

**Association of British Neurologists  
Services & Standards Committee  
Tuesday 25 January 2011  
Minutes**

1.

In attendance:

JG Llewelyn (Chair), K Reeves (ABN), Raeburn Forbes (Northern Ireland), Craig Heath (E Scotland), Lucy Kinton (Wessex), Jeremy Gibbs (Thames NE), M Manford (East Anglia), A Weir (Oxford), R Bosnell (Trainee rep), M Rosser (President Elect), Ralph Gregory (Hon assistant ABN Secretary), Dr N Fletcher (Mersey), J Quirk (LTFT rep), J Sussman (North West), P Mckee (Northern), R Grunewald (Trent), P Heywood (South West), O Malik (Thames NW), A Ming (Yorkshire), P Jarman (NHNN), Christopher Rickards (Wales).

Apologies received from: Heather Angus-Leppan, Brendan Davies

2.

Minutes of last meeting 13 May 2010

These were agreed. As matters arising, the job description for members of the SSC was agreed but it was noted that there some areas where the RSA was not the SSC member (OM and LK). KR to write to Patrick Cadigan at the RCP to correct this. KR to contact JS re circulating the audit of GP referrals mentioned in the last minutes for circulation.

3.

Update on "Local adult neurology services for the next decade" RCP/ABN report:

David Bateman and Steve Pollock joined the meeting. There was agreement that the vision for Neurology services set out in the document represents a desirable goal. There was discussion about a number of potential dangers: commissioners might take parts, out of context, as encouragement to dismantle services for people with LTNC, currently provided from secondary care, before alternative networks of care had been developed; the financial consequences of this for many centres could be very damaging. The role of urgent ambulatory care neurology clinics to improve care, reduce demand on A&E/MAUs and stabilise the finances of neurology departments was recognised, as was the need to agree mechanisms within acute trusts to credit neurology departments for the increasing amount of liaison neurology they were doing. SP and DB exhorted members of the SSC to go out and engage commissioners on the importance of commissioning acute care services in which patients with neurological problems received timely review by consultant neurologists.

It was agreed that the document which is "owned" by the RCP could not be altered further but that it would released with a communication summary which would address these issues.

4.

Consultant physicians working with patients 5<sup>th</sup> ed

Individual sections of this document has been updated by SSC members and sent to GL; these were reviewed. GL will integrate these and will submit directly to RCP given the tight time schedule. It was agreed that advice on job plans remained useful for neurologists to use in discussions with managers. The committee confirmed some specific recommendations: new op slot 30min, f.up slot 15 min, 0.5 pa admin/1 pa clinic, 45 min / ward consult. It also agreed that job plans should contain 1.5 SPA for core supporting activities (CME, audit, clin gov, revalidation); further SPA time (typically 1 PA) should be specifically justified by other activities (teaching, educational supervision, research, management...).

5.

Regional reports:

RB (Trainees):

Confirmed that thrombolysis service demands and their impact on juniors especially in London were the major issues fed back to her.

JQ (LTFT):

No new LTFT issues.

PH (SW):

Considerable pressure from PCT to reduce new:fu ratio. PH advised looking hard at supposed comparator figures: some low ratios may reflect a high level of inappropriate referrals or patterns of care in which people with LTNC are passed on to other centres.

OM (NW Thames):

Massive issues especially re juniors. The deanery is cutting the number of training posts; this and the demands of thrombolysis services are straining rotas (now full shift) and lowering morale. Separately the consultants are considering moving to an attending system.

PJ(NHNN):

The demands of running a HASU and the tPA service: trainees often busy away from the other roles and beds full. Their deanery has told them that they will lose 5 StR posts over the next 3 years.

MM(East Anglia):

The consultants are considering moving to an attending system. Integration with stroke service underway.

CR (Wales):

Problems getting any neurological input to some of the more remote DGHs (Aberystwyth, Haverfordwest). Telemedicine solution?

LK(Wessex):

Problems keeping their registrar rota an on-call pattern. Problems with trainees leaving at various points in the year when they were allowed to recruit once/year only.

AM (Yorkshire):

There were currently vacant consultant posts (Grimsby, Scunthorpe); consultant numbers were also likely to expand. Trainee difficulties accommodating lots of OOP; now improving. To keep middle grade rota OK more consultants first on call for periods. Neuro involvement in tPA varies widely across region; in his trust it was significant and leading to some unsustainable job plans (9DCC/1SPA).

NF (Mersey):

Major issue was tariff. Other developments: more satellite clinics in the community. Trial of community based generic neurology nurse specialists. Lots of work with PCT on demand management (referrals screened and some returned with a request for information and 5 page proforma). Because of uncertainty re future (what will demand be? "any willing provider"?) recruitment was currently nil.

JS (NW):

Current service model profitable. Trusts keen for more activity in A&E; funding unclear. ASU integrating with neurology with cross-covering middle grade rotas. They have implemented a demand management program focusing on high referring GPs. This has achieved a welcome 10% drop in referrals.

CH (Scotland E):

Some but not all vacancies are being replaced. Major reductions in number of trainees (1/3). 9:1 consultant contract in use for other physicians and likely to become an issue for neurologists as competition for posts increases.

RF(NI):

RVI problems from enforced 30% reduction in Neurology bed numbers. tPA having a big impact on registrars (40 calls per actual tPA use). Pressure for consultants to provide tPA service and ambulatory urgent clinics with no extra resource.

PM (N):

There are consultant vacancies; several locums in posts. Vacancies from retirement will be filled (driven by op demand). Losing one StR post; all StR posts currently filled (has been a problem).

RG (Trent):

Because of future uncertainty, 2 consultant positions have been filled by locums to maintain flexibility. Demands of HASU mean middle grade on call rota only just works; would not work if it becomes regional service.

AW (Oxford):

1 vacancy (Kettering). Pressure on follow up: new from some PCTs. Commissioners becoming worried about IVIG panel working.

6.

Updates on:

6.1 PBR & Neurology Tariff

NF explained that he saw this as the key issue for neurology in England in the coming year. OP activity is now at a sufficient volume to trigger the setting of a mandatory national tariff a part of Payment By Results. This had been proposed for 2011/12 but was not now going ahead because when "sense-checked" it was realised that it would have disastrous consequences for many centres. The non-mandatory tariff for 2011-12 was £217 for new and £120 for a follow up. There would be a mandatory tariff for 2012-13.

6.2 Manpower

MM: The Centre for workforce intelligence recommended no change in the current number of training posts. **Check with MM.**

6.3 Revalidation

JQ: The RCP continues to work with the GMC to try to simplify the process. Key elements will be enhanced appraisal, MSF, CPD and participation in high quality audit (1/5 years).

6.4 Quality outcome measures

OM: had attended a meeting with adult social services which was undergoing huge upheaval. Developments in the Quality Outcome Measure area were likely to come from the recently announced quality outcome framework and NICE quality standards.

6.5 Audit

PJ reported that the project to collect audits from neurology units around the country on the ABN website was not succeeding: the IT resources were not available to support the project and there seemed little enthusiasm from neurology departments. PJ had talked to Jonathan Potter (of the RCP Clinical Effectiveness and Evaluation Unit and HQIP). PJ described three levels of audit projects: National audits, multicentre audits (an approach much used by the British Thoracic Society) and local audit. A bidding process for further national audits (30 bids for 5 slots) was underway; perhaps NASH (National Audit of Seizures in Hospital – run from University of Liverpool) was a contender. PJ wondered whether the approach to multicentre audit used by the British Thoracic Society might be a useful model (intensive collection of data over a month to provide a snap shot). GL thought this still required very significant admin/IT support by the BTS; he would discuss with Council its appetite for this.

7.

Other business:

GL congratulated Andrew Weir on becoming SSC secretary.

GL suggested that the ABN website might be able to host patient information sheets.

ABN meeting Newcastle – session on service/standards. Thurs late am 1.5h slot. SSC members to email GL with ideas for this session.

8.

Date of next meeting will be during the ABN meeting in Newcastle in October. Date to be confirmed. It was agreed that 2 meetings were needed per year and could not take place via teleconference.

Andrew Weir  
Jan 2011