissioning group decision-making?

2 If so, how would you want to see this working?

Please email us your views at: **dpc@sbcommunicationsgroup.com**